

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency) be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 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_8iBzregPEo1y1Ei

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency)

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery

Commission on Dental Accreditation

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Chicago, Illinois 60611

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<https://coda.ada.org/>

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Commission on Dental Accreditation

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Proposed Revisions to Oral and Maxillofacial Surgery (Residency) Standards
CODA Summer 2023

Document Revision History

Date	Item	Action
February 12, 2021	Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery	Adopted and Implemented
February 12, 2021	Revised Standards 4-4 and 4-6 through 4-8; Deletion of Standard 4-6.1; and Addition of 4-8.2 and 4-18 through 4-20	Adopted
August 6, 2021	Revised Mission Statement	Adopted
January 1, 2022	Revised Standards 4-4 and 4-6 through 4-8; Deletion of Standard 4-6.1; and Addition of 4-8.2 and 4-18 through 4-20	Implemented
January 1, 2022	Revised Mission Statement	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: 8/18; 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.

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

Other Accreditation Actions:

Teach-Out: An action taken by the Commission on Dental Accreditation to notify an accredited program and the communities of interest that the program is in the process of voluntarily terminating its accreditation due to a planned discontinuance or program closure. The Commission monitors the program until students/residents who matriculated into the program prior to the reported discontinuance or closure effective date are no longer enrolled.

Reaffirmed: 8/18; Adopted: 2/16

Discontinued: An action taken by the Commission on Dental Accreditation to affirm a program’s reported discontinuance effective date or planned closure date and to remove a program from the Commission’s accredited program listing, when a program either 1) voluntarily discontinues its participation in the accreditation program and no longer enrolls students/residents who matriculated prior to the program’s reported discontinuance effective date or 2) is closed by the sponsoring institution.

Intent to Withdraw: A formal warning utilized by the Commission on Dental Accreditation to notify an accredited program and the communities of interest that the program’s accreditation will be withdrawn if compliance with accreditation standards or policies cannot be demonstrated by a specified date. The warning is usually for a six-month period, unless the Commission extends for good cause. The Commission advises programs that the intent to withdraw accreditation may have legal implications for the program and suggests that the institution’s legal counsel be consulted regarding how and when to advise applicants and students of the Commission’s accreditation actions. The Commission reserves the right to require a period of non-enrollment for programs that have been issued the Intent to Withdraw warning.

Revised: 2/16; 8/13; Reaffirmed: 8/18

Withdraw: An action taken by the Commission when a program has been unable to demonstrate compliance with the accreditation standards or policies within the time period specified. A final action to withdraw accreditation is communicated to the program and announced to the communities of interest. A statement summarizing the reasons for the Commission’s decision and comments, if any, that the affected program has made with regard to this decision, is available upon request from the Commission office. Upon withdrawal of accreditation by the Commission, the program is no longer recognized by the United States Department of Education. In the event the Commission withdraws accreditation from a program, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program, will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission accredited program. Such graduates may be ineligible for certification/licensure examinations.

Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9

Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

Reaffirmed: 8/18; 8/13; Adopted: 8/11

Preface

Maintaining and improving the quality of advanced dental education programs is a primary aim of the Commission on Dental Accreditation. The Commission is recognized by the public, the profession and the United States Department of Education as the specialized accrediting agency in dentistry.

Accreditation of advanced dental education programs is a voluntary effort of all parties involved. The process of accreditation ensures residents, the dental profession, specialty boards and the public that accredited training programs are in compliance with published standards.

Accreditation is extended to institutions offering acceptable programs in the disciplines of advanced dental education: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, advanced education in general dentistry, general practice residency, dental anesthesiology, oral medicine, and orofacial pain. Program accreditation will be withdrawn when the training program no longer conforms to the standards as specified in this document, when all first-year positions remain vacant for a period of two years or when a program fails to respond to requests for program information. Exceptions for non-enrollment may be made by the Commission for programs with “approval without reporting requirements” status upon receipt of a formal request from an institution stating reasons why the status of the program should not be withdrawn.

Advanced dental education may be offered on either a certificate-only or certificate and degree-granting basis.

Accreditation actions by the Commission on Dental Accreditation are based upon information gained through written submissions by program directors and evaluations made on site by assigned site visitors. The Commission has established review committees to review site visit and progress reports and make recommendations to the Commission. Review committees are composed of representatives nominated by dental organizations and nationally accepted certifying boards. The Commission has the ultimate responsibility for determining a program’s accreditation status. The Commission is also responsible for adjudication of appeals of adverse decisions and has established policies and procedures for appeal. A copy of policies and procedures may be obtained from the Director, Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, Illinois 60611.

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all disciplines of advanced dental education, institutions and programs. Each discipline develops discipline-specific standards for educational programs in its discipline. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the

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standards for the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.

As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status.

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).

Definitions of Terms Used in Oral and Maxillofacial Surgery Accreditation Standards

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

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

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

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

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

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

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

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

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

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

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

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

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

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program recognized by the American Dental Association.

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

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

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

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

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

*Epstein, R.M. (2007) *Assessment in Medical Education*. The New England Journal of Medicine, 387-96.

Oral and Maxillofacial Surgery Terms:

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Oral and maxillofacial surgery teaching service: that service in which the resident plays the primary role in the admission, management and/or discharge of patients.

General anesthesia: is a controlled state of unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or combination thereof.

Deep sedation: is a controlled state of depressed consciousness, accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to verbal command, and is produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

Board Certified: as defined by the American Board of Oral and Maxillofacial Surgery.

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

The program **must** develop clearly stated goals and objectives appropriate to advanced dental education, addressing education, patient care, research and service. Planning for, evaluation of and improvement of educational quality for the program **must** be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.

The program **must** document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced dental education resident achievement.

- 1-1 The program must document success of graduates in obtaining American Board of Oral and Maxillofacial Surgery certification.**
- 1-2 The program must document participation in a national, standardized and psychometrically validated in-service examination.**

Example of Evidence to demonstrate compliance may include:

- OMSITE

***Intent:** The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of oral and maxillofacial surgery and that one of the program goals is to comprehensively prepare competent individuals to initially practice oral and maxillofacial surgery. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program's purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f) review the assessment plan, revise as appropriate, and continue the cyclical process.*

Example of Evidence to demonstrate compliance may include:

- OMSITE

1-3 The program must document ongoing structured use of a standardized educational curriculum.

Examples of evidence to demonstrate compliance may include:

- Consistent use of a structured curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.
- Conference schedule including This Week In SCORE(TWIS)

The financial resources **must** be sufficient to support the program's stated goals and objectives.

***Intent:** The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment, procure supplies, reference material and teaching aids as reflected in annual budget appropriations. Financial allocations should ensure that the program will be in a competitive position to recruit and retain qualified faculty and residents. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the advanced dental education discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.*

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

Advanced dental education programs **must** be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced dental education programs **must** ensure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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.

The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters **must** rest within the sponsoring institution. The institution/program **must** have a formal system of quality assurance for programs that provide patient care.

The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director **must** have the authority, responsibility and privileges necessary to manage the program.

1-31-4 There must be adequate bed availability to provide for the required number of patient admissions and appropriate independent care by the oral and maxillofacial surgery service.

1-41-5 Oral and maxillofacial surgeons who are members of the teaching staff participating in an accredited educational program must be eligible to practice the full scope of the advanced dental education discipline in accordance with their training, experience and demonstrated competence.

Examples of evidence to demonstrate compliance may include:

- Details of bylaws and credentialing process that document that oral and maxillofacial surgeons are allowed to practice those aspects of the advanced dental education discipline for which they have documented evidence of training and experience
- List of procedures performed that show scope, and/or hospital privileges list

1-51-6 The educational mission must not be compromised by a reliance on residents to fulfill institutional service, teaching or research obligations. Resources and time must be provided for the proper achievement of educational obligations.

Intent: All resident activities have redeeming educational value. Some teaching experience is part of a residents training, but the degree to which it is done should not abuse its educational value to the resident.

Examples of evidence to demonstrate compliance may include:

- Clinic assignment schedule

USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

The primary sponsor of the educational program **must** accept full responsibility for the quality of education provided in all sites where educational activity occurs.

1-61-7 All arrangements with major and minor activity sites, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

Intent: Ownership may entail clinical operations, and not necessarily the physical facility.

1-71-8 Documentary evidence of agreements, for major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

- a. Designation of a single program director;
- b. The teaching staff;
- c. The educational objectives of the program;
- d. The period of assignment of residents; and
- e. Each institution's financial commitment

Intent: An “institution (or organizational unit of an institution)” is defined as a dental, medical or public health school, patient care facility, or other entity (e.g., OMS practice facility) that engages in advanced dental education. The items that are covered in inter-institutional 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).

1-81-9 Rotations to an affiliated institution which sponsors its own accredited oral and maxillofacial surgery residency program must not exceed 26 weeks in duration.

1-91-10 All standards in this document must apply to training provided in affiliated institutions.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Accreditation of Off-Campus Sites found in the Evaluation and Operational Policies and Procedures manual (EOPP).

1-11 The program and sponsoring institution's collaborative responsibilities must include an ongoing effort for recruitment and retention of a diverse and inclusive workforce of faculty, residents and staff.

Examples of evidence to demonstrate compliance may include:

- Nondiscriminatory policies and practices at all organizational levels.
- Mission and policy statements which promote diversity and inclusion.
- Evidence of training in diversity, inclusion, equity, and belonging.

STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, **must** be board certified.)

***Intent:** The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.*

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.

Documentation of all program activities **must** be ensured by the program director and available for review.

2-1 Program Director: The program must be directed by a single responsible individual who is a full time faculty member as defined by the institution.

***Intent:** Other activities do not dilute a program director's ability to discharge his/her primary obligations to the educational program.*

The responsibilities of the program director must include:

2-1.1 Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.

2-1.2 Ensuring the provision of adequate physical facilities for the educational process.

2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff. This must include documentation of evaluation of the members of the teaching staff by the residents at least annually.

Intent: In some situations, the evaluation of the teaching staff may be performed by the chairman of the department of oral and maxillofacial surgery in conjunction with the program director.

2-1.4 Responsibility for adequate educational resource materials for education of the residents, including access to an adequate health science library and electronic reference sources.

Examples of evidence to demonstrate compliance may include:

- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

2-1.5 Responsibility for selection of residents and ensuring that all appointed residents meet the minimum eligibility requirements, unless the program is sponsored by a federal service utilizing a centralized resident selection process.

2-1.6 Maintenance of appropriate records of the program, including resident and patient statistics, institutional agreements, and resident records.

Examples of evidence to demonstrate compliance may include:

- Copies of faculty meeting minutes
- Sign-in sheets
- Monthly records of outpatient visits by category
- Resident surgical logs/other electronic record databases
- Evaluations of teaching staff

2-1.7 The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

Intent: The program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, residents, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, residents, and staff, open communication, leadership, and scholarship.

Examples of evidence to demonstrate compliance may include:

- Established policies regarding ethical behavior by faculty, staff and residents that are regularly reviewed and readily available
- Resident, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities
- Focus groups and/or surveys directed towards gathering information on resident, faculty, patient, and alumni perceptions of the cultural environment

2-1.8 The program director and teaching staff must lead by example in all aspects of professionalism.

Intent: The purpose of the program's culture and environment is to promote excellence in safe, high-quality care, preparing residents for lifetime learning and a successful future professional life. Practices and policies that exemplify faculty well-being and promote resident well-being in a humanistic environment, while not compromising on quality and safety, create the optimal culture and environment. Professionalism, integrity, and an open culture; where problems can be raised and solved as a team, allow for progress and flexibility while promoting a shared responsibility of all involved to create and maintain an optimal educational environment. Program directors' and teaching staff model, at all times, excellence in patient care, demonstrated by safe and compassionate clinical practice, integrity in their approach to service and scholarly activity, respect for others, especially residents, in their efforts to assure an optimal educational environment.

Examples of evidence to demonstrate compliance may include:

- Written evaluations from faculty and the chair of the program director and teaching staff.
- Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.
- External evaluations of culture, climate, and learning environment.
- Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation.

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- Policies and requirements that promote an optimal educational experience, working culture and environment.

2-1.9 Lines of communication must be established and ongoing within the program to address culture concerns without the fear of retaliation.

Examples of evidence to demonstrate compliance may include:

- Written evaluations from faculty that occur at least twice a year.
- Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.
- Anonymous evaluations of culture, climate, and learning environment.
- Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation.
- Policies and requirements that promote an optimal educational experience, working culture and environment.

2-2 Teaching Staff: The teaching staff must be of adequate size and must provide for the following:

2-2.1 Provide direct supervision in all patient care settings appropriate to a resident's competence and level of training.

Intent: Faculty is present and available in clinics, emergency rooms and operating rooms for appropriate level supervision during critical parts of procedures.

Examples of evidence to demonstrate compliance may include:

- Faculty coverage for clinic, operating room and call schedules
- Patient records

2-2.2 In addition to the full time program director, the teaching staff must have at least one full time equivalent oral and maxillofacial surgeon as defined by the institution per each authorized senior resident position. One of the teaching staff who is not the program director must be at least half-time faculty as defined by the institution.

CODA authorized enrollment per year (n)	Required Program Director F.T.E.	Required minimum F.T.E. of second faculty member	Required cumulative additional F.T.E. of faculty who are not program director	Required Total faculty F.T.E. for program
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1	1	0.5	0.5	2
2	1	0.5	1.5	3
3	1	0.5	2.5	4
n	1	0.5	n - 0.5	n + 1

2-2.3 Eligible oral and maxillofacial surgery members of the teaching staff, with greater than a .5 FTE commitment appointed after January 1, 2000, who have not previously served as teaching staff, must be diplomates of the American Board of Oral and Maxillofacial Surgery or in the process of becoming board certified. Foreign trained faculty must be comparably qualified.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the oral and maxillofacial surgery faculty.

Examples of Evidence to demonstrate compliance may include:

- a. Participation in clinical and/or basic research particularly in projects funded following peer review;
- b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media; and
- c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.

2-4 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

Student/Resident assessment

Cultural Competency

Ability to work with students/residents of varying ages and backgrounds

Use of technology in didactic and clinical components of the curriculum

Evidence of participation in continuing education activities

Consistent faculty use of a national curriculum (e.g., SCORE).

Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

STANDARD 3 – FACILITIES AND RESOURCES

Institutional facilities and resources **must** be adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies **must** be readily accessible and functional.

***Intent:** The facilities and resources (e.g.; support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.*

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 bloodborne and infectious diseases. Policies **must** be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on bloodborne and infectious diseases **must** be made available to applicants for admission and patients.

***Intent:** The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the residents, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.*

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 to patients and dental personnel.

***Intent:** The program should have written policy that encourages (e.g., delineates the advantages of) immunization for residents, faculty and appropriate support staff.*

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:** Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.*

The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.

- 3-1 Clinical facilities must be properly equipped for performance of all ambulatory oral and maxillofacial surgery procedures, including administration of general anesthesia and sedation for ambulatory patients.**
- 3-2 There must be a space properly equipped for monitoring patients' recovery from ambulatory surgery, general anesthesia and sedation.**
- 3-3 An adequate and accessible dental laboratory facility must be available to the residents to utilize for patient care.**
- 3-4 Adequate onsite computer resources with internet access must be available to the residents.**
- 3-5 Adequate on call facilities must be provided to residents when fulfilling in-house call responsibilities.**
- 3-6 Adequate and accessible diagnostic imaging facilities must be available to residents to utilize for patient care.**

STANDARD 4 - CURRICULUM AND PROGRAM DURATION

The advanced dental education program **must** be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards of the discipline's practice as set forth in specific standards contained in this document.

***Intent:** The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies standards for the discipline.*

Advanced dental education programs **must** include instruction or learning experiences in evidence-based practice. Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or "searching publication databases and appraisal of the evidence")
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of national in-service examinations or board certification examinations.

The level of discipline-specific instruction in certificate and degree-granting programs **must** be comparable.

***Intent:** The intent is to ensure that the residents of these programs receive the same educational requirements as set forth in these Standards.*

If an institution and/or program enrolls part-time residents, the institution **must** have guidelines regarding enrollment of part-time residents. Part-time residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls residents on a part-time basis **must** ensure that: (1) the educational experiences,

including the clinical experiences and responsibilities, are the same as required by full-time residents; and (2) there are an equivalent number of weeks spent in the program.

- 4-1 An advanced dental education program in oral and maxillofacial surgery must encompass a minimum duration of four (4) years of full-time study.**
- 4-2 Each resident must devote a minimum of 120 weeks to clinical oral and maxillofacial surgery.**

Intent: While enrolled in an oral and maxillofacial surgery program, full-time rotations on the oral and maxillofacial surgery service while doing a non-oral and maxillofacial surgery residency year or full-time service on oral and maxillofacial surgery during vacation times during medical school may be counted toward this requirement.

Examples of evidence to demonstrate compliance may include:

- Complete schedule of resident activity
 - 4-2.1 Fifty-two weeks of the time spent on the oral and maxillofacial surgery service must be at a senior level of responsibility, 26 weeks of which must be in the final year.**

Intent: Senior level responsibility means residents serving as first assistant to attending surgeon on major cases. Resident serves as first assistant for the majority of surgical procedures performed during this rotation. They are to be present for most pre- and post-operative patient visits.
 - 4-2.2 Rotations to affiliated institutions outside the United States and Canada must not be used to fulfill the core 120 weeks clinical oral and maxillofacial surgery training experience. Surgical procedures performed during foreign rotations must not count toward fulfillment of the 175 major surgical procedures.**
 - 4-2.3 Rotations to a private practice ~~must not be used to~~ that fulfill the core 120 weeks of clinical oral and maxillofacial surgery training experience must not exceed 4 weeks.**

Intent: It is recognized that educational value exists in resident exposure to the private practice environment. Rotations to private practice are intended to broaden the educational experience of residents and not for service needs of the private practice.

- 4-3 The residency program in oral and maxillofacial surgery must include education and training in the basic and clinical sciences, which is integrated into the training program. A distinct and specific curriculum must be provided in anesthesia, clinical medicine and surgery.**

The integrated clinical science curriculum must include off-service rotations, lectures, ~~and seminars,~~ **and high-quality educational materials in a structured program for learning** given during the oral and maxillofacial surgery training program by oral and maxillofacial surgery residents and attending staff.

Intent: Course work and training taken as requirements for the medical degree and the general surgery residency year provided within integrated MD or DO/oral and maxillofacial surgery training programs may also qualify to satisfy some of the clinical science curriculum requirements.

When assigned to a required rotation on another service (surgery, medicine, anesthesiology, and eight weeks of additional off-service elective), the oral and maxillofacial surgery resident must devote full-time to the service and participate fully in all the teaching activities of the service, including regular on-call responsibilities.

Intent: Beyond the required 56 week rotations, residents may take call on the oral and maxillofacial surgery service when on additional rotations (oral pathology, etc.).

Examples of evidence to demonstrate compliance may include:

- Lecture schedules
- Curriculum; behavioral objectives
- Attendance sign-in sheets
- Policy of anesthesia department related to on-call participation by residents if residents are not permitted to be on-call
- Rotation schedules
- **Consistent use of a national curriculum (e.g., SCORE).**
- **Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.**

4-3.1 Anesthesia and Medical Service:

The combined assignment must be for a minimum of 32 weeks. A minimum of 20 weeks must be on the anesthesia service and should be consecutive. Four of these 20 weeks should be dedicated to pediatric anesthesia. The resident must function as an anesthesia resident with commensurate level of responsibility. A minimum of 8 weeks must be on the medicine or medical subspecialty services.

Intent: It is desirable that four weeks of the required 32 weeks, not fulfilled by the 20 weeks on anesthesia and 8 weeks on medicine or medical subspecialty services be an experience in pre-anesthetic risk stratification and perioperative medical assessment of the surgical patient. The experience beyond the 20 weeks rotation on the anesthesia service may be at the medical student or resident level, and may include the rotations on medical/anesthesia specialty services (e.g., Medicine, Cardiology, Critical Care, Pediatrics, anesthesia perioperative medicine clinic). The 20 week Anesthesia Service time can be during medical school as long as the oral and maxillofacial surgery trainee functions at the anesthesia resident level.

Examples of evidence to demonstrate compliance may include:

- Resident on-call anesthesia and medicine schedules
- Resident anesthesia and medical service rotation schedules
- Anesthesia records

4-3.2 Surgical Service:

A minimum of 16 weeks of clinical surgical experience must be provided. This experience should be achieved by rotation to a surgical service (not to include oral and maxillofacial surgery) and the resident must function as a surgery resident with commensurate level of responsibility.

Intent: The intent is to provide residents with adequate training in pre- and post-operative care, as well as experience in intra-operative techniques. This should include management of critically ill patients. Oral and maxillofacial surgery residents operate at a PGY-1 level of responsibilities or higher, and are on the regular night call schedule.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

4-3.3 Other Rotations:

Eight additional weeks of clinical surgical or medical education must be assigned. These must be exclusive of all oral and maxillofacial surgery service assignments.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

- 4-4 Departmental seminars and conferences, directed by participating members of the teaching staff, must be conducted to augment the biomedical science and clinical program. They must be scheduled and structured to provide instruction in the broad scope of oral and maxillofacial surgery and related sciences and must include retrospective audits, clinicopathological conferences, tumor conferences and guest lectures. The majority of teaching sessions must be presented by the institutional teaching staff and may include remote access educational opportunities. The residents must also prepare and present departmental conferences under the guidance of the faculty.**

***Intent:** The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain.*

Examples of evidence to demonstrate compliance may include:

- Seminar schedules for at least one year
- Resident log of lectures attended
- Course outlines
- Sign-in sheets
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

BASIC SCIENCES

- 4-5 Instruction must be provided in the basic biomedical sciences at an advanced level beyond that of the predoctoral dental curriculum. These sciences must include anatomy (including growth and development), physiology, pharmacology, microbiology and pathology. This instruction may be provided through formal courses, seminars, conferences or rotations to other services of the hospital.**

Intent: This instruction may be met through the completion of the requirements for the M.D./D.O. or any other advanced degrees.

- 4-5.1 Instruction in anatomy must include surgical approaches used in various oral and maxillofacial surgery procedures.**

Examples of evidence to demonstrate compliance may include:

- Resident log of lectures attended
- Course outlines
- Goals and objectives of biomedical sciences curriculum
- Sign-in sheets
- Schedule showing curriculum in the mandated areas for a typical year
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

PHYSICAL DIAGNOSIS

- 4-6 A didactic and practical course in physical diagnosis must be provided. This instruction must be initiated in the first year of the program. Resident competency in physical diagnosis must be documented prior to the completion of the program.**

Intent: A medical student/resident level course in physical diagnosis, or a faculty led, formally structured and comprehensive physical diagnosis course that includes didactic and practical instruction should be completed prior to commencement of rotations on the anesthesia, medicine and surgical services. This is to ensure that residents have the opportunity to apply this training throughout the program on adult and pediatric patients.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Course syllabi
- Course schedules

CLINICAL ORAL AND MAXILLOFACIAL SURGERY

- 4-7 The program must provide a complete, progressively graduated sequence of outpatient, inpatient and emergency room experiences. The residents' exposure to non-surgical management and surgical procedures must be integrated throughout the duration of the program.**

In addition to providing the teaching and supervision of the resident activities described above, there must be patients of sufficient number and variety to give residents exposure to and competence in the scope of oral and maxillofacial surgery. The program director must ensure that all residents receive comparable clinical experience.

***Intent:** The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain.*

Examples of evidence to demonstrate compliance may include:

- Records kept by program director that show comparability of surgical experiences in the various aspects of oral and maxillofacial surgery across years and among residents.
- Oral and Maxillofacial Surgery Benchmarks

MINIMUM CLINICAL REQUIREMENTS

OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE

- 4-8 The program must ensure a progressive and continuous outpatient surgical experience in non-surgical and surgical management, including preoperative and postoperative evaluation, in a broad range of oral and maxillofacial surgery involving adult and pediatric patients. This experience must include dentoalveolar surgery, the placement of implant devices, management of traumatic injuries and pathologic conditions including temporomandibular disorders and facial pain, augmentations and other hard and soft tissue surgery, including surgery of the mucogingival tissues. Faculty cases may contribute to this experience, but they must have resident involvement.**

Oral and Maxillofacial Surgery Standards

Intent: Residents are to participate in outpatient care activities.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules
- Outpatient clinic schedules
- Outpatient surgery case log
- Dentoalveolar-related didactic course materials

4-8.1 Dental implant training must include didactic and clinical experience in comprehensive preoperative, intraoperative and post-operative management of the implant patient.

The preoperative aspects of the comprehensive management of the implant patient must include interdisciplinary consultation, diagnosis, treatment planning, biomechanics, biomaterials and biological basis.

The intraoperative aspects of training must include surgical preparation and surgical placement including hard and soft tissue grafts.

The post-operative aspects of training must include the evaluation and management of implant tissues and complications associated with the placement of implants.

Examples of evidence to demonstrate compliance may include

- Implant-related didactic course materials
- Patient records, indicating interaction with restorative dentists
- Consistent use of a national curriculum (e.g., SCORE)
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-8.2 The training program must include didactic and clinical experience in the comprehensive management of temporomandibular disorders and facial pain.

Examples of evidence to demonstrate compliance may include:

- Education in the diagnosis, imaging, surgical and non-surgical management, including instruction in biomaterials.
- Didactic Schedules
- Resident case logs
- Clinic Schedules

GENERAL ANESTHESIA AND DEEP SEDATION

- 4-9 The off-service rotation in anesthesia must be supplemented by longitudinal and progressive experience throughout the training program in all aspects of pain and anxiety control. The ambulatory oral and maxillofacial anesthetic experience must include the administration of general anesthesia/deep sedation for oral and maxillofacial surgery procedures to pediatric, adult, and geriatric populations, including the demonstration of competency in airway management.**

Examples of evidence to demonstrate compliance may include:

- Resident's anesthetic log
- Clinical tracking system
- Anesthesia records
- Oral and Maxillofacial Surgery Benchmarks

- 4-9.1 The cumulative anesthetic experience of each graduating resident must include administration of general anesthesia/deep sedation for a minimum of 300 cases. This experience must involve care for 50 patients younger than 13. A minimum of 150 of the 300 cases must be ambulatory anesthetics for oral and maxillofacial surgery outside of the operating room.**

***Intent:** The cumulative experience includes time on the anesthesia rotation as well as anesthetics administered while on the oral and maxillofacial surgery service. Locations for ambulatory anesthesia may include dental school clinics, hospital clinics, emergency rooms, and oral and maxillofacial surgery offices.*

Examples of evidence to demonstrate compliance may include:

- Resident's anesthetic log.
- Clinical tracking system.
- Anesthesia records.

- Oral and Maxillofacial Surgery Benchmarks

4-9.2 The graduating resident must be trained to competence in the delivery of general anesthesia/deep sedation to patients of at least 8 years of age and older.

4-9.3 The graduating resident must be trained in the management of children younger than 8 years of age using techniques such as behavior management, inhalation analgesia, sedation, and general anesthesia.

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-9.4 The graduating resident must be trained in the anesthetic management of geriatric patients.

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-9.5 The clinical program must be supported in part by a core comprehensive didactic program on general anesthesia, deep sedation, moderate sedation, behavior management and other methods of pain and anxiety control. The didactic program must include lectures and seminars emphasizing:

- a. Perioperative evaluation and optimization of patients of all ages,
- b. Risk assessment,
- c. Anesthesia and sedation techniques,
- d. Monitoring, and
- e. The diagnosis and management of complications.

4-9.6 Advanced Cardiac Life Support (ACLS) must be obtained in the first year of residency and must be maintained throughout residency training.

Examples of evidence to demonstrate compliance may include:

- ACLS certification records and cards

4-9.7 Each resident must be certified in Pediatric Advanced Life Support (PALS) prior to completion of training.

Examples of evidence to demonstrate compliance may include:

- PALS certification records and cards

ADMISSIONS

4-10 Inpatient surgical experience must ensure adequate training in a broad range of inpatient oral and maxillofacial surgery care, including admission and management of patients.

MAJOR SURGERY

4-11 For each authorized final year resident position, residents must perform 175 major oral and maxillofacial surgery procedures on adults and children, documented by at least a formal operative note. For the above 175 procedures there must be at least 20 procedures in each category of surgery. The categories of major surgery are defined as: 1) trauma 2) pathology 3) orthognathic surgery 4) reconstructive and cosmetic surgery. Sufficient variety in each category, as specified below, must be provided. Surgery performed by oral and maxillofacial surgery residents while rotating on or assisting with other services must not be counted toward this requirement.

Intent: The intent is to ensure a balanced exposure to comprehensive patient care for all major surgical categories. In order for a major surgical case to be counted toward meeting this requirement, the resident serves as an operating surgeon or first assistant to an oral and maxillofacial surgery teaching staff member. The program documents that the residents have played a significant role (diagnosis, perioperative care and subsequent follow-up) in the management of the patient.

Examples of evidence to demonstrate compliance may include:

- Department and institution general operating room statistics and logs
- Patient Medical Records
- Schedules showing that resident was present in pre- and post-operative visits
- Progress notes or resident logs showing resident was present during pre- and post-operative visits
- Resident logbook of all procedures with which resident had active participation

4-11.1 In the trauma category, in addition to mandibular fractures, the surgical management and treatment of maxillary, nasal and orbito-zygomatico-maxillary complex injuries must be included.

Intent: Trauma management includes, but is not limited to, tracheotomies, open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region and repair of facial, oral, soft tissue injuries and injuries to specialized structures.

4-11.2 In the pathology category, experience must include management of temporomandibular joint pathology and at least three other types of procedures.

Intent: Pathology of the temporomandibular joint includes, but is not limited to, internal derangement arthritis, post-traumatic dysfunction, and neoplasms. Management of temporomandibular joint pathology may include medical or outpatient procedures. Other Pathology management includes, but is not limited to, major maxillary sinus procedures, salivary gland/duct surgery, management of head and neck infections, (incision and drainage procedures), and surgical management of benign and malignant neoplasms and cysts.

4-11.3 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.

Intent: Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial

bones as well as the treatment of obstructive sleep apnea. Surgical procedures in this category include, but are not limited to, ramus and body procedures, subapical segmental osteotomies, Le Fort I, II and III procedures and craniofacial operations. Comprehensive care should include consultation and treatment by an orthodontic specialist when indicated; and a sleep medicine team should be included when indicated. Residents participate in the pre- and post-operative care and intra-operative participation in the treatment of the orthognathic patient and the sleep apnea patient.

Examples of evidence to demonstrate compliance may include:

- Evidence of collaborative care (with orthodontist and/or sleep medicine team)
- Oral and maxillofacial surgery record with orthodontic and/or sleep medicine involvement

4-11.4 In the reconstructive and cosmetic category, both bone grafting and soft tissue grafting procedures must be included. Residents must learn the harvesting of bone and soft tissue grafts during the course of training.

Intent: Distant bone graft sites may include but are not limited to calvarium, rib, ilium, fibula and tibia. Harvesting of soft tissue grafts may be from intraoral or distant sites. Distant soft tissue grafts include but are not limited to cartilage, skin, fat, nerve & fascia.

Examples of evidence to demonstrate compliance may include:

- Patient records revealing evidence of hard - and soft-tissue harvesting and grafting to maxillofacial region, including donor sites distant from oral cavity

4-11.5 Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of hard and soft tissue maxillofacial defects, insertion of craniofacial implants, facial cleft repair, peripheral nerve reconstruction and other reconstructive surgery.

Intent: It is expected that in this category there will be both reconstructive and cosmetic procedures performed by residents.

Cosmetic surgery should include but is not limited to three of the following types of procedures: rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty, and scar revision.

Examples of evidence to demonstrate compliance may include:

- Patient records revealing resident experience in reconstructive and cosmetic surgery

4-12 Accurate and complete records of the amount and variety of clinical activity of the oral and maxillofacial surgery teaching service must be maintained. These records must include a detailed account of the number and variety of procedures performed by each resident. Records of patients managed by residents must evidence thoroughness of diagnosis, treatment planning and treatment.

4-12.1 Residents must keep a current log of their operative cases.

4-13 Emergency Care Experience: Residents must be provided with emergency care experience, including diagnosing, rendering emergency treatment and assuming major responsibility for the care of oral and maxillofacial injuries. The management of acute illnesses and injuries, including management of oral and maxillofacial lacerations and fractures, must be included in this experience. A resident must be available to the emergency service at all times.

4-13.1 Each resident must be certified in Advanced Trauma Life Support (ATLS) prior to completion of training.

4-14 The program must provide instruction in the compilation of accurate and complete patient records.

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedule on patient record keeping

4-15 The program must provide training in interpretation of diagnostic imaging.

Ethics and Professionalism

4-16 Graduates Residents must receive instruction in the application of the principle of ethical reasoning, and ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

Intent: Graduates 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.

4-17 The program must include participation in practice and risk management seminars and instruction in coding and nomenclature.

Intent: *Parameters of Care should be taught either in a seminar setting, individually or shown to be utilized throughout the program, i.e. Morbidity & Mortality Conferences.*

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedules on practice and risk management
- Familiarity with AAOMS Parameters of Care

Patient Safety

4-18 Residents must receive formal training in programs, policies, and procedures enhancing patient safety.

Intent: *An ongoing, comprehensive focus on promoting safety and quality improvement is an essential part of quality patient care. Residents are exposed throughout training to theoretical and practical means to ensure that consideration of patient safety is routine and consistent.*

Examples of evidence to demonstrate compliance may include:

- Documentation of an active, ongoing clinical safety training program. This may include participation in institution-wide programs, or documentation of training in Crew Resource Management, Root Cause Analysis, or other safety-focused protocols
- Formative and summative evaluation of residents' knowledge of and engagement and compliance with safety initiatives (e.g., use of Benchmarks)
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-18.1 The program must provide resident supervision to promote safe and optimal patient care.

Intent: Comprehensive guidelines and consistent communication assist residents in decision making regarding the balance between a relatively autonomous learning environment and direct supervision of patient care. Patient care is a shared responsibility among faculty and residents with the faculty ultimately responsible. Supervision ensures safety and excellence. Supervision is accomplished through a variety of methods including direct supervision with physical presence and where applicable indirect supervision including the use of fellows or residents or through means of telecommunication and general oversight.

Examples of evidence to demonstrate compliance may include:

- Resident supervision policy
- Documented resident responsibility based on OMS benchmarks or similar metrics.
- Faculty and resident call schedules
- Documentation of didactic and clinical competency or Core Entrustable Professional Activities (EPAs)
- Didactic sessions focused on the process of progressive entrustment

4-19 The program must have a formal program for medical emergency preparedness in its ambulatory surgery clinics.

Intent: Safety training is enhanced by immersing residents at all stages of training in policies, procedures, and practices which minimize the risk of harm to patients. Active participation by residents, faculty, and appropriate clinical staff in regular routines, including mock emergency drills, reinforces theoretical concepts and models the attention to patient safety expected of the contemporary surgical team. Programs meet or exceed applicable minimal institutional or regulatory requirements, and may develop and implement protocols custom to their clinical facilities.

Examples of evidence to demonstrate compliance may include:

- Logs of mock emergency drills demonstrating participation by faculty, residents and clinical staff
- Ongoing training using high fidelity simulation adapted to simulate the community-based, ambulatory surgery environment
- Adherence to established emergency preparation recommendations, e.g. the AAOMS Office Anesthesia Evaluation Manual

4-20 The program must routinely employ patient safety tools and techniques in its clinical facilities.

Examples of evidence to demonstrate compliance may include:

- Documentation of routine procedural time-outs
- Checklists for preanesthetic preparation, patient and procedure readiness verification, or similar
- Readily available cognitive aids (e.g. charts, placards, checklists, guides) for management of anesthetic and or/medical emergencies

Wellness

4-21 Residents must be educated in wellness, impairment, burnout, depression, suicide, and substance abuse as well as on the importance of adequate rest to avoid fatigue in order to balance their professional lives and deliver high quality care.

Intent: It is understood that many competing interests exist both within and outside of their commitment to residency obligations. Residents need to understand the value of wellness and fatigue and have the ability to openly address individual and programmatic concerns. Programs need to be responsive to concerns raised regarding out of balance or inappropriate burdens placed on residents that undermine the primary purposes of their training. Programs also need to look for resident duties that could be reasonably offloaded to non-residents in order to optimize resident education, promote wellness, and avoid fatigue.

Examples of evidence to demonstrate compliance may include:

- ROAAOMS Wellness Webinar Series
- Resident Evaluations of the program
- SCORE and/or institutional modules on wellness

4.21.1 The program must have policies in place that promote faculty and residents looking out for the wellness of one another and fitness for patient care with mechanisms for reporting at-risk behaviors without the fear of retaliation.

4-21.2 Programs must blend supervised patient care, teaching responsibilities of residents, didactic commitments, and scholarly activity of residents such that it is accomplished without the excessive reliance on residents to fulfill other service needs and without compromising wellness and fatigue.

4-21.3 Resident work hours must be monitored and reviewed.

Intent: It is required that programs have a system in place for ongoing monitoring of weekly work hours including total number of hours worked, time off between shifts, and days off per week. This data can then be reviewed in appropriate settings such as faculty and resident meetings, annual reviews, and morbidity and mortality conferences. The tracking of hours creates data for shared decision making and assists programs in addressing outlying individuals or situations that could be avoided with more effective training and programmatic structure.

4-21.4 The program must have policies and procedures which allow residents leaves of absence from work in order to address issues not limited to fatigue, illness, family emergencies, and parental leave.

**STANDARD 5 - ADVANCED DENTAL EDUCATION RESIDENTS
ELIGIBILITY AND SELECTION**

Eligible applicants to advanced dental education programs accredited by the Commission on Dental Accreditation **must** be graduates from:

- a. Predoctoral dental programs in the U.S. accredited by the Commission on Dental Accreditation; or
- b. Predoctoral dental programs in Canada accredited by the Commission on Dental Accreditation of Canada; or
- c. International dental schools that provide equivalent educational background and standing as determined by the program.

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.*

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:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge

5-1 If the program has determined that graduates of U. S. or Canadian accredited medical schools are eligible for admission, the candidate must obtain a dental degree from a

predoctoral dental education program accredited by the Commission on Dental Accreditation prior to starting the final 52 weeks of the required 120 weeks of core OMS training.

Intent: The obtainment of a Medical Degree provides a degree of patient care knowledge and technical skill translatable to many aspects of oral and maxillofacial surgery. This prior experience is amenable to the possibility of simultaneous credit for certain training experiences but not for any aspect of the final 52 weeks of training in OMFS.

EVALUATION

A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program:

- a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods;
- b. Provides to residents an assessment of their performance, at least semiannually;
- c. Advances residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and
- d. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Intent: (a) *The evaluation of competence is an ongoing process that requires a variety of assessments that can measure the acquisition of knowledge, skills and values necessary for discipline-specific level practice. It is expected that programs develop and periodically review evaluation methods that include both formative and summative assessments.* (b) *Resident evaluations should be recorded and available in written form.* (c) *Deficiencies should be identified in order to institute corrective measures.* (d) *Resident evaluation is documented in writing and is shared with the resident.*

5-2 The program director must provide written evaluations of the residents based upon written comments obtained from the teaching staff. The evaluation must include:

- a. **Cognitive skills;**
- b. **Clinical skills;**
- c. **Interpersonal skills;**
- d. **Patient management skills; and**
- e. **Ethical standards.**

Examples of evidence to demonstrate compliance may include:

- Rotational evaluations

- Semi-annual summative/formative evaluations
 - Oral and Maxillofacial Surgery Benchmarks
 - AAOMS DVD on Professionalism, AAOMS Code of Professional Conduct, ADA Principles of Ethics and Code of Professional Conduct, ADEA Statement on Professionalism in Dental Education, Institutional ethics guidelines, lecture on ethics
- 5-3 The program director must provide counseling, remediation, censuring, or after due process, dismissal of residents who fail to demonstrate an appropriate level of competence, reliability, or ethical standards.**
- 5-4 The program director must provide a final written evaluation of each resident upon completion of the program. The evaluation must include a review of the resident's performance during the training program, and must state that the resident has demonstrated competency to practice independently. The final evaluation must be a summative assessment demonstrating a progression of formative assessments throughout the residency program. This evaluation must be included as part of the resident's permanent record and must be maintained by the institution. A copy of the final written evaluation must be provided to each resident upon completion of the residency.**

***Intent:** The summative assessment may include utilization of formative assessments such as Simulation training, Objective Structured Clinical Exam, Resident Surgical Log, Resident semi-annual evaluations, Oral and Maxillofacial Surgery Benchmarks, and In-Service **Training** Examinations.*

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the advanced dental education residents **must** be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all advanced dental education residents **must** be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.

***Intent:** Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a resident (for academic or disciplinary*

reasons). In addition to information on the program, residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the residents 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; and due process policy and current accreditation status of the program.

STANDARD 6 – RESEARCH

Advanced dental education residents **must** engage in scholarly activity.

***Intent:** The resident is encouraged to be involved in the creation of new knowledge, evaluation of research, development of critical thinking skills and furthering the profession of oral and maxillofacial surgery.*

6-1 Each graduating resident must demonstrate evidence of scholarly activity.

Examples of evidence to demonstrate compliance may include:

- Oral or poster presentations at scientific meetings aside from program curriculum
- Submission for publication of abstracts, journal articles (particularly peer reviewed) or book chapters
- Active participation in or completion of a research project (basic science or clinical) with mentoring

6-2 The program must provide instruction in research design and analysis.

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in research design and analysis
- Participation in a clinical trials course
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

6-3 The program must provide instruction in the critical evaluation of scientific literature.

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in the critical evaluation of scientific literature through journal club or other educational seminars
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.