

Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in General Practice Residency

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**Commission on Dental Accreditation
401 North Michigan Avenue, Suite 3300
Chicago, Illinois 60611-4250
800-232-6108**

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GPR Standards

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Accreditation Standards for Advanced Dental Education Programs in General Practice Residency

Document Revision History

<u>Date</u>	<u>Item</u>	<u>Action</u>
August 5, 2022	Accreditation Standards for Advanced Dental Education Programs in General Practice Residency	Adopted and Implemented
August 11, 2023	Revised Accreditation Status Definitions	Adopted and Implemented
August 9, 2024	Revised Definitions of Terms and Standard 1-1 related to Sponsoring Institution and Authority to Operate	Adopted
January 1, 2025	Revised Definitions of Terms and Standard 1-1 Related to Sponsoring Institution and Authority to Operate	Implemented
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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and dental professions by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Commission on Dental Accreditation
Adopted: August 5, 2016; Revised August 6, 2021

Accreditation Status Definitions

Programs That Are Fully Operational

Approval (*without reporting requirements*): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval (*with reporting requirements*): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards or policies must be demonstrated within a timeframe not to exceed eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

Circumstances under which an extension for good cause would be granted include, but are not limited to:

- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

Revised: 8/17; 2/16; 5/12; 1/99; Reaffirmed: 8/23; 8/13; 8/10, 7/05; Adopted: 1/98

Programs That Are Not Fully Operational

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status. The developing education program must not enroll students/residents/fellows with advanced standing beyond its regularly enrolled cohort, while holding the accreditation status of “initial accreditation.”

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).

Revised: 8/23; 7/08; Reaffirmed: 8/18; 8/13; 8/10; Adopted: 2/02

Introduction

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in General Practice Residency for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

The standards identify those aspects of program structure and operation that the Commission regards as essential to program quality and achievement of program goals. They specify the minimum acceptable requirements for programs and provide guidance regarding alternative and preferred methods of meeting standards.

Although the standards are comprehensive and applicable to all institutions that offer advanced dental education programs in general dentistry programs, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession, and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in General Practice Residency provide an identifiable and characteristic core of required training and experience.

Goals

Advanced Dental Education Programs in General Practice Residency are educational programs designed to provide training beyond the level of pre-doctoral education in oral health care, using applied basic and behavioral sciences. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates' knowledge and skills to enable them to provide comprehensive oral health care to a wide range of population groups.

The goals of these programs should include preparation of the graduate to:

1. Act as a primary care provider for individuals and groups of patients. This includes: providing emergency and multidisciplinary comprehensive oral health care; providing patient focused care that is coordinated by the general practitioner; and directing health promotion and disease prevention activities.
2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively within the hospital and other health care environments.
5. Function effectively within interdisciplinary health care teams.
6. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making, and technology-based information retrieval systems.
7. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
8. Understand the oral health needs of communities and engage in community service.

Accreditation of One-Year and Two-Year GPR Programs

The Commission on Dental Accreditation will accredit the following types of General Practice Residency (GPR) programs: one-year programs, one-year programs with an optional second year of training where residents enroll for the second year of training during the first year, and two-year programs where residents enroll for two years at the beginning of the program. For programs offering an optional second year of training, accreditation of the program will be continued whether or not a resident is enrolled each year for the second year of training as long as there is enrollment of residents in the program's first year.

The addition of an optional second year of training to an existing one-year program will be considered as a major change to that program rather than as the development of a separate new program. Programs wishing to add an optional second year of training should contact Commission staff to acquire the appropriate forms for reporting a major change.

Definitions of Terms

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

Competencies: Written statements describing the levels of knowledge, skills, and values expected of residents completing the program.

Competent: The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

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

Goals and Objectives:

Program: Educational goals that describe what the resident will be able to do upon completion of the program. These should describe the resident's abilities rather than the educational experiences they participate in.

Resident Training: Educational goals describing the levels of knowledge, skills and values attained when a particular activity is accomplished.

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education, accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS), or receiving regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV).

HIPAA: Health Insurance Portability and Accountability Act

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

Interdisciplinary: Including dentistry and other health care professions.

Manage: Coordinate the delivery of care using a patient-focused approach within the scope of their training. Patient-focused care should include concepts related to the patient's social, cultural, behavioral, economic, medical and physical status.

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

Mirrored Patient Records: Records of actual patients prepared solely for training purposes.

Multidisciplinary: Including all disciplines within the profession of dentistry.

Must: Indicates an imperative or duty; an essential or indispensable item; mandatory.

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

Should: Indicates a method to achieve the standard; highly desirable, but not mandatory.

Sponsor: The institution that has the overall administrative control and responsibility for the conduct of the program.

Resident: The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.

STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

- 1-1** The program **must** be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution **must** be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) or receive regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV) process.

United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) **must** demonstrate successful achievement of Service-specific organizational inspection criteria.

Examples of evidence to demonstrate compliance may include:

Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization.

Evidence of successful achievement of Service-specific organizational inspection criteria

Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Evidence of successful achievement of regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV) process.

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

***Intent:** The educational program demonstrates either: a) documentation of receipt of federal aid as evidence to operate, or b) documentation of a state business license as evidence to operate. Additionally, as required by the state, the program demonstrates authority through an appropriate state agency when issuing a certificate of completion. If conferring a degree, the program demonstrates authorization from its institutional accrediting agency.*

Examples of evidence to demonstrate compliance may include:

State license or federal authority documenting the institution's approval to operate and confer

a credential.

Institutional accreditation indicating approval to confer a degree.

- 1-2** The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:

Written agreement(s)

Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

- 1-3** The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

- 1-4** The financial resources **must** be sufficient to support the program's stated purpose/mission, goals and objectives.

Examples of evidence to demonstrate compliance may include:

Program budgetary records

Budget information for previous, current and ensuing fiscal year

- 1-5** Arrangements with all sites not owned by the sponsoring institution where educational activity occurs **must** be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

***Intent:** Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).*

Examples of evidence to demonstrate compliance may include:

Written agreements

- 1-6** The medical staff bylaws, rules, and regulations of the sponsoring, co-sponsoring, or affiliated hospital **must** ensure that dental staff members are eligible for medical staff membership and privileges including the right to:

- a) vote and hold office;
- b) serve on medical staff committees; and
- c) manage patients.

***Intent:** Dental staff members have the same rights and privileges as other medical staff of the sponsoring, co-sponsoring or affiliated hospital, within the scope of practice.*

Examples of evidence to demonstrate compliance may include:

All hospital bylaws related to a, b, and c.

Copy of institutional committee structure and/or roster of membership by dental faculty

- 1-7** Dental residents **must** be appointed to the house staff of the sponsoring, co-sponsoring, or affiliated hospital and have the same privileges and responsibilities provided residents in other professional education programs.

Examples of evidence to demonstrate compliance may include:

House staff roster

Related hospital bylaws

- 1-8** The program **must** have written overall program goals and objectives that emphasize:

- a) general dentistry,
 - b) resident education,
 - c) patient care, and
 - d) community service and
- include training residents to provide oral health care in a hospital setting.

***Intent:** The “program” refers to the General Practice Residency that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standards 2-1, 2-2, 2-3 and 2-4. Specific learning objectives for residents are intended to be described as goals and objectives or competencies for resident training and included in the response to Standards 2-1, 2-2, 2-3, and 2-4. An example of overall goals can be found in the Goals section on page 8 of this document.*

The program is expected to define community service within the institution’s developed goals and objectives.

Examples of evidence to demonstrate compliance may include:

Written overall program goals and objectives

- 1-9** The program **must** have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s overall goals and objectives are being met and make program improvements based on an analysis of that data.

***Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-8 are being met.*

The outcomes process developed should include each of the following steps:

1. *development of clear, measurable goals and objectives consistent with the program's purpose/mission;*
2. *implementation of procedures for evaluating the extent to which the goals and objectives are met;*
3. *collection of data in an ongoing and systematic manner;*
4. *analysis of the data collected and sharing of the results with appropriate audiences;*
5. *identification and implementation of corrective actions to strengthen the program; and*
6. *review of the assessment plan, revision as appropriate, and continuation of the cyclical process.*

Examples of evidence to demonstrate compliance may include:

Written overall program goals and objectives

Outcomes assessment plan and measures

Outcomes results

Annual review of outcomes results

Meeting minutes where outcomes are discussed

Decisions based on outcomes results

Ethics and Professionalism

- 1-10** The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

***Intent:** Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*

STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

- 2-1** The program **must** provide didactic and clinical training to ensure that upon completion of training, the resident is able to:
- a) Act as a primary oral health care provider to include:
 - 1) providing emergency and multidisciplinary comprehensive oral health care;
 - 2) obtaining informed consent;
 - 3) functioning effectively within interdisciplinary health care teams, including consultation and referral;
 - 4) providing patient-focused care that is coordinated by the general practitioner; and
 - 5) directing health promotion and disease prevention activities.
 - b) Assess, diagnose, and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.
 - c) Manage the delivery of patient-focused oral health care.

Intent: “Patients with special needs” is defined in the Definition of Terms on page 10 of this document.

Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.

Examples of evidence to demonstrate compliance may include:

Written goals and objectives or competencies for resident training organized by the areas described above
Didactic and clinical schedules
Resident evaluations
Documentation of treatment planning sessions
Documentation of chart reviews
Records of resident clinical activity including procedures performed in each area described above
Documentation of case simulations

- 2-2** The program **must** have written goals and objectives or competencies for resident training and provide didactic and clinical training to ensure that upon completion of training the resident is able to provide the following at an advanced level of skill and/or case complexity beyond that accomplished in pre-doctoral training:
- a) operative dentistry;
 - b) restoration of the edentulous space;
 - c) periodontal therapy;

- d) endodontic therapy;
- e) oral surgery;
- f) evaluation and treatment of dental emergencies; and
- g) pain and anxiety control utilizing behavioral and/or pharmacological techniques.

***Intent:** Determination of “complexity beyond that accomplished in a pre-doctoral training” may be from various aspects including, but not limited to: depth of topic discussion, variety of topic/procedures, quantity of topics/procedures, underlying medical/health considerations related to delivery of topic/procedures, etc.*

Examples of evidence to demonstrate compliance may include:

Written goals and objectives or competencies for resident training organized by the areas described above
 Didactic and clinical schedules
 Records of resident clinical activity including procedures performed in each area described above
 Patient records
 Resident evaluations

- 2-3** The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions in dentistry and medicine, designed to achieve the written goals and objectives or competencies for resident training.

***Intent:** The program is expected to organize the didactic and clinical educational experience into a formal curriculum plan.*

For each specific goal or objective or competency described in response to Standard 2-1, 2-2, and 2-4, 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 written 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

- 2-4** The program **must** provide training to ensure that upon completion of the program, the resident is able to manage the following:

- a) medical emergencies;
- b) implants;
- c) oral mucosal diseases;
- d) temporomandibular disorder, and
- e) orofacial pain.

Intent: “Manage” is defined in the Definition of Terms on page 9 of this document.

The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident’s ability to manage the above areas.

Examples of evidence to demonstrate compliance may include:

Written goals and objectives or competencies for resident training and proficiencies organized by the areas described above
Didactic and clinical schedules
Records of resident clinical activity including procedures performed in each area described above
Patient records
Resident evaluations

2-5 Residents **must** be assigned to an anesthesia rotation with supervised practical experience in the following:

- a) preoperative evaluation;
- b) assessment of the effects of behavioral and pharmacologic techniques;
- c) venipuncture technique;
- d) patient monitoring;
- e) airway management;
- f) understanding of the use of pharmacologic agents;
- g) recognition and treatment of anesthetic emergencies; and
- h) assessment of patient recovery from anesthesia.

Intent: Program directors should interact with the anesthesia department to determine the rotation length and methods necessary to meet the requirements of the standard. Generally a minimum of 70 hours is considered to provide the appropriate practical experience.

Examples of evidence to demonstrate compliance may include:

Written rotation objectives
Rotation schedules including supervising faculty
Resident evaluations

2-6 Residents **must** be assigned to a rotation in medicine that has supervised practical experiences, to include:

- a) obtaining and interpreting the patient’s chief complaint, medical, and social history, and review of systems;
- b) obtaining and interpreting clinical and other diagnostic data from other health care providers;
- c) using the services of clinical, medical, and pathology laboratories; and

- d) performing a history and physical evaluation and collect other data in order to establish a medical assessment.

***Intent:** Program directors should interact with the relevant department to determine the rotation length and methods necessary to meet the requirements of the standard. Ideally, this rotation should be in a primary care setting. However, other medical settings that provide this experience are acceptable. Generally a minimum of 70 hours is considered to provide the appropriate practical experience.*

Examples of evidence to demonstrate compliance may include:

Written rotation objectives
Rotation schedules including supervising faculty
Resident evaluations

- 2-7** The program **must** provide formal instruction in physical evaluation and medical assessment, including:

- a) taking, recording, and interpreting a complete medical history;
- b) understanding the indications of and interpretations of laboratory studies and other techniques used in the diagnosis of oral and systemic diseases;
- c) understanding the relationship between oral health care and systemic diseases; and
- d) interpreting the physical evaluation performed by a physician with an understanding of how it impacts on proposed dental treatment.

***Intent:** Residents should be able to interact appropriately with other health care providers. It is intended that medical assessment be conducted during formal instruction as well as during in-patient, same day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and medical assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data is being recorded.*

Examples of evidence to demonstrate compliance may include:

Didactic schedules
Course outlines
Resident evaluations

- 2-8** 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

2-9 The program **must** provide instruction in the principles of practice management.

Intent: Suggested topics include: management of allied dental professionals and other office personnel; 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.

Examples of evidence to demonstrate compliance may include:

Course outlines

2-10 The program **must** provide residents with an understanding of hospital organization, functioning, and credentialing process.

Intent: Information about the credentialing process, application for privileges, and hospital records protocol is expected to be included in the curriculum.

Examples of evidence to demonstrate compliance may include:

Didactic schedules

2-11 Residents **must** receive training and experience in the management of inpatients or same-day surgery patients, including:

- a) reviewing medical histories and physical examinations;
- b) prescribing treatment and medication;
- c) providing care in the operating room; and
- d) preparing the patient record, including notation of medical history, review of physical examination, pre- and post-operative orders, and description of surgical procedures.

Intent: These experiences should occur in conjunction with patients receiving dental care in the hospital operating room, ambulatory surgery clinic, same-day surgery clinic, or a free-standing surgical center. Where this is not possible, the experiences may occur on other services providing care in the same settings. Clinical experiences are expected to be supervised by an attending faculty member.

Examples of evidence to demonstrate compliance may include:

Evidence of resident participation in the activities listed above and evidence of attending faculty supervision (for example, patient records, mirrored patient records, co-signature on chart notes, coverage schedule, or attending notes)

Record review policy

Documentation of record review

- 2-12** Formal patient care conferences **must** be scheduled at least twelve (12) times a year.

***Intent:** Conferences should be distributed throughout the year so that diagnosis, treatment planning, progress, and outcomes can be followed and discussed. These conferences should be attended by residents and faculty and should not replace the daily faculty and resident interactions regarding patient care.*

Examples of evidence to demonstrate compliance may include:

Conference schedules

- 2-13** 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.*

Examples of evidence to demonstrate compliance may include:

Evidence of experiences requiring literature review

Program Length

- 2-14** The program **must** be one or two calendar years in length.

Examples of evidence to demonstrate compliance may include:

Program schedules

Written curriculum plan

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

Examples of evidence to demonstrate compliance may include:

Written second year goals and objectives or competencies for resident training

Written curriculum plan

Schedules

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

Examples of evidence to demonstrate compliance may include:

Resident records or certificate

- 2-17** The program **must** have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program. The optional second year **must** include continuing experience in advanced general dentistry and may include more focused training and experience in other areas of dentistry or in treating select populations.

Intent: The optional second year will have continuing experiences in the areas of advanced general dentistry.

Examples of evidence to demonstrate compliance may include:

Written second year goals and objectives or competencies for resident didactic and clinical training

Written curriculum plan

- 2-18** 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 two years of study for a one-year program and four years of study for a two-year program.

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

- 2-19** The program's resident evaluation system **must** assure that, through the director and faculty, each program:

- a) periodically, but at least three times annually, evaluates and documents the resident's progress towards achieving the program's written goals and objectives or competencies for resident training 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 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.*

Examples of evidence to demonstrate compliance may include:

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

STANDARD 3 – FACULTY AND STAFF

- 3-1** The program **must** be administered by a director who has authority and responsibility for all aspects of the program.

Intent: The program director's responsibilities include:

- a) *program administration;*
- b) *development and implementation of the curriculum plan;*
- c) *ongoing evaluation of program content, faculty teaching and resident performance;*
- d) *evaluation of resident training and supervision in affiliated institutions and off-services rotations;*
- e) *maintenance of records related to the educational program; and*
- f) *resident selection.*

It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:

- 1) *what duties are assigned,*
- 2) *to whom they are assigned, and*
- 3) *what systems of communication are in place between the program director and individuals who have been assigned responsibilities.*

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:

Program director's job description

Job description of individuals who have been assigned some of the program director's job responsibilities

Formal plan for assignment of program director's job responsibilities as described above

Program records

- 3-2** Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, **must** have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.

Examples of evidence to demonstrate compliance may include:

Program director's completed BioSketch

- 3-3 For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.

Examples of evidence to demonstrate compliance may include:

Completed BioSketch for on-site clinical supervisor/director
Written criteria used to certify a non-specialist faculty member as responsible for a specialty teaching area

- 3-4 All sites where educational activity occurs **must** be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dentistry included in the program.

Intent: Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible (e.g., the faculty member responsible for endodontics is not required to be an endodontist. Instead, it could be someone with current knowledge and appropriate level of experience in endodontics). The faculty, collectively, should have competence in all areas of dentistry covered in the program.

The program is expected to develop written criteria and qualifications that would enable a faculty member to be responsible for a particular specialty teaching area if that faculty member is not a specialist in that area. The program is expected to evaluate non-specialist faculty members who will be responsible for a particular specialty teaching area and document that they meet the program's criteria and qualifications.

Whenever possible, programs should avail themselves of specialists as trained consultants for the development of a mission and curriculum, and for teaching.

Examples of evidence to demonstrate compliance may include:

Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Written criteria used to certify a non-specialist faculty member as responsible for a specialty teaching area
Records of program documentation that non-specialist faculty members as responsible for a specialty teaching area

- 3-5 General dentists **must** have a significant role in program development and instruction.

Intent: General dentists are expected to be actively involved in developing the curriculum and clinical rotations, as well as in the instruction of the residents.

Examples of evidence to demonstrate compliance may include:

Faculty meeting minutes
Faculty roster
Departmental policies
Completed BioSketch of faculty members

- 3-6** A formally defined evaluation process **must** exist that ensures measurement of the performance of faculty members annually.

***Intent:** The written annual performance evaluations should be shared with the faculty members.*

Examples of evidence to demonstrate compliance may include:

Faculty files
Performance appraisals

- 3-7** The program **must** show evidence of an ongoing faculty development process.

***Intent:** Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.*

Examples of evidence to demonstrate compliance may include:

Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

- 3-8** A faculty member **must** be present in the dental clinic for consultation, supervision and active teaching when residents are treating patients in scheduled clinic sessions.

***Intent:** This statement does not preclude the rare situation where a faculty member cannot be available. This Standard applies not only to clinic sessions, but to any location or situation where residents are treating patients in scheduled sessions.*

Examples of evidence to demonstrate compliance may include:

Faculty clinic schedules

3-9 At each site where educational activity occurs, adequate support staff **must** be consistently available to ensure:

- a) residents do not regularly perform the tasks of allied dental personnel and clerical staff,
- b) resident training and experience in the use of current concepts of oral health care delivery and
- c) efficient administration of the program.

***Intent:** This statement is meant to emphasize the importance of a well-balanced dental staff that can help address aspects of the delivery of dentistry and the business of dentistry. The areas that are considered current concepts would be scheduling, insurance, dental assisting, dental hygiene and lab procedures. The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives. Allied support may include dental assistants, dental hygienists, dental laboratory technicians and front desk personnel as needed.*

Examples of evidence to demonstrate compliance may include:

Staff schedules

3-10 The program **must** provide ongoing faculty calibration at all sites where educational activity occurs.

***Intent:** Faculty calibration should be defined by the program.*

Examples of evidence to demonstrate compliance may include:

Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared

STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

- 4-1 The sponsoring institution **must** provide adequate and appropriately maintained facilities and learning resources to support the goals and objectives of the program.

***Intent:** The facilities should permit the attainment of program goals and objectives. Residents should have access to equipment and well-equipped operatories in the dental clinic that permit utilization of current concepts of practice. Equipment, current medications and protocols for treating medical emergencies, dental intra-oral and extra-oral radiographic facilities, equipment for managing medical emergencies, and library resources that include dental resources should be available. Equipment for handling medical emergencies and current medications for treating medical emergencies should be readily accessible. “Readily accessible” does not necessarily mean directly in the dental clinic. Protocols for handling medical emergencies should be developed and communicated to all staff in patient care areas.*

Examples of evidence to demonstrate compliance may include:

Description of facilities

Selection of Residents

- 4-2 Applicants **must** have one of the following qualifications to be eligible to enter the advanced dental education program in general practice residency:
- a) Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;
 - b) Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and
 - c) Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.
- 4-3 Specific written criteria, policies and procedures **must** be followed when admitting residents.

***Intent:** Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.*

Examples of evidence to demonstrate compliance may include:

Written admission criteria, policies and procedures

- 4-4 Admission of residents with advanced standing **must** be based on the same standards of achievement required by residents regularly enrolled in the program. Residents with advanced standing **must** receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

Intent: Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant's past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing residents will not result in an increase of the program's approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for residents in the conventional program and be held to the same academic standards. Advanced standing residents, to be certified for completion, are expected to demonstrate the same standards of competence as those in the conventional program

Examples of evidence to demonstrate compliance may include:

Written policies and procedures on advanced standing

Results of appropriate qualifying examinations

Course equivalency or other measures to demonstrate equal scope and level of knowledge

4-5 The program's description of the educational experience to be provided **must** be available to program applicants and include:

- a) A description of the educational experience to be provided,
- b) A list of goals and objectives or competencies for resident training, and
- c) A description of the nature of assignments to other departments or institutions.

Intent: Programs are expected to make their lists of specific goals and objectives or competencies for resident training developed in response to Standards 2-1, 2-2, 2-3, and 2-4 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs to apply to. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

Examples of evidence to demonstrate compliance may include:

Brochure or application documents

Description of system for making information available to applicants who do not visit the program

Due Process

4-6 There **must** be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

Intent: Adjudication procedures should include institutional policy that provides due process for all individuals who may potentially be involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should

be provided with written information that affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the resident should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due process policy, and current accreditation status of the program.

Examples of evidence to demonstrate compliance may include:

Written policy statements and/or resident contract

Health Services

- 4-7** Residents, faculty and appropriate support staff **must** be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

Examples of evidence to demonstrate compliance may include:

Immunization policy and procedure documents

STANDARD 5 – PATIENT CARE SERVICES

- 5-1** The program must ensure the availability of adequate clinical patient experiences that afford all residents the opportunity to achieve the program’s written goals and objectives or competencies for resident training.

Examples of evidence to demonstrate compliance may include:

Written goals and objectives or competencies for resident training
Records of resident clinical activity, including specific details on the variety and type and quantity of cases treated and procedures performed
Description of the method used to monitor the adequacy of patient experiences available to the residents and corrective actions taken if one or more resident is not receiving adequate patient experiences

- 5-2** Patient records **must** be organized in a manner that facilitates ready access to essential data and be sufficiently legible and organized so that all users can readily interpret the contents.

***Intent:** Essential data is defined by the program and based on the information included in the record review process as well as that which meets the multidisciplinary educational needs of the program.*

The program is expected to develop a description of the contents and organization of patient records and a system for reviewing records.

Examples of evidence to demonstrate compliance may include:

Patient records
Record review plan
Documentation of record reviews

- 5-3** The program **must** conduct and involve residents in a structured system of continuous quality improvement for patient care.

***Intent:** Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.*

Examples of evidence to demonstrate compliance may include:

Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

- 5-4** All residents, faculty and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

***Intent:** ACLS and PALS are not a substitute for BLS certification.*

Examples of evidence to demonstrate compliance may include:

Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program
Exemption documentation for anyone who is medically or physically unable to perform such services

- 5-5** The program **must** document its compliance with the institution's policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies **must** be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases **must** be made available to applicants for admission and patients.

***Intent:** The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.*

Examples of evidence to demonstrate compliance may include:

Infection and biohazard control policies
Radiation policy

- 5-6** The program's policies **must** ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

Examples of evidence to demonstrate compliance may include:

Confidentiality policies