REPORT OF THE REVIEW COMMITTEE ON DENTAL ANESTHESIOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Joseph Giovannitti. Committee Members: Dr. Gerard Kugel, Dr. Mana Saraghi, and Dr. Philip Yen. Ms. LaShun James was not in attendance. Guest (Open Session Only): Ms. Erin Baker, executive director, American Society of Dentist Anesthesiologists; Dr. Sheila Brear, chief learning officer, American Dental Education Association. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education and Ms. Bridget Blackwood, senior project assistant, CODA. The meeting of the Review Committee on Dental Anesthesiology Education (DENTANES RC) was held on January 11, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL ANESTHESIOLOGY EDUCATION

Informational Report on Dental Anesthesiology Programs Annual Survey Curriculum Data (p. 1500): At its Winter 2015 meeting, the Commission directed that all Review Committees consider the informational report on aggregate data from the Curriculum Section of the Annual Survey in years when this data is available. At this meeting, the Dental Anesthesiology RC reviewed the informational report on aggregate data from the Curriculum Section for the dental anesthesiology programs conducted in August 2022. The RC noted the data provided in each area closely aligns with the Accreditation Standards following its recent revision. Further, the RC discussed that the Curriculum Section of the Annual Survey may need additional modification if the Accreditation Standards with proposed revisions are approved and noted it will have the opportunity to do so at the Winter 2024.

Recommendation: This report is informational in nature and no action is required.

Consideration of Proposed Revisions of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 1501): At its Winter 2022 meeting, the Dental Anesthesiology Review Committee (DENTANES RC) continued review of the survey data and the written comments gathered through the Spring 2021 Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology, to identify Accreditation Standards, if any, which warranted revision. Through its review of the survey data and comments, the DENTANES RC noted that subparts of Standard 2-2 specific to curriculum content related to pain associated with the head and neck region, and Standard 2-6, related to minimum number of clinical procedures residents must complete, appeared to be the most frequently identified by survey respondents.

Following considerable discussion, the DENTANES RC believed that Standards 2-2 and 2-6 warranted modification, specifically subpart 2-2 i, regarding chronic pain related to the head and neck region and subpart 2-6 c, regarding exposure to the management of patients with chronic orofacial pain. Additionally, the DENTANES RC discussed whether these two subparts should remain as requirements given that treatment of patients with chronic pain related to the head and

neck region and chronic orofacial pain is provided by orofacial pain practitioners and generally not considered within the scope of practice for dental anesthesiology. Therefore, the DENTANES RC believed that these subparts should be deleted from the Dental Anesthesiology Standards and recommended that the proposed revisions to Standards 2-2 and 2-6 be circulated to the communities of interest for review and comment. At its Winter 2022 meeting, the Commission agreed and directed circulation of the proposed revisions to Standard 2-2 and 2-6 of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology **(Appendix 1, Policy Report 1501)** to the communities of interest for review and comment, with Hearings conducted in conjunction with the March 2022 American Dental Education Association (ADEA) Annual Session and the October 2022 American Dental Association (ADA) Annual Meeting, with comments reviewed at the Commission's Winter 2023 meetings.

As directed by the Commission, the proposed revisions to Standards 2-2 and Standard 2-6 of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology were circulated for comment through December 1, 2022. No (0) comments were received at the Spring 2022 Virtual Hearing on Standards and no (0) comments were received at the Fall 2022 Virtual Hearing on Standards. The Commission office received three (3) written comments prior to the December 1, 2022 deadline **(Appendix 2, Policy Report 1501)**.

At this meeting, the DENTANES RC considered the proposed revisions to Standards 2-2 and 2-6 of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology and all of the comments received prior to the December 1, 2022 deadline.

The Review Committee carefully reviewed the written comments and noted that comments were in support of the proposed revisions with one exception. One comment noted the importance of familiarity with the diagnosis and treatment of chronic pain conditions in the head and neck region and believed this requirement should be retained in the Accreditation Standards.

Upon conclusion of the discussion and review of all written comments received, the Review Committee determined the Accreditation Standards for Advanced Dental Education Programs, including the proposed revisions to Standards 2-2 and 2-6, found in **Appendix 1** should be adopted for implementation on July 1, 2023. The DENTANEC RC considered whether a longer implementation period was warranted but believed the implementation period is adequate since the revisions are not substantial and involve removal of requirements rather than addition of requirements.

> **Recommendation:** It is recommended that the Commission on Dental Accreditation adopt Accreditation Standards for Advanced Dental Education Programs including the proposed revisions to Standards 2-2 and 2-6 found in **Appendix 1** and related documents for implementation July 1, 2023.

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL ANESTHESIOLOGY EDUCATION

The Review Committee on Dental Anesthesiology Education (DENTANES) considered site visitor appointments for 2023-2024. The Committee's recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Joseph Giovannitti
Chair, Review Committee on Dental Anesthesiology Education

Commission on Dental Accreditation

At its Winter 2022 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2022, for review at the Winter 2023 Commission meeting. The proposed revisions circulated related specifically to Standards 2-2 and 2-6.

This document represents the proposed changes made based upon review of comment received from communities of interest from February 11, 2022 through December 1, 2022. This document will be considered by the Commission in Winter 2023.

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology

Accreditation Standards For Advanced Dental Education Programs in Dental Anesthesiology

Commission on Dental Accreditation
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Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology

Document Revision History

Date	Item	Action
February 10, 2023	Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology	Approved
July 1, 2023	Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology	Implemented
~~January 25, 2007~~	~~Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology~~	~~Approved, Implemented~~
~~July 26, 2007~~	~~Standards to Ensure Program Integrity Examples of Evidence Modified (Standard 1-2)~~	~~Adopted and Implemented~~
~~July 26, 2007~~	~~Name Change: The Joint Commission on Accreditation of Healthcare Organizations to The Joint Commission~~	~~Adopted and Implemented~~
~~February 1, 2008~~	~~Revised Definition of Terms and Usage of Examples of Evidence~~	~~Adopted and Implemented~~
~~July 31, 2008~~	~~Addition of intent statement to Standard 1-5~~	~~Adopted and Implemented~~
~~January 29, 2009~~	~~Revised Standards 2-2 and 3-2~~	~~Adopted and Implemented~~
~~July 31, 2009~~	~~Revised Definition of Terms (Anxiety and Pain Control), Revised Standards 2-6 and 5-3~~	~~Adopted and Implemented~~
~~August 6, 2010~~	~~Revised Accreditation Status Definitions section~~	~~Adopted~~
~~January 1, 2011~~	~~Revised Accreditation Status Definitions section~~	~~Implemented~~
~~February 4, 2011~~	~~Revised Standard 3-2~~	~~Adopted, Implemented~~

February 4, 2011	Ethics and Professionalism Standard (1-10)	Adopted
July 1, 2011	Ethics and Professionalism Standard (1-10)	Implemented
August 5, 2011	Addition of intent statement to Standard 5-4	Adopted, Implemented
August 9, 2012	Revised Mission Statement	Adopted, Implemented

Document Revision History (continued)

February 1, 2013	Revised definitions, Standards 2-4, 2-6, 2-7, 2-7, 2-8, 2-9, 2-10, 2-17, 3-2, 5-3, and 6-1, and removal of "proficient and proficiency"	Adopted
February 1, 2013	Addition of Standard 3-7	Adopted
July 1, 2013	Addition of Standard 3-7	Implemented
February 6, 2015	Revised Standard 1-1	Adopted, Implemented
February 6, 2015	Revised Standard 4-4	Adopted, Implemented
February 6, 2015	Addition of intent statement to Standard 4-4	Adopted, Implemented
July 1, 2015	Revised definitions, Standards 2-4, 2-6, 2-7, 2-7, 2-8, 2-9, 2-10, 2-17, 3-2, 5-3, and 6-1, and removal of "proficient and proficiency"	Implemented
August 7, 2015	Revision of term "student/resident" to "resident"; revision of definition of "student/resident."	Approved, Implemented
February 5, 2016	Revised Accreditation Status Definitions	Approved, Implemented
August 5, 2016	Revised Standard 3-1	Approved
August 5, 2016	Revised Mission Statement	Adopted
January 1, 2017	Revised Mission Statement	Implemented

July 1, 2017	Revised Standard 3-1	Implemented
August 4, 2017	Revised Accreditation Status Definitions	Approved, Implemented
August 4, 2017	Revised Standards 1-5, 1-8, 1-9, 2-1, 2-2, 2-3, 2-6, 2-9, 2-11, 2-12, 2-17, 2-19, 3-3, 4-3, 4-4, 4-5, and 4-6 and new Standards 3-8 and 3-9	Adopted
July 1, 2018	Revised Standards 1-5, 1-8, 1-9, 2-1, 2-2, 2-3, 2-6, 2-9, 2-11, 2-12, 2-17, 2-19, 3-3, 4-3, 4-4, 4-5, and 4-6 and new Standards 3-8 and 3-9	Implemented
August 3, 2018	Revised Terminology Related to Advanced Education Programs	Adopted

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Document Revision History (continued)

January 1, 2019	Revised Terminology Related to Advanced Education Programs	Implemented
August 2, 2019	Revised Definition of "Patients with special needs"	Adopted and Implemented
August 2, 2019	Revised Standard 3-2	Adopted
August 2, 2019	Revised Definition of "Should"	Adopted
January 1, 2020	Revised Standard 3-2	Implemented
January 31, 2020	Revised Definition of "Should"	Implemented
August 6, 2021	Revised Mission Statement	Adopted
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: 8/13; 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).

Introduction

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

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

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

Goals

Advanced Dental Education Programs in Dental Anesthesiology are educational programs designed to train the dental resident, in the most comprehensive manner, to use pharmacologic and non-pharmacologic methods to manage anxiety and pain of adults, children, and patients with special care needs undergoing dental, maxillofacial and adjunctive procedures, as well as to be qualified in the diagnosis and non-surgical treatment of acute orofacial pain and to participate in the management of patients with chronic orofacial pain.

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

1. Deliver anxiety and pain control services for emergency and comprehensive multidisciplinary oral health care.
2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively within the hospital, dental office, ambulatory surgery center, and other health care environments.
5. Function effectively within interdisciplinary health care teams.
6. Apply scientific principles to learning and anesthesia-related oral health care. This includes using critical thinking, evidence- or outcomes-based clinical decision-making, and technology-based information retrieval systems.
7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.

Definitions of Terms

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

Anxiety and Pain Control: Includes the following: analgesia; local anesthesia; minimal, moderate, and deep sedation; and general anesthesia as defined in the American Dental Association's "Guidelines for the Use of Sedation and General Anesthesia by Dentists."

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

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

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

In-Depth: A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.

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

Interdisciplinary: Including dentistry and other health care professions.

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

Multidisciplinary: Including all disciplines within the profession of dentistry.

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

Outpatient Anesthesia for Dentistry: The administration of anesthesia services to patients who are discharged from anesthetic care within the same treatment day (same-day surgery) from a facility where only procedures within the scope of dental practice are carried out.

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

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

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

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

STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 The program **must** be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution **must** be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

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

Examples of Evidence to demonstrate compliance may include:
Written agreement(s)
Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

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

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

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year

1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs **must** be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.
Intent*: Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).*

Examples of evidence to demonstrate compliance may include:
Written agreements

1-6 The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions **must** ensure that dentists are eligible for staff membership and privileges including the right to:

a) Vote and hold office;
b) Serve on institutional staff committees; and
c) Admit, manage, and discharge patients.

Examples of evidence to demonstrate compliance may include:
All institutional bylaws related to a, b, and c
Copy of institutional committee structure and/or roster of membership by dental faculty

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

Examples of evidence to demonstrate compliance may include:
Institutional staff roster
Related institutional bylaws

Intent: *Residents are to be appointed to at least one of the above noted institutions.*

1-8 The program **must** develop a mission statement and supporting written overall program goals and objectives that emphasize:

a) anesthesia for dentistry,
b) resident education, and
c) patient care.

and include training residents to provide dental anesthesia care in office-based and hospital settings.

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

Examples of evidence to demonstrate compliance may include:
Mission statement and supporting written program goals and objectives

1-9 The program **must** have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program's written goals and objectives are being met.

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

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

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

Examples of evidence to demonstrate compliance may include:
Mission statement and supporting written goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results

Ethics and Professionalism

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

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

STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program **must** list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

Intent: *The program is expected to develop specific competency-statements that describe what the resident will be able to do upon completion of the program. These statements should describe the resident's abilities rather than educational experiences the residents may participate in. These competency statements are to be circulated to program faculty and staff and made available to applicants of the program.*

Examples of evidence to demonstrate compliance may include:
Written competency requirements

2-2 Upon completion of training, the resident **must** be:

a) Able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;
b) Able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;
c) Competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients' physiological and psychological factors;
d) Competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;
e) Competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;
f) Competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
g) Competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

h) Competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region; and

~~i) Familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and~~

~~j)~~ i) Able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

Intent: *The program's specific competency requirements and the didactic and clinical training and experiences in each area described above are expected to be at a level of skill and complexity beyond that accomplished in pre-doctoral training and consistent with preparing the dentist to utilize anxiety and pain control methods safely in the most comprehensive manner as set forth in the specific standards contained in this document.*

Examples of evidence to demonstrate compliance may include:
Written competency requirements
Didactic coursework, including lecture schedules and assigned reading
Case review conferences
Records of resident clinical activity including procedures performed in each area described above
Resident logs
Patient records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards
Resident evaluations

2-3 The program **must** have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program's written competency requirements.

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

For each specific competency statement described, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

Examples of evidence to demonstrate compliance may include:
Formal written curriculum plan with educational experiences tied to specific competency requirements
Didactic schedules
Clinical schedules

Didactic Components

2-4 Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum **must** be provided and include:

a) Applied biomedical sciences foundational to dental anesthesiology,

Intent: *Instruction should include physiology, pharmacology, anatomy, biochemistry, pathology, physics, pathophysiology, and clinical medicine as it applies to anesthesiology. The instruction should be sufficiently broad to provide for a thorough understanding of the body processes related to anxiety and pain control. Instruction should also provide an understanding of the mechanisms of drug action and interaction, as well as information about the properties of drugs used.*

b) Physical diagnosis and evaluation,

Intent: *This instruction should include taking, recording and interpreting a complete medical history and physical examination, and understanding the indications for and interpretations of diagnostic procedures and laboratory studies.*

c) Behavioral medicine,

Intent: *This instruction should include psychological components of human behavior as related to the management of anxiety and pain.*

d) Methods of anxiety and pain control,

Intent: *This instruction should include a detailed review of all methods of anxiety and pain control and pertinent topics (e.g., anesthesia delivery devices, monitoring equipment, airway management adjuncts, and perioperative management of patients).*

e) Complications and emergencies,

Intent: *This instruction should include recognition, diagnosis, and management of anesthesia-related perioperative complications and emergencies.*

f) Pain management, and

Intent*: This instruction should include information on pain mechanisms and on the evaluation and management of acute and chronic orofacial pain.*

g) Critical evaluation of literature.

Intent: *This instruction should include an understanding of scientific literature pertaining to dental anesthesiology and the development of critical evaluation skills, including an understanding of relevant research and statistical methodology.*

Clinical Components

2-5 The program **must** ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program's stated goals and competency requirements in dental anesthesiology.

Examples of evidence to demonstrate compliance may include:
Records of resident clinical activity, including specific details of the variety, type, and quantity of cases treated and procedures performed

2-6 The following list represents the minimum clinical experiences that **must** be obtained by each resident in the program at the completion of training:

a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
   (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty five (25) advanced airway technique requirements can be blind nasal intubations.
   (2) One hundred and twenty five (125) children age seven (7) and under, and
   (3) Seventy five (75) patients with special needs, and
b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation.~~; and~~
~~c) Exposure to the management of patients with chronic orofacial pain.~~

Intent: *The resident should be competent in the various methods of sedation and anesthesia for a variety of diagnostic and therapeutic procedures in the office or ambulatory care setting and the operating room. The resident should gain clinical experience in current monitoring procedures, fluid therapy, acute pain management and operating room safety. Instruction and experience in advanced airway management techniques are important parts of the training program and may include but are not*

limited to the following devices and techniques: blind nasal intubation, bougie, fiberoptic intubation, intubating laryngeal mask airway (LMA), light wand, and video laryngoscopes.

General Anesthesia Experience/Anesthesia Service

2-7 At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period **must** be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

Examples of evidence to demonstrate compliance may include:
Anesthesia rotation schedules
Records of resident clinical activity

2-8 Residents **must** be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

Intent: *This service should be under the direction of an anesthesiologist with a full time commitment, and each resident should participate in all of the usual duties and responsibilities of anesthesiology residents, including preanesthetic patient evaluation, administration of anesthesia in the operating room on a daily scheduled basis, postanesthetic patient management, and emergency call.*

Outpatient Anesthesia for Dentistry

2-9 At the completion of the program, each resident **must** have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

1. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.
2. Experience as the provider of supervised anesthesia care.

Intent: *Adequate experience in the unique aspects of dental anesthesia care with and without the use of an anesthesia machine and operating room facilities should be provided. Supervising dentist anesthesiologists shall have completed a CODA-accredited dental anesthesiology residency program or a two-year anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable*

provided that continuous significant practice of general anesthesia in the previous two years is documented.

Examples of evidence to demonstrate compliance may include:
Anesthesia rotation schedules
Records of resident clinical activity
Schedules of dental anesthesia faculty

Medicine Rotations

2-10 Residents **must** participate in at least four (4) months of clinical rotations from the following list. If more than one rotation is selected, each **must** be at least one month in length.

a) Cardiology,
b) Emergency medicine,
c) General/internal medicine,
d) Intensive care,
e) Pain medicine,
f) Pediatrics,
g) Pre-anesthetic assessment clinic (max. one [1] month), and
h) Pulmonary medicine.

Intent: *The dental anesthesia resident should have a strong foundation in clinical medicine that can be achieved through rotations in the above-mentioned areas. When the resident entering the program has minimal clinical medicine experience, the program director should attempt to increase the time in these rotations beyond the minimum number of months required. The goal is to give the resident experience in medical evaluation and long-term management of patients. Therefore, only one month of the four months of this requirement may be met in the pre-anesthetic assessment clinic, although longer periods of time may be arranged as desired.*

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations

2-11 Each assigned rotation or experience **must** have:

a) Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and
c) Evaluations performed by designated faculty.

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

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

2-12 Residents **must** be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

Intent: *Programs are expected to define the educational goals or competency statements in this area. Residents should be able to interact appropriately with other health care providers.*

Examples of evidence to demonstrate compliance may include:
Consultation records or patient records
Written competency requirements
Resident evaluations

2-13 The program **must** provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a) Taking, recording, and interpreting a complete medical history;
b) Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;
c) Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and
d) Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

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

Examples of evidence to demonstrate compliance may include:
Course outlines
Patient records
Resident evaluations

Record review policy
Documentation of record review

Other Components

2-14 The program **must** provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

Intent: *Information about the credentialing processes involved in hospitals, free-standing surgical centers, and private offices should be provided.*

Examples of evidence to demonstrate compliance may include:
Didactic schedules

2-15 Residents **must** be given assignments that require critical review of relevant scientific literature.

Intent: *Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care.*

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

2-16 The program **must** conduct and involve residents in a structured system of continuous quality improvement for patient care.

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

Examples of evidence to demonstrate compliance may include:
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

Program Length

2-17 The duration of a dental anesthesiology program **must** be a minimum of thirty six (36) months of full-time formal training.

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

2-18 Where a program for part-time residents exists, it **must** be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

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

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

Evaluation

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

a) Periodically, but at least twice annually, evaluates and documents the resident's progress towards achieving the program's written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;
b) Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and
c) Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Intent: *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific competency and anesthesia case requirements described in response to Standards 2-1, 2-2, and 2-6.*

Examples of evidence to demonstrate compliance may include:
Written evaluation criteria and process
Resident evaluations
Resident case logs
Personal record of evaluation for each resident
Evidence that corrective actions have been taken

STANDARD 3 – FACULTY AND STAFF

3-1 The program **must** be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

Intent: *The program director's responsibilities include:*

1. *program administration;*
2. *development and implementation of the curriculum plan;*
3. *ongoing evaluation of program content, faculty teaching and resident performance;*
4. *evaluation of resident training and supervision in affiliated institutions and off-services rotations;*
5. *maintenance of records related to the educational program; and*
6. *Resident selection.*

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

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

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

Examples of evidence to demonstrate compliance may include:

Program director's job description
Job description of individuals who have been assigned some of the program director's job responsibilities
Formal plan for assignment of program director's job responsibilities as described above
Program records

3-2 The program director **must** be board certified in dental anesthesiology. Program directors appointed after January 1, 2020, who have not previously served as program directors, **must** be board certified in dental anesthesiology. The program director **must** have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. A two-year anesthesiology residency for dentists completed

prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.

Intent: *The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology.*

Examples of Evidence to demonstrate compliance may include:
Certificate of completion of anesthesiology residency
Copy of board certification certificate
Letter from board attesting to current/active board certification

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

Intent: *Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible. The faculty, collectively, should have competence in all areas of dental anesthesiology covered in the program.*

The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of dental anesthesiology if that faculty member is not trained in dental anesthesiology. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program's criteria and qualifications.

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

Examples of evidence to demonstrate compliance may include:
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Written criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of dental anesthesiology
Program documentation that non-discipline specific faculty members are responsible for teaching an area of dental anesthesiology
Program documentation that faculty members are responsible for a particular teaching area

3-4 The number and time commitment of the faculty **must** be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

Examples of evidence to demonstrate compliance may include:
Faculty roster
Clinical and didactic schedules

3-5 A formally defined evaluation process **must** exist that ensures measurement of the performance of faculty members annually.

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

Examples of evidence to demonstrate compliance may include:
Faculty files
Performance appraisals

3-6 A faculty member **must** be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

Examples of evidence to demonstrate compliance may include:
Faculty clinic schedules

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

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

Examples of evidence to demonstrate compliance may include:
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation

Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-8 At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, **must** be consistently available to allow for efficient administration of the program.

Intent: *The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives.*

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-9 The program **must** provide ongoing faculty calibration at all sites where educational activity occurs.

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

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

STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

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

Intent: *Appropriate information resources should be readily available and include access to electronic databases, biomedical textbooks, dental journals, the internet and other learning resources. Lecture and seminar rooms and study areas for residents should be available.*

Examples of evidence to demonstrate compliance may include:
Description of resources

Selection of Residents

4-2 Applicants **must** have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:

a. Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b. Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c. Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-3 Specific written criteria, policies, and procedures **must** be followed when admitting residents.

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

Examples of evidence to demonstrate compliance may include:
Written criteria, policies, and procedures

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

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

Examples of evidence to demonstrate compliance may include:
Written policies and procedures on advanced standing
Results of appropriate qualifying examinations
Course equivalency or other measures to demonstrate equal scope and level of knowledge

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

a) A description of the educational experience to be provided
b) A list of competencies of residency training
c) A description of the nature of assignments to other departments or institutions

***Intent:** Programs are expected to make their lists of competency requirements developed in response to Standards 2-1 and 2-2 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs for which to apply. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.*

Examples of evidence to demonstrate compliance may include:
Program brochure, application documents or website content
Description of system for making information available to applicants who do not visit the program

Due Process

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

Intent: *Adjudication procedures should include institutional policy that provides due process for all individuals who may potentially be involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the 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, due-process policy, and current accreditation status of the program.*

Examples of evidence to demonstrate compliance may include:
Written policy statements and/or resident contract

Health Services

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

Examples of evidence to demonstrate compliance may include:
Immunization policy and procedure documents

STANDARD 5 - FACILITIES AND RESOURCES

5-1 Institutional facilities and resources **must** be adequate to provide the didactic and clinical 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 competency requirements. To ensure health and safety for patients, residents, faculty, and staff, the physical facilities and equipment should effectively accommodate the educational and patient care programs. Equipment and supplies for delivery of all forms of anesthesia care for dental patients should be readily accessible and functional. There should be a space properly equipped for monitoring patients' recovery from general anesthesia and sedation.*

5-2 In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies **must** be available in accord with all applicable accrediting bodies and state rules and regulations.

Examples of evidence to demonstrate compliance may include:
Certifications of current compliance/accreditation by appropriate governmental/accrediting agencies

5-3 All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care **must** be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

Examples of evidence to demonstrate compliance may include:
Certification/recognition records demonstrating advanced cardiovascular life support training or summary log of certification/recognition maintained by the program

5-4 All other faculty (not included in Standard 5-3) and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support for health care providers.

Examples of evidence to demonstrate compliance may include:
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program

5-5 Secretarial and clerical assistance **must** be sufficient to permit efficient operation of the program.

Intent: *The intent is to ensure operations of the program are managed in an efficient and expeditious manner without placing undue hardship on the faculty and residents in the program.*

Examples of evidence to demonstrate compliance may include:
Staff schedules

5-6 The program **must** document its compliance with the institution's policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies **must** be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases **must** be made available to applicants for admission and to patients.

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

Examples of evidence to demonstrate compliance may include:
Infection and biohazard control policies
Radiation policy

5-7 The program's policies **must** ensure that the confidentially of information pertaining to the health status of each individual patient is strictly maintained.

Examples of evidence to demonstrate compliance may include:
Confidentiality policy
HIPAA policy

STANDARD 6 – RESEARCH

6-1 Residents **must** engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

Intent: *One (1) month of scholarly activity could be gained in one (1) block or in smaller segments. Scholarly activity may include a hypothesis-driven research project, formal case review or review of literature. Options for advanced academic degrees are highly desirable.*