2028 Accreditation Standards for Dental Education Programs
Questions & Answers | October 2026

Q: When will updated self-study guides, most-cited standards, and interpretive resources be available?

The revised self-study report template for the 2028 standards has been developed and is being finalized for distribution. The goal is to make the self-study guide available to dental education programs by *January 1, 2027*. Programs should monitor the CODA website (coda.ada.org) for the official release of the template and any accompanying guidance documents.

It is planned to have the self-study report template refined over time. As programs begin working with the 2028 standards and clarifications are needed, the template and accompanying guidance are expected to be updated to reflect those clarifications.

Programs planning for a 2027 or 2028 site visit utilizing the revised standards should access the updated documents once released and contact the CODA office directly to confirm the timeline for resource availability and to obtain access to the Electronic Submission Portal.

The frequently cited standards document will be made available in accordance with CODA policies. Once the standards have been implemented in July 2028, the frequently cited standards documents will be created and updated once every year. CODA has indicated its intent to provide interpretive resources, including examples of evidence, to assist programs in preparation for site visits under the new standards.

Q: Site visitor training, calibration, and feedback mechanisms.

> ***How will CODA train site visitors to apply the revised standards consistently across schools with different educational models? Can site-team calibration efforts be more fully described? Will there be a method of grievance and feedback for programs if a site visit team's findings are out of alignment with expectations?***

CODA conducts site visitor training programs that are updated in conjunction with each major standards revision. Under the 2028 revised standards, site visitors will receive training that addresses the intent and application of the revised standards, with particular emphasis on areas that have been substantially restructured.

Regarding consistency across different educational models: the revised standards are designed to be outcome-focused rather than prescriptive about specific processes. Site visitors are expected to evaluate whether a program achieves the required outcomes, not whether it uses a particular delivery model. The self-study report and accompanying evidence documentation are the program's primary tools for demonstrating compliance, and well-documented programs are better positioned to address any interpretive differences.

Programs that believe site visit findings are inconsistent with the standards may use CODA's formal response process. Programs may provide feedback through the post-site visit surveys. Survey responses are reviewed frequently and individual comments on site visitors are reviewed annually through CODA’s site visitor reappointment process. Programs also may provide a response to its preliminary draft site visit report citing any factual inaccuracies and/or differences in perception. Responses to site visit reports are reviewed with the program’s preliminary draft site visit report by CODA’s discipline Review Committees and CODA.

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The CODA Policy Manual describes the procedures for responding to site visit reports and formal appeals for adverse actions. CODA has also encouraged programs to submit questions and interpretive concerns in advance of site visits by contacting the CODA office directly.

Standard 1-1: Institutional Effectiveness.

Q: What distinguishes an acceptable outcomes-assessment process from an insufficient one?

What will distinguish an acceptable outcomes-assessment process from an insufficient one under the revised standards, particularly regarding the use of student performance, graduate outcomes, and program data to document that curricular improvements are effective?

Standard 1-1 has three distinct requirements: (a) a mission statement and strategic plan that are regularly reviewed; (b) a broad-based, systematic, and continuous formal outcomes assessment process with measurable goals and objectives; and (c) active use of that data for program improvement.

The self-study template distinguishes between collecting data (1-1b) and using it to close the loop (1-1c). An insufficient process typically demonstrates one without the other: for example, programs that collect Competence Exams failure rates at the first attempt annually but are unable to show that a specific data finding led to a specific curriculum change.

Characteristics of an acceptable process include:

- Measurable benchmarks established in advance (not retrospectively applied)
- Multiple data streams: student performance data, graduation outcomes (e.g., licensure examination results), patient care data, surveys, and faculty/student feedback
- A defined review cycle with an identifiable oversight body and clear reporting lines
- Documented examples of actions taken as a result of data analysis, including implementation timeline and evidence that the action produced the expected improvement
- A mechanism for evaluating whether corrective actions were effective (re-assessment after the change)

The self-study report template requires a benchmark/results/action steps table for Standard 1-1c. This table is the primary evidence document and should contain multiple years of data. Programs should avoid presenting the same benchmark as 'met' every cycle without evidence of ongoing monitoring and any adjustment to benchmarks themselves over time.

Standard 2-4: Curriculum Management Plan.

Q-A through E: Curriculum mapping expectations and documentation

What level of curriculum mapping will CODA expect under the revised standards, particularly to demonstrate integration of biomedical, behavioral, and clinical sciences, and will CODA provide examples of sufficient documentation?

Standard 2-4 requires a curriculum management plan that ensures, among other elements, integration of biomedical, behavioral, and clinical science instruction (2-4e). The standard does not prescribe a

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specific mapping format, but the self-study template makes clear that the expectation is a documented, systematic process (not a one-time or informal review).

For integration specifically (2-4e), the narrative should describe where and how the three science domains intersect in the curriculum. Examples of sufficient documentation include:

- A curriculum matrix showing which courses address biomedical, behavioral, and clinical content, with integration highlighted at specific points
- Case studies or course descriptions demonstrating that clinical problems are taught with their biomedical basis (e.g., a caries management module that explicitly integrates microbiology, behavioral risk factors, and clinical assessment and management)
- Curriculum committee review reports that address integration gaps and how they were addressed

The standard for all six sub-elements (2-4 a–f) is the same: the program must demonstrate that its curriculum management plan actively ensures each element is ongoing. A curriculum map alone is insufficient if there is no evidence of ongoing review, identification of gaps, and response to findings.

Q-F: Documenting innovations: AI, digital dentistry, simulation, and alternative delivery models.

How should programs evaluate and document innovations (e.g., AI-supported learning, digital dentistry, simulation, and alternative clinical delivery models) within the revised standards, and when should schools consult CODA or submit a formal report before implementation?

Standard 2-4f requires the curriculum management plan to ensure the 'incorporation of emerging information and technologies.' This is an ongoing obligation, not a one-time adoption. The self-study should describe the process by which the program evaluates new technologies and integrates them into the curriculum, including the body responsible for review and the criteria used.

For documentation purposes, programs should be able to show:

- How emerging technologies are monitored and reviewed (e.g., a standing curriculum committee agenda item, faculty development programs on new technologies)
- The criteria used to evaluate a new technology for adoption (e.g., evidence base, educational value, patient safety, equity of student access)
- Examples of technologies recently incorporated, with the educational rationale

Regarding when to consult CODA or submit a formal report: CODA's policy on Reporting Program Changes (Policy Manual, coda.ada.org) specifies which changes require advance approval versus notification. Significant changes to clinical delivery models may constitute a substantive program change requiring CODA approval. When in doubt, programs should contact the CODA office for guidance before implementation.

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Standard 2-10: Social and Behavioral Sciences: Clinical Competency.

Q: How does CODA define 'cultural norms' and what constitutes demonstrated competence?

> ***Standard 2-10a: patient management, including considerations of cultural norms and interpersonal communication skills. How does CODA define 'cultural norms'? What would be examples of demonstrating competence in 'cultural norms'?***

The 2028 revised standards include a definition of cultural competence that provides the interpretive framework for this standard: 'Having the ability to provide care to patients with diverse backgrounds, values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers' understanding the relationship between diversity of culture, values, beliefs, behavior, and language and the needs of patients.'

In the context of Standard 2-10a, 'cultural norms' refers to the practices, values, and behaviors that shape how patients from different backgrounds understand illness, communicate with health care providers, make treatment decisions, and engage with the dental care system. A student demonstrating competence in this area would be expected to:

- Conduct a patient interview that elicits culturally relevant information about health beliefs and treatment preferences without making assumptions based on appearance or background
- Modify communication style to meet the patient's linguistic, literacy, and cultural needs (including appropriate use of interpreter services)
- Document cultural considerations in the treatment plan and adjust the care approach accordingly
- Demonstrate awareness of how cultural factors, including distrust of health systems, economic constraints, and family decision-making structures, may affect treatment acceptance and follow-through

Assessment instruments for Standard 2-10a should be designed to capture observable behaviors in actual or simulated clinical encounters, not merely knowledge of cultural differences. Faculty observation rubrics, standardized patient encounters, and reflective portfolios are all acceptable assessment modalities, provided the instrument evaluates performance in the context of patient care, consistent with the intent statement.

Standard 2-11: Breadth of Patient Experience

Q: What does 'treating' mean for pediatric and adolescent patients?

> ***For children and adolescent patient populations, how will site visitors interpret 'must have experience treating a broad spectrum of patients'? Does 'treating' include: restorative care for primary teeth, stainless steel crowns, exodontia, pulpotomy? For procedures that are difficult to ensure for all students, would observation or assisting be considered experiences? Simulation?***

Standard 2-11 requires programs to 'ensure that graduates have experience treating a broad spectrum of patients to include children, adolescents, adults, and geriatric patients, as defined by the program.' Two elements are notable: first, the word 'treating' (rather than 'observing'); second, the qualifying

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phrase 'as defined by the program,' which gives each program the authority to define its own age-group categories and to describe what constitutes adequate experience for each.

The standard does not enumerate specific procedures for pediatric patients. The key requirement is that every graduate must have direct care experience with each age group. Programs have significant latitude in defining what 'experience' means within each group, provided the definition is explicitly stated in program policy and consistently applied.

With respect to specific procedures for pediatric patients:

- **Restorative care / primary teeth:** Programs may define pediatric restorative experience broadly (e.g., any operative procedure on a primary tooth) or by specific procedure. The standard does not require specific procedures to demonstrate compliance, i.e., stainless steel crowns or pulpotomies specifically.
- Please be reminded that there is an expectation that graduates have experience treating patients across all age groups (child, adolescent, adult, and geriatric), and each school has the capacity of defining each of those terms.
- **Observation and assisting:** These do not constitute 'treating' under any reasonable reading of the standard. Observation alone is not sufficient for compliance.
- **Simulation:** Standard 2-11 requires 'experience treating' patients, which implies real patients. Simulation alone is not consistent with the plain language of this standard. However, simulation may supplement direct experience and may be useful for skills preparation. Note that Standard 2-15's 50% direct patient assessment rule applies to competency demonstration, not to experience under 2-11.

Programs should note that CODA has historically evaluated compliance with 2-11 holistically, site visitors look at the program's documented policy, the data on actual student patient experiences, and whether the program has systems to track and verify compliance. It is important to emphasize that CODA does not evaluate compliance by counting the number of pediatric patients alone, site visitors also examine the oral health care that was actually provided to those patients. The nature and breadth of the treatment rendered across age groups is a central part of the review.

Standard 2-14: Patient-Based Instruction and Experiences

Q: Orofacial pain conditions in 2-14a(2).

> ***Standard 2-14a(2): Comprehensive clinical examination, including radiographic examination and temporomandibular disorders and orofacial pain conditions. What does CODA expect in terms of patient experiences in orofacial pain conditions?***

The 2028 revised standards explicitly added 'temporomandibular disorders and orofacial pain conditions' to the comprehensive clinical examination requirement in both Standards 2-13 and 2-14. This reflects the growing recognition that orofacial pain assessment is a core component of the comprehensive examination for every patient, not a specialty referral skill.

For Standard 2-14, the expectation is that students perform direct patient-based history taking and examination that includes a structured TMD/orofacial pain screening for each patient. This does not require students to manage complex chronic orofacial pain as a primary provider, that level of management is addressed in Standard 2-13 instruction. Rather, programs should demonstrate that

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students are trained to screen for TMD and orofacial pain as part of every comprehensive examination, document findings, and make appropriate referrals.

Evidence that will satisfy this requirement includes: documentation that the clinic's standard examination form includes a structured TMD/orofacial pain screening component; clinical instruction confirming this is part of the comprehensive examination; and patient records showing students complete this component consistently.

Q: Definition of 'pulpal therapy' in Standard 2-14b(6)

> ***Standard 2-14b(6): Endodontics, to include pulpal therapy and non-surgical root canal therapy. How is 'pulpal therapy' defined? Does it include vital pulp therapy (e.g., indirect pulp capping, direct pulp capping)?***

The 2028 revised standards distinguish between 'pulpal therapy' and 'non-surgical root canal therapy' as distinct items within the endodontics requirement in both Standards 2-13 and 2-14. Note that Standard 2-13 (instruction) additionally includes 'endodontic retreatment,' which is not required in 2-14 (patient-based experience).

The term 'pulpal therapy' is broader than root canal therapy and encompasses procedures directed at maintaining pulp vitality or managing pulpal disease short of complete pulp extirpation.

Q: Interceptive orthodontic therapy in Standard 2-14b(9).

> ***Standard 2-14b(9): Orthodontics, to include diagnosis of malocclusion and interceptive therapy. What is included under 'interceptive therapy'? Can this experience be observational?***

Interceptive orthodontic therapy refers to early orthodontic interventions performed during the mixed dentition phase to prevent, redirect, or correct a developing malocclusion. In the context of a general dentistry predoctoral curriculum, this typically includes:

- Space maintenance
- Space regaining following premature primary tooth loss
- Habit appliances
- Simple removable appliances for minor tooth movement

Observation alone does not constitute 'experience' under Standard 2-14. However, programs have flexibility in how they structure this experience. Programs may also satisfy this requirement through structured rotations to orthodontic departments or community partners where students serve as the provider of record for the diagnosed treatment.

Q: Pharmacologic anxiety management in Standard 2-14b(11)

> ***Standard 2-14b(11): Management of Anxiety, to include pharmacologic and non-pharmacologic approaches. Is nitrous oxide sufficient as a pharmacologic agent?***

The 2028 revised standards require patient-based experience in anxiety management including both pharmacologic and non-pharmacologic approaches. Nitrous oxide inhalation sedation is a pharmacologic agent and is generally considered sufficient to meet the pharmacologic component of this requirement in the predoctoral general dentistry context.

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Programs should ensure the self-study documentation describes: (1) the specific pharmacologic agents or modalities used (e.g., nitrous oxide, oral premedication if permitted by state law and scope), (2) how students acquire and demonstrate clinical competency with each agent.

Note that Standard 2-13 instruction requires coverage of the full range of pharmacologic and non-pharmacologic approaches at an in-depth level. The distinction between 2-13 (instruction) and 2-14 (patient-based experience) is measured: patient-based experience requirements are met by direct student use of the modalities within the program's clinical scope.

Q: Infection 'prevention' vs. 'control' in Standard 2-14c(6)

> ***Standard 2-14c(6): infection prevention and control practices. Is there a difference between infection 'prevention' and 'control' practices?***

The phrasing 'infection prevention and control' in the 2028 revised standards is consistent with contemporary usage in health care settings and does not create a meaningful distinction between two separate concepts. The Centers for Disease Control and Prevention (CDC) and OSHA use 'infection prevention and control' (or IPC) as a unified term describing the set of practices designed to prevent transmission of microorganisms between patients and health care workers.

In the context of Standard 2-14c(6), the expectation is that students demonstrate competency in the full scope of IPC practices in the clinical setting, including: standard precautions, PPE use and donning/doffing, surface disinfection, sharps handling, etc. Programs should ensure their clinical competency assessment for this item captures the breadth of these practices, not merely one component.

Q: Demonstrating breadth and depth of clinical experience given patient availability challenges

> ***How should programs demonstrate that students receive an appropriate breadth and depth of clinical experience while meeting competency expectations, especially when patient availability, case complexity, or access to particular procedures varies across clinical sites?***

This question goes to the center of the relationship between Standards 2-14 (patient-based experience) and 2-15 (competency demonstration). The 2028 revised standards were intentionally designed to give programs flexibility in how they achieve required outcomes while maintaining clear expectations about what those outcomes are.

The primary documentary tools for demonstrating compliance are:

- The clinical experience table required by Standard 2-14: programs must report the class average, minimum, and maximum numbers for each category and numbered item for the last two graduating classes. This data, rather than policies alone, is what site visitors will assess for breadth.
- The competency compliance table required by Standard 2-15: this table maps each numbered subcategory to its assessment method and demonstrates that the 50% direct patient threshold is met within each of the three categories.
- The program's clinical requirements document: this should explicitly state the program's expectations for each category, not just totals, and describe how minimums are enforced.
- Tracking and verification documentation: programs must describe how they track individual student progress and intervene when a student is not on pace to complete requirements.

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- Please be reminded that students must be provided with appropriate patient clinical experiences.

Standard 2-15: Graduate Competency Demonstration

Q: When 2-15 drops 'including...' language present in 2-13 and 2-14, does that reduce the competency scope?

> ***If a competency standard drops the ', including...' language mentioned in 2-13 and 2-14, does that mean that it is NOT required to the level of competence? In some cases this would make sense (e.g., dropping implant 'placement'), whereas in others it would not (e.g., dropping 'including radiographic interpretation' from 'comprehensive clinical examination'). How will site visitors interpret this?***

This is one of the most important structural questions raised by the 2028 standards, and the answer requires careful attention to the relationship between the three new clinical standards.

The deliberate design principle is: Standard 2-13 defines the full scope of in-depth instruction; Standard 2-14 defines the direct patient care experiences required; Standard 2-15 defines what graduates must demonstrate at the competency level. Each standard's scope was tailored to what is appropriate for each function.

Where 2-15 drops sub-items from 2-14 language, the intent is that the narrower scope represents what CODA considers a competency-level requirement for general dentistry graduates. Two examples clarify the principle:

- **Implant placement (narrowed in 2-15):** Standard 2-14 requires patient experience in 'treatment planning, restoration, and maintenance of dental implants.' Standard 2-15 narrows this to 'restoration of dental implants' only. This is intentional, implant placement is beyond the expected competency for a general dentist at graduation; instruction and exposure (2-13/2-14) are required, but competency assessment at graduation is scoped to restoration and maintenance.
- **Comprehensive clinical examination (scope retained even if language is slightly shortened):** Where 2-15a(2) states 'comprehensive clinical examination' without restating every sub-element listed in 2-14, this should not be interpreted as eliminating radiographic interpretation or TMD/orofacial pain screening from the competency expectation. The definition of 'clinical examination' in the standards explicitly includes radiographic, TMD, and orofacial pain components. Programs should assess competency in the full scope of the clinical examination as defined.

The general principle: where 2-15 language differs from 2-14 by omitting specific sub-items for clinical procedures (implant placement, endodontic retreatment, surgical periodontics), the narrowing is intentional and reflects what CODA considers appropriate for general dentistry graduate competency. Where 2-15 language is shorter but the standard refers to the same clinical function (comprehensive examination, informed consent), programs should apply the full functional scope as defined in the standards document.

Q: Must patient experiences precede competency examinations that are not patient-based?

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Can you clarify whether patient experiences must come before the competency exam, specifically when the exam is not patient-based? This seems like an assumption held by some site visitors, but it is not written in the standards.

Patient experiences must precede competency assessment. The self-study's Assessment Framework response for Standard 2-15 requires programs to address how students are prepared for each competency examination, including the role of prior patient experience in readiness determination. This readiness determination is grounded in prior patient-based experience, programs must be able to demonstrate that students have had the relevant patient experience before challenging competency assessment.

The expectation in Standard 2-14 is that patient-based instruction and experiences occur; the requirement in Standard 2-15 is that graduates demonstrate competency. These two standards work together sequentially: 2-14 experiences build the foundation, and 2-15 assessment confirms that graduates have achieved competency based on that foundation.

Programs should document in the self-study how their curriculum sequence ensures that students complete relevant patient-based experience before each competency examination, and how readiness for competency assessment is determined. This documentation is a core component of the Standard 2-15 Assessment Framework response.

Q: Competency expectations for recall strategies based on oral-systemic health status (2-15c(7))

Standard 2-15c(7): 'recall strategies based on patient-centered risk assessment, treatment outcomes, and oral-systemic health status.' What are the expectations for competency in strategies based on oral-systemic health status?

Standard 2-15c(7) was updated in the 2028 revised standards to explicitly include 'oral-systemic health status' in recall strategy planning. This reflects the increasing evidence base for the relationship between oral health and systemic conditions (cardiovascular disease, diabetes, pregnancy complications, etc.).

At the competency level, graduates are expected to demonstrate the ability to incorporate oral-systemic health considerations into recall interval decisions. This means going beyond caries and periodontal risk to include:

- Recognizing that patients with certain systemic conditions (e.g., diabetes, immunosuppression, osteoporosis) may require modified recall intervals or additional monitoring
- Incorporating relevant medical history into the documentation of a recall plan
- Communicating with other members of the health care team where oral-systemic health intersects (connecting to the intra- and inter-professional collaboration requirements in Standards 2-9 and 2-10)

Programs should ensure that their recall strategy competency assessment instrument includes an oral-systemic health status component. A rubric that addresses only caries and periodontal risk without systemic integration may not fully capture the Standard 2-15c(7) requirement.

Q: What evidence will site visitors expect for competency demonstration, and how much flexibility in assessment methods?

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Given the revised standards' increased emphasis on competency statements, what evidence will site visitors expect to demonstrate that each student has achieved competence, and how much flexibility will programs have in choosing assessment methods, benchmarks, and remediation processes?

The 2028 revised standards preserve significant program flexibility in the design of competency assessment systems while establishing clear minimum requirements. The primary evidence documents required by the self-study template are:

- A competency compliance table (Standard 2-15) showing each numbered subcategory, the assessment method (direct patient vs. equivalent assessment), and that the 50% direct patient threshold is met within each of categories a, b, and c
- Competency assessment instruments for each category, including how passing standards are defined
- First-attempt pass rate data for all competency examinations by category, for the last two graduating classes
- A graduation competency verification process description demonstrating that individual student completion is confirmed before graduation is approved

Programs have flexibility in the assessment method for each item (provided the 50% direct patient threshold is met per category), in defining passing benchmarks appropriate to each competency, and in designing remediation processes. What is required is that these are defined, documented, and consistently applied and that data on outcomes is tracked and reported. The standards are outcome-focused: site visitors will assess whether the program's system produces graduates who can demonstrate the required competencies, not whether a particular assessment format was used.

Standard 5-10: External Site Compliance

Q: Sites where student procedures are not 'credited' toward graduation: do they trigger Standard 5-10?

We have external community sites where our students rotate and provide treatment to patients, but individual procedures are not counted towards their course grade or any graduation requirements. Would these external sites be excluded under this standard?

Standard 5-10 applies to 'external sites not owned and/or operated by the dental school and where patient experiences are credited for graduation and/or where competency is assessed.' The triggering condition has two prongs: either (1) patient experiences credited for graduation, or (2) competency is assessed.

The critical interpretive question is what 'credited for graduation' represents. A strong reading of the standard focuses on whether the clinical activity at the site is part of the program's required educational experience that students must complete to graduate, rather than whether individual procedure counts from that site are logged in a tracking system. Under this reading, a required rotation counts even if individual procedures are not tallied toward a graduation number.

If a rotation is truly elective and participation has no impact on graduation, and no competency assessment occurs at that site, then the site would likely fall outside the 5-10 trigger. However, programs should be cautious: if students have obligations to complete rotation hours at a site, or if the

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rotation is part of the clinical program sequence (even without procedural counting), site visitors may consider that as experience 'credited' toward graduation in the broader educational sense.

Programs should also note that regardless of Standard 5-10, Standard 4-5 (written agreements) applies to any external site where required educational activity occurs: a broader trigger than 5-10. If a rotation is 'required educational activity' for Standard 4-5 purposes, it needs a written agreement even if 5-10 does not fully apply.

Q: Do Standard 5-10 requirements apply to dental hygiene and GPR residents at external sites?

> ***We have external sites where our dental hygiene and GPR residents but not our predoctoral students provide treatment counted toward graduation requirements. DH standards have their own requirements for extended campus facilities that do not specify all of the 5-10 requirements. Do these Standard 5-10 requirements apply to DH students and residency programs?***

Standard 5-10 appears in the Accreditation Standards for Dental Education Programs (DDS/DMD), which govern predoctoral dental education. It does not directly govern dental hygiene programs or postdoctoral residency programs, which have their own separate CODA accreditation standards. The DH Standards have distinct requirements for extended campus facilities, and the CODA Advanced Dental Education Standards govern GPR programs separately.

For the purposes of a predoctoral self-study, Standard 5-10 applies only to external sites where predoctoral students' patient experiences are credited for graduation or where predoctoral student competency is assessed. Sites used exclusively by DH or GPR programs, where no predoctoral students receive credited patient experiences, would not be required to meet Standard 5-10 in the predoctoral self-study.

Standard 6-2: Evidence of Faculty Research

Q: Will programs be expected to show evidence of research for ALL faculty?

> ***The standard leaves room for interpretation, but the intent indicates that not all faculty are expected to engage in research. Because programs are held to the standard and not the intent, we would like assurance that we will not be expected to show evidence of research for all faculty with appointments in the dental school.***

Standard 6-2 requires the dental school to 'demonstrate evidence of research by faculty who have appointments in the dental school.' The intent statement provides important context: 'While not all faculty are expected to engage in research, the dental school employs dental faculty with time dedicated and allocated to the research mission of the dental school.' The 2028 revised standards added the phrase 'with time dedicated and allocated to the research mission', a meaningful clarification that the research expectation applies to faculty who have research as part of their assignment of duties/contract.

The question correctly identifies a potential interpretive tension. The answer, grounded in the standard's text and intent together, is that programs are NOT expected to demonstrate research activity for every faculty member. The standard requires the school to demonstrate that:

- Research is an integral component of the school's mission (Standard 6-1)

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- The school employs faculty with research appointments, i.e., faculty whose duties include dedicated research time
- Those faculty with research duties demonstrate evidence of actual research activity (publications, presentations, funded projects, scholarly productivity)

Programs should document clearly in the self-study which faculty have research as a component of their assignment of duties (FTE allocated to research), and present evidence of scholarly productivity specifically for those faculty. The self-study should not be construed as requiring a complete publication list for every clinician-educator on the faculty.

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