

**INFORMATIONAL REPORT ON ORTHODONTICS AND DENTOFACIAL
ORTHOPEDICS PROGRAMS (RESIDENCY AND FELLOWSHIP) ANNUAL SURVEY
CURRICULUM DATA**

Background: At its Winter 2015 meeting, the Commission directed that each Review Committee review a draft of its discipline-specific Annual Survey Curriculum Section during the Winter meeting in the year the Survey will be distributed. The Commission further suggested that each Review Committee review aggregate data of its discipline-specific Annual Survey Curriculum Section, as an informational report, when the materials are available following data collection and analysis. The Commission noted that all survey data is considered confidential at the programmatic level.

The Curriculum Section of the Commission's Annual Survey is conducted for orthodontics and dentofacial orthopedics residency programs and clinical fellowship training programs in craniofacial and special care orthodontics in alternate years. The most recent Curriculum Section was conducted in August/September 2024. Aggregate data of the most recent Curriculum Section for review by the Orthodontics and Dentofacial Orthopedics Review Committee as an informational report is provided in **Appendix 1** (residency) and **Appendix 2** (fellowship).

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education is requested to review the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Section (**Appendix 1** and **Appendix 2**).

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

2024-25 Orthodontics and Dentofacial Orthopedics Curriculum Survey Results

This report includes data collected in the 2024-25 *Survey of Advanced Dental Education* from all 68 advanced dental education programs in orthodontics and dentofacial orthopedics and one combined orthodontics/periodontics program accredited at the time of the survey.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?

Field	Minimum	Maximum	Mean	Count
a. Clinical (include related laboratory activity)	30.0	80.0	60.8	69
b. Didactic (include assigned laboratory activity)	8.0	50.0	22.9	69
c. Research	4.0	25.0	11.6	69
d. Teaching	0.0	10.0	4.1	69
e. Other, please specify	0.0	21.9	0.6	69

e. Other, please specify - Text

This time is allotted for the students to attend scientific meetings and courses that are deemed to enrich their educational experience

Attending Local, Regional and National Meetings and Seminars

Emergency on call, continuing education

Enrichment/ National and regional meetings

Independent Study

Lab Duties

Military

Participation in scientific conferences and lectures from invited speakers.

21e. Guest speakers and interdepartmental seminars

22. In which of the following interdisciplinary approaches did students/residents receive instruction or gain clinical consultation experience during the past 24-month period for the management of dental patients?

Question	Yes	No	Total
a. Case history	100.0%	0.0%	69
b. Cephalometric analysis	100.0%	0.0%	69
c. Intraoral radiographs	98.6%	1.4%	69
d. Model Analysis	98.6%	1.4%	69
d-1. Model Analysis: Plaster cast	82.6%	17.4%	69
d-2. Model Analysis: Digital models	100.0%	0.0%	69
e. Photographics	100.0%	0.0%	69
f. Cone beam imaging	100.0%	0.0%	69
g. Other, please specify	27.5%	72.5%	69

g. Other, please specify - Text

- 3-D printing (2)
- 3D facial scans
- Cleft Palate and Orthognathic Surgery
- Digital treatment planning, digital set up
- ITero scanning, Dental Monitoring, Aligners, 3D printing models, ULab
- Intraoral scanning
- Mechanotherapy
- Panoramic X-Ray, MRI for TMJ (2)
- Perio-AEGD-OMFS
- Simulation softwares
- TADs, Laser
- Various digital technologies such as intraoral scanners, 3D printers, diagnostic/treatment outcome simulations. Interdisciplinary seminar series (ortho/perio/prostho), oral maxillofacial surgery and craniofacial case discussions/treatment planning sessions.
- appliance design and fabrication
- digital panoramic imaging
- interdisciplinary seminars
- skeletal anchorage
- virtual surgical planning

23. What percentage of all patients are managed by the students/residents in each of following treatment mechanisms?

Field	Minimum	Maximum	Mean	Count
a. Fixed appliance (with or without a functional appliance)	10.0	99.0	77.7	69
b. Aligners (with or without a functional appliance)	1.0	90.0	17.9	69
c. Functional appliance (alone)	0.0	20.0	3.6	69
d. Other, please specify	0.0	22.2	0.8	69

d. Other, please specify - Text

Carrieri, Herbst, Class II correctors (like Forsus) are used with fixed appliances

Phase I/Phase II

SARPE/MARPE/RED/DECLEARC

Space maintainers, RPE

TAD/MAPRES

space maintenance

Comments from Orthodontics Curriculum Section page 1

21e. Guest speakers and interdepartmental seminars

Our program has a robust curriculum that covers biomechanics related to aligner therapy. However, our state medical assistance insurance does not provide coverage for aligner therapy at this time.

There are required military computer base trainings that need to be completed annually. The senior residents do teach the incoming residents regarding Dolphin, photography, and some Problem list and diagnosis. They are also assigned an appliance to present for the 1st year Appliance design course. Also, the seniors present a lecture of their choosing to the entire AFPDS.

24. What clinical procedures exist to ensure program objectives are met?

	Percentage
Experience with pre-surgical orthopedics for infants born with cleft lip and palate	50.7%
Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition	87.0%
Orthodontic management of patients with cleft or craniofacial anomalies	92.8%
Surgical/orthodontic treatment planning	100.0%
Pre- and post-surgical orthodontic management	98.6%
Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement	71.0%
Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs	98.6%
Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&SC) patients	92.8%
Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients	95.7%
Supervised participation in craniofacial team activities	79.7%
Participate in craniofacial team meetings	76.8%
Total	69

25. What is the average number of patients managed per student/resident during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	45	208	92.4	69

26. What is the average number of surgical orthodontic cases per student/resident managed with the active participation of the students/residents during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	0	30	5.4	69

27. What is the total number of patients with craniofacial abnormalities managed with the active participation of the students/residents during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	0	905	50.7	69

Comments from Orthodontics Curriculum Section page 2

25) Average number of patients for 1st Year: 50 2nd Year: 100 26) Average number of surgical patients for 1st Year: 2 2nd Year: 5 27) Total of 905 patients are followed by the team at REDACTED with approximately 300 in active orthodontic care. Each resident rotates through REDACTED for team activities and the CFA Orthodontic area of the orthodontic clinic

25. Average number of active patients per student = 45. Average number of active patients and active retention per student = 58

NAM procedures are performed by FT faculty with residents rotating through and observing. REDACTED Craniofacial Team has not reconvened since COVID as State program was defunded.

Question 25: PG1 is 88 and PG2 is 118

Question 25: This figure includes active retention patients and transfers

Surgical Orthodontic cases: Each resident has at least two or three patients assigned to them on average but they actively participate in the treatment of surgical orthodontic cases when they rotate with full-time faculty at the REDACTED

Surgical is related to Orthognathic surgery and Craniofacial is related to Phase I of cleft lip and palate (Alveolar Bone Graft)

Surgical splint design and construction are carried out by OMFS residents in conjunction with Virtual Surgical Planning. Orthodontic residents observe in the operation room.

The answer for Q25 included the transferred cases from the graduating class; the answer for Q26 could be at least one case occasionally; the answer for Q27 included the patients with craniofacial deformities seen at REDACTED for Cleft and Craniofacial Care.

The first year residents are assigned 35-38 cases. As second years, cases are inherited from the graduating class. This includes active cases, retention cases, and observation cases. The total number of patients managed by the second year residents can be 75-90 patients when including retention patients. Each first year is assigned 2 surgical cases as they are available. Surgical cases transfer to the second year resident from the graduating class. Some residents could manage 4-6 surgical cases in the second year. This could include cases with craniofacial anomalies.

Third year residents had about 144 patients between active and retention. Second year residents had about 105 patients between active and retention. First years were assigned around 90 new patients, but not all started.

This is a 2 year program. Each resident starts approximately 40-45 new cases. However, each resident additionally receives a considerable number of ongoing cases from their assigned senior upon graduation ("lineage cases").

We assign each resident 50-55 initial patients to diagnose and treatment plan in the fall of the 1st year and they receive 10-20 transfer patient at the end of their 2nd year from the graduating 2nd year residents

We do a significant amount of Orthognathic Surgery, Cleft Palate Treatment and Craniofacial Patients.

28. What is the average number of patients per student/resident initiating active treatment that were assigned to the students/residents during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
a. 1st year students/residents	6	200	54.9	69
b. 2nd year students/residents	0	200	20.1	69
c. 3rd year students/residents	0	80	4.7	69

29. What is the average number of patients who completed active treatment by the students/residents during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
a. 1st year students/residents	0	90	6.7	69
b. 2nd year students/residents	0	320	31.2	69
c. 3rd year students/residents	0	85	29.4	69

30. What is the average number of active retention patients managed per student/resident during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
a. 1st year students/residents	0	100	15.4	69
b. 2nd year students/residents	0	150	36.1	69
c. 3rd year students/residents	0	100	24.2	69

Comments from Orthodontics Curriculum Section page 3

Additional comprehensive case load for second years are limited to transfer cases from graduating residents

All completed/debonded patients are provided retainers that are planned and designed with the residents. Our follow up with these patients in retention is the approximate average noted in #30.

Most of retention patients are divided to 3rd year and 2nd year. 2nd year receive most of the retention patients from the 3rd year after graduation.

Program started October 2023. Each student started 50 cases and were given transfer cases from those in the ortho clinic to complete and/or monitor retention

There is an overlap of patients followed for active retention in all three years.

Treatment is done in vertical teams (R1,R2, & R3). Starts were broken down by year, but all team members play a role in the treatment of new patients.

31. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the students/residents.

Field	Minimum	Maximum	Mean	Count
a. Number of faculty positions	2	26	11.4	69
b. Total number of hours per week	22	300	87.6	69

32. How often does the program conduct formal documented evaluations of student/resident clinical performance?

	Percentage
Weekly	1.5%
Monthly	0.0%
Quarterly	14.7%
Biannually (i.e., twice a year)	80.9%
Annually	2.9%
Total	68

33. How often does the program conduct formal documented evaluations of faculty?

	Percentage
Weekly	0.0%
Monthly	0.0%
Quarterly	2.9%
Semiannually	20.6%
Annually	76.5%
Total	68

Comments from Orthodontics Curriculum Section page 4

#31. One full-time faculty: 32 hours/week + Three part-time faculty: 20 hours/week #32 and #33: **REDACTED**
Orthodontic Division conducts formal document evaluations of residents and faculty semiannually.

2 FT (100%) faculty One faculty at 50% Two faculty at 20% each 22 faculty at 10% each

31: adjunct/part-time faculty included

Faculty are reviewed annually via the **REDACTED** Credentials office and through the end of the year resident evaluations

For Q32, we also conduct daily evaluations with Survey Monkey.

Most faculty members are on an every other week schedule. If they attend one day every other week, they are scheduled for 7 hours of clinic supervision every day they cover clinic. That equates to 3.5 hours of supervision per week. There are 3.68 FTE when adding together the percent of effort from all 17 faculty members.

The program also has 10+ community-based contracted-volunteer orthodontic faculty members that are dedicated to providing clinic supervision, and didactic instruction, to the residents.

the program director reviewed resident evaluation and clinical performance with each resident semi-annually and more frequently if required

2024-25 Clinical Fellowships in Craniofacial and Special Care Orthodontics Curriculum Survey Results

This report includes data collected in the 2024-25 *Survey of Advanced Dental Education* from all seven clinical fellowship training programs in craniofacial and special care orthodontics accredited at the time of the survey.

21. What clinical procedures exist to ensure program objectives are met?

	Percentage
Experience with pre-surgical orthopedics for infants born with cleft lip and palate	100.0%
Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition	100.0%
Orthodontic management of patients with cleft or craniofacial anomalies	85.7%
Surgical/orthodontic treatment planning	100.0%
Pre- and post-surgical orthodontic management	100.0%
Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement	85.7%
Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs	100.0%
Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&SC) patients	85.7%
Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients	100.0%
Supervised participation in craniofacial team activities	100.0%
Participate in craniofacial team meetings	100.0%
Total	7

22. Which of the following experiences exist in the program for each student/fellow?

	Percentage
Regularly scheduled grand rounds case presentations	100.0%
Historical and current scientific literature review	100.0%
Research methodology and biostatistics	100.0%
Training in the allied medical sciences and social services required to manage the unique needs of CFA&SC patients and their families	85.7%
Total	7

We have a full-time social worker who is part of the dental division at **REDACTED**.

23. What is the average number of patients completing a full sequence of treatment logged by each student/fellow per year?

Field	Minimum	Maximum	Mean	Count
	0	450	103.1	7

24. What is the average number of orthognathic cases managed per student/fellow during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	5	50	28.6	7

25. What is the average number of patients with craniofacial abnormalities managed per student/fellow during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	10	950	257.1	7

26. What is the average number of patients per student/fellow initiating active treatment during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	10	700	132.1	7

27. What is the average number of retention patients managed per student/fellow during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	15	80	41.4	7

28. What is the average number of patients per student/fellow who completed active treatment during the 2023-24 academic year?

Field	Minimum	Maximum	Mean	Count
	5	60	30.0	7

Comments from Craniofacial and Special Care Orthodontics Clinical Fellowships Curriculum Section page 2

The craniofacial team examines 25 patients per week, over 1200 craniofacial patients per year. Over 450 patients are in active treatment. The orthodontic clinic treats 12-16 patients per morning or afternoon session. Treatment occurs 4 days per week, craniofacial patient examinations and nasoalveolar molding for 1 day per week.

29. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the students/fellows.

Field	Minimum	Maximum	Mean	Count
a. Number of faculty positions	3	10	5.7	7
b. Total number of hours per week	32	240	80.0	7

30. How often does the program conduct formal documented evaluations of students'/fellows' clinical performance?

	Percentage
Weekly	0.0%
Monthly	0.0%
Quarterly	14.3%
Semiannually	85.7%
Annually	0.0%
Total	7

31. How often does the program conduct formal documented evaluations of faculty?

	Percentage
Weekly	0.0%
Monthly	0.0%
Quarterly	0.0%
Semiannually	57.1%
Annually	42.9%
Total	7

32. Does anyone else treat the patients of the orthodontic fellows?

Treat craniofacial anomaly patients?	Yes	No	Total
a. Orthodontic students/residents	28.6%	71.4%	7
b. Postdoctoral students/residents in other types of programs	0.0%	100.0%	7

Number of craniofacial anomaly patients

	Minimum	Maximum	Mean	Count
a. Orthodontic students/residents	0	95	46.7	3
b. Postdoctoral students/residents in other types of programs	0	0	0.0	0

Treat special care needs patients?	Yes	No	Total
a. Orthodontic students/residents	28.6%	71.4%	7
b. Postdoctoral students/residents in other types of programs	0.0%	100.0%	7

Number of special care needs patients	Minimum	Maximum	Mean	Count
a. Orthodontic students/residents	0	30	11.7	3
b. Postdoctoral students/residents in other types of programs	0	0	0.0	0

Comments from Craniofacial and Special Care Orthodontics Clinical Fellowships Curriculum Section page 3

The number of patients who require care exceeds the capacity of the fellow to treatment them all. Therefore, orthodontic residents also treat craniofacial and special care patients. The fellow treats the most complex patients.

We do work closely with oral and maxillofacial surgery residents.

**CONSIDERATION OF PROPOSED REVISION TO THE ACCREDITATION
STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN
ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RELATED TO
FACULTY RATIOS**

Background: On September 18, 2023, the Commission on Dental Accreditation (CODA) received a request from Dr. Daniel Rinchuse, professor and program director of the orthodontics and dentofacial orthopedics education program at Seton Hill University, to consider a proposed revision to Standards 2-9 and 2-10 of the Accreditation Standards for Advanced Dental Education Program in Orthodontics and Dentofacial Orthopedics (**Appendix 1**).

Dr. Rinchuse believes that Standards 2-9 and 2-10 of the Orthodontics and Dentofacial Orthopedics Standards should be reviewed and revised related to the required faculty to student/resident ratios.

Winter 2024 Commission Meeting: At its Winter 2024 meeting, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) reviewed the request from Dr. Daniel Rinchuse on faculty-to-student/residents ratios in the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics. The Review Committee began with a discussion of the process to revise Accreditation Standards. The ORTHO RC recalled that the Standards were revised to assure the quality of education provided to students/residents within the program. The Committee noted that the Council of Education (COE) of the American Association of Orthodontists (AAO), and the Society of Educators (SOE) reviewed and received feedback from the orthodontic community on these Standards before submitting them to the Commission on Dental Accreditation. However, the ORTHO RC believed that the Standards may need to be reviewed at this time to ensure clarity given their intent and impact of their application on educational programs.

Regarding Standard 2-9, the ORTHO RC discussed that there may be confusion related to the ratio as it pertains to faculty interaction with students/residents in the entire program. The ORTHO RC noted that the faculty-to-student/resident ratio in Standard 2-9, requires one (1) faculty to every four (4) students/residents, including all the faculty “for the entire program,” and it is not limited to board-certified orthodontists. It was noted that the further consideration of this Standard and the portion “for the entire program,” is warranted.

The ORTHO RC noted that Standard 2-10 concentrates on clinical coverage for student/resident education, which could be affected by external factors such as limited faculty, unexpected faculty absences due to illness, and the students’/residents’ competence level. It was also noted in the request that the number of patients per student/resident may affect the ratio of faculty needed to oversee student/resident clinical care provided to patients. The ORTHO RC also noted that consideration of this Standard may warrant a review of procedure-based ratios to assure adequate faculty supervision based on the complexity of procedures that may be performed by students/residents.

Following discussion, the ORTHO Review Committee recommended formation of an Ad Hoc Committee of ORTHO RC members to further review Standards 2-9 and 2-10. The ORTHO RC also recommended that the Ad Hoc Committee include two (2) to three (3) individuals from a

group of individuals nominated by the AAO and selected by the Commission. Further, the ORTHO RC recommended that the Commission contact the American Association of Orthodontists (AAO), Council on Education (COE), and Society of Educators (SOE) to provide feedback to the CODA Ad Hoc Committee, including information on this topic from orthodontics and dentofacial orthopedics education programs.

At its Winter 2024 meeting, the Commission concurred with the recommendations of the ORTHO RC and directed the formation of an Ad Hoc Committee of ORTHO RC members and two (2) to three (3) individuals from a group of individuals nominated by the AAO and selected by the Commission. Additionally, CODA directed that the Commission contact AAO, COE and SOE to provide feedback on Standards 2-9 and 2-10 to the Ad Hoc Committee.

Meetings of the Ad Hoc Committee: In accordance with the prior directives of the Commission on Dental Accreditation, an Ad Hoc Committee was established. The Ad Hoc Committee meet on May 28, 2024 and October 7, 2024. All Ad Hoc Committee members attended both meetings, as follows: Dr. Glenn Sameshima (Ad Hoc Chair and Commissioner), Dr. Sarandeep Huja (RC Member), Dr. Laura Iwasaki (AAO), Dr. Ki Beom Kim (AAO), Dr. Howard Lieb (RC Member), Ms. Marty Nicholson (RC Member), Dr. Juan Palomo (RC Member), Dr. Emile Rossouw (RC Member) and Dr. Reginald Taylor. (AAO). Dr. Yesenia Ruiz, manager, Advanced Dental Education, and Dr. Sherin Tooks, senior director, CODA and Ms. Samara Schwartz, senior associate general counsel, ADA/CODA attended both meetings. Ms. Peggy Soeldner, senior manager, Administration and Committees, attended the meeting on October 7, 2024.

The Ad Hoc Committee initiated its discussion by reviewing its charge and the background materials, including feedback from the American Association of Orthodontists (AAO), Council on Education (COE), and Society of Educators (SOE) (**Appendix 2**), and Frequency of Citings (**Appendix 3**). The most current Citings was provided following the Commission's Summer 2024 meeting and reviewed at the second meeting of the Ad Hoc Committee.

Related to Standard 2-9, which requires a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components, the Ad Hoc Committee first noted that institutions may have different definitions related to FTE faculty. The Committee also believed that there may be confusion about which faculty members are included in the FTE required by Standard 2-9. The Ad Hoc Committee concluded that Standard 2-9 should be retained to ensure sufficient overall resources to the program in all aspects, including didactic, clinical, administration, and research components of the program. However, the Ad Hoc Committee believed that further clarification to Standard 2-9, through a new intent statement, was warranted. The proposed intent statement could clarify that any faculty member who teaches in the advanced dental education program in orthodontics and dentofacial orthopedics, whether a faculty within the orthodontics and dentofacial orthopedics program or outside of the program, would be included in the ratio to comply with Standard 2-9. The proposed revision to Orthodontics and Dentofacial Orthopedics Standard 2-9 is found in **Appendix 4**.

The Ad Hoc Committee also discussed Standard 2-10, which requires no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program. The Committee noted that for a four-

hour clinical session with eight (8) students/residents and one (1) faculty, there is approximately 30 minutes of faculty time per student/resident for instruction, patient examination, discussion of cases, clinical administration duties, etc. The Committee noted that Standard 2-10 is intended to ensure appropriate faculty coverage to oversee patient care and provide educational oversight of the clinical portion of the program. Therefore, the Ad Hoc Committee concluded that the current ratio required by Standard 2-10 is appropriate and no further revisions are warranted at this time.

Summary: At this meeting, the Orthodontics and Dentofacial Orthopedics Review Committee and the Commission are asked to consider the background information (**Appendices 1, 2, and 3**) and proposed new intent statement to Standard 2-9 of the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (**Appendix 4**). The Orthodontics and Dentofacial Orthopedics Review Committee may recommend, and the Commission may direct, that the proposed new intent statement to Standard 2-9 be adopted and implemented immediately. Alternately, the Review Committee may recommend, and the Commission may direct, circulation to the communities of interest for review and comment, with Hearings and future consideration by the Commission. The Orthodontics and Dentofacial Orthopedics Review Committee may also recommend, and the Commission may direct, that there be no revision to the Accreditation Standards at this time, or the Review Committee may recommend, and the Commission may direct, circulation of additional proposed revisions to Accreditation Standards for Orthodontics and Dentofacial Orthopedics Education Programs.

Recommendation:

Prepared by: Dr. Sherin Tooks and Dr. Yesenia Ruiz

From: [Daniel Rinchuse](#)
To: [Tooks, Sherin](#)
Cc: [Susan Yochum](#)
Subject: CODA Faculty to Student ratios
Date: Monday, September 18, 2023 1:43:01 PM

Date: September 18, 2023

RE: Discussion points for CODA, Faculty to resident ratios

Dear Dr. Sherin Tooks, CODA Senior Director:

The purpose of this letter is to briefly comment on the new CODA requirements regarding the number of faculty to student/resident ratios. I write this from the perspective of someone who has been in graduate orthodontic education for 47 years, and has earned a PhD in Higher Education from the University of Pittsburgh. Importantly, I would have you consider our concerns even though we are a rather small orthodontic program of 8 residents per year and in compliance with these ratios:

- *The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components. (Standard 2-9)*

- *For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program. (Standard 2-10)*

How were these ratios determined? Is there any educational foundation? Is this based on oral surgery residencies? Oral surgery and orthodontics are likely the most polar opposite advanced dental education (specialty) programs, with oral surgery potentially needing more supervision because of relatively high morbidity compared to orthodontics with relatively little morbidity, and no mortality.¹ Jerrold,² an orthodontist and attorney, argued that orthodontics is essentially elective, correcting a malocclusion is not medically necessary, and “for the most part, humans can live very well with crooked teeth.”

Specific faculty to resident ratios can be punctilious, arbitrary, capricious, simplistic, and not considering the many ramifications. For instance, for a 30-month program like ours, half of the year the faculty to student/resident ratios will be different. Particularly, at Seton Hill University we have 8 residents per year so half the year we have two classes for a total of 16 residents, and the other half we have three classes for a total of 24 residents. Also, the number of patients seen by residents per day is not factored in. For example, in one program residents could be seeing 4-6 patients per day (*at Seton Hill University*) while in other programs residents may be seeing as many as 20 or more patients.

It could be argued that graduate students may need less academic supervision than undergraduates since more responsibility for their own education is required of them. In other words, learners should be the agents of their own learning.³ The teacher being more of a guide, fostering curiosity, creativity, innovations, and life-long learning. With emphasis on metacognition, the process of the student reflecting on and directing his/her own thinking and learning, learning becoming more self-directed. Especially at the graduate level, learning is more ubiquitous, with no boundaries, happening everywhere at any time. This would align with focus on learning rather than teaching.^{3,4}

These ratios, requiring more faculty, are going to tremendously increase the cost of an orthodontic education with already exorbitant student debt. In their 2019 article Samson and Schwartz⁵ reported orthodontic accumulative educational debt as being as high as \$700,000-\$1,000,000. Stoker et al⁶ suggested that orthodontics may be nearing a “bubble market” where the educational debt outweighs the gain.

There is already a significant orthodontic faculty shortage,⁷ which has been identified years ago.^{8,9} Trotman et al⁹ concluded in their article: “As the dental profession enters the new millennium, it is faced with a serious manpower shortage caused both by the retirement of aging faculty and clinical practitioners, and by a decrease in the number of people entering dental education.” To this point, Vaden¹⁰ wrote that we lack qualified and enlightened teachers. He went on to say that: “Many bright young graduates who would make great educators have so much debt, and so many family demands, that they seek what are, at present, more lucrative avenues in the private sector.” How will orthodontic programs be able to recruit quality faculty? Hiring by numbers only and not experience and quality, will result (and is currently readily observed as Vaden remarked) in having inexperienced and under qualified faculty. All faculty are not the same,¹¹⁻¹³ and education should ultimately not be a numbers game only.

We would appreciate very much your response to our concerns, and would encourage further dialogue.

REFERENCES

- 1 Rinchuse DJ, Rinchuse DJ. Orthodontics justified as a profession. *Am J Orthod Dentofacial Orthop* 2002;121:93-96.
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- 3 Ambrose SA, Wankel LA. Higher education’s road to relevance. Jossey-Bass:Hoboken, NJ, 2020.
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Sincerely,

Daniel Rinchuse, DMD, MS, MDS, PhD

Professor and Program Director

Advanced Education Program in Orthodontics and Dentofacial Orthopedics

Seton Hill University, Center for Orthodontics

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Received by CODA
4/19/2024

Dear Dr. Tooks,

Myron Guymon, DDS, MS
President

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Please pardon the delayed response. We had hoped to get more feedback from orthodontic educators on Standards 2-9 and 2-10. Not everyone responded. Unfortunately, I don't know that our data will provide a lot of assistance.

Our request was straightforward. Senior educators (program chairs or equivalent) were asked the following questions.

1. After listing Standard 2.9, participants were asked ...

Does this standard make sense to you?

80% yes
20% no

-
2. **If you answered NO, do you have any suggestions or comments on this standard?** (Direct comments copied below, we did not edit. If we received identical comments, it's only noted once.)

- Do faculty need to be part of the orthodontic department/division?
- Do all faculty need to be orthodontists
- Do the same 1 FTE have to be the students, didactic and research faculty?
- Why must they be full-time faculty? Could they be part-time faculty?
- **Could it be worded:** "The program must maintain a minimum ratio of one FT-equivalent faculty to four students/residents across all program components, including clinical didactic, administrative and research activities. Only faculty actively engaged in residents' teaching and research activities can be counted to this ratio."
- Provide the definition of full time **equivalent** faculty?
- Multiple "no comment"

-
3. After listing Standard 2.10, participants were asked ...

Does this standard make sense to you?

78% yes
22% no

#3 is continued on next page.

NOTE regarding Question #3: There were responders who answered no to both question 1 & 3. But there were multiple who answered differently to questions 1 & 3.

4. If you answered NO do you have any suggestions or comments on this standard?

- I understand it, but does it need to be eight to one for all clinics? Some days we don't need that type of ratio. Why was this implemented?
- Not sure where the ratio 1 per 8 came from, but there is no reason for it to be independent of the procedure. Other specialties have faculty supervision requirements for sedation or procedures that are life threatening to patients, but we do not have such situation in orthodontics. Several procedures such as records and retainer check can have a faculty member cover more than 8 residents easily. I don't think 2.10 is a requirement that is doing what it was designed to do, and should be retired.
- Why? How was this number determined? In order to assure that the orthodontic graduate students/residents are provided supervision that is adequate for them to be educated and trained to the required level of proficiency in orthodontics, the program must ensure the presence of at least one (1) faculty per each eight (8) students per clinical period.
- Based on this not mentioning FTE, this could include part-time faculty on the clinic floor?
- Are all programs really following this? It seems that if you have over 60 residents, you're not going to always have 8 educators on the clinic floor.
- Confusing and should be eliminated.
- Multiple no comment.

We hope that the educators selected for the subcommittee / task force will be able to use this in some way.

Sincerely,
Michelle Ritterskamp
Senior Continuing Education Specialist / COE & SOE Liaison
Education & Events Team

**ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION
PROGRAMS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS
(January 2014 Standards)**

Frequency of Citings Based on Required Areas of Compliance

Total Number Programs Evaluated: 77

January 1, 2014 through June 30, 2022

STANDARD 1 – INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS –
23 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	1	Documentary evidence of agreements, approved by the sponsoring and relevant affiliated institutions, must be available.
1	1-2	All arrangements with sites where educational activity occurs, 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.
	1-3	Documentary evidence of agreements, approved by the sponsoring and relevant 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:
1	1-3d	d. The period of assignment of students/residents;
1	1-3e	e. Each institution's financial commitment.

STANDARD 2 – PROGRAM DIRECTOR & TEACHING STAFF – 19 Required Areas
of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	2-8	The number and time commitment of faculty must be sufficient to provide full supervision of the clinical portion of the program.

STANDARD 3 – FACILITIES AND RESOURCES – 17 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
2	3	All students/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.
1	3	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.
1	3-1	Adequate space must be designated specifically for the advanced dental education program in orthodontics and dentofacial orthopedics.
1	3-2	Facilities must permit the students/residents to work effectively with trained allied dental personnel.
2	3-5	Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/residents to achieve the educational goals of the program.

STANDARD 4 – CURRICULUM AND PROGRAM DURATION – 48 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	4-2a	Biomedical Sciences: A graduate of an advanced dental education program in orthodontics must be competent to: Develop treatment plans and diagnosis based on information about normal and abnormal growth and development;
1	4-3.4i	A graduate of an advanced dental education program in orthodontics must be competent to: Develop and document treatment plans using sound principles of appliance design and biomechanics;
	4-4	The orthodontic graduate must have understanding of:
1	4-4a	a. Biostatistics;
1	4-4c	c. Jurisprudence;
1	4-4d	d. Oral Physiology;

Proposed Revision to Orthodontics and Dentofacial

Orthopedics Standards Related to Faculty Ratios

Orthodontics and Dentofacial Orthopedics RC

CODA Winter 2025

1	4-4e	e. Pain and Anxiety Control;
1	4-4g	g. Periodontics;
1	4-4h	h. Pharmacology;
1	4-4j	j. Psychological Aspects of Orthodontic and Dentofacial Orthopedic Treatment;
1	4-4k	k. Public Health Aspects of Orthodontics and Dentofacial Orthopedics;
1	4-4l	l. Speech Pathology and Therapy;

STANDARD 5 – ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS –
 16 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	5, 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.
	5, Evaluation	A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program:
1	5a, Evaluation	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.
1	5b, Evaluation	Provides students/residents an assessment of their performance, at least semiannually.

STANDARD 6 – RESEARCH – 2 Required Areas of Compliance

**ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION
PROGRAMS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS
(July 2022 Standards)**

Frequency of Citings Based on Required Areas of Compliance

Total Number Programs Evaluated: 5
July 1, 2022 through October 31, 2022

STANDARD 1 – INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS –
26 Required Areas of Compliance

STANDARD 2 – PROGRAM DIRECTOR & TEACHING STAFF – 22 Required Areas
of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	2	Documentation of all program activities must be ensured by the program director and available for review.
1	2-2	The program director position must be full-time as defined by the institution.
1	2-3	There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.

STANDARD 3 – FACILITIES AND RESOURCES – 18 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	3-6	Clinical facilities must be provided within the sponsoring or affiliated institution to fulfill the educational needs of the program.

STANDARD 4 – CURRICULUM AND PROGRAM DURATION – 47 Required Areas
of Compliance

STANDARD 5 – ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS – 9
Required Areas of Compliance

STANDARD 6 – RESEARCH – 2 Required Areas of Compliance

ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Frequency of Citings Based on Required Areas of Compliance

Total Number Programs Evaluated: 18

July 1, 2022 through October 31, 2023

STANDARD 1 – INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS – 26 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	1	The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement.
1	1-1	Graduates must receive instruction in 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.

STANDARD 2 – PROGRAM DIRECTOR & TEACHING STAFF – 22 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
2	2	Documentation of all program activities must be ensured by the program director and available for review.
1	2-2	The program director position must be full-time as defined by the institution.
1	2-3	There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.
1	2-5	For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.

Proposed Revision to Orthodontics and Dentofacial
Orthopedics Standards Related to Faculty Ratios
Orthodontics and Dentofacial Orthopedics RC
CODA Winter 2025

1	2-8	In addition to their regular teaching responsibilities with the department, fulltime faculty must have adequate time for their own professional development.
3	2-9	The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.
1	2-10	For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program.

STANDARD 3 – FACILITIES AND RESOURCES – 18 Required Areas of Compliance

Noncompliance Citings	<u>Accreditation Standard</u>	Required Area of Compliance
1	3	All students/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.
1	3-5	Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/residents to achieve the educational goals of the program.
2	3-6	Clinical facilities must be provided within the sponsoring or affiliated institution to fulfill the educational needs of the program.

STANDARD 4 – CURRICULUM AND PROGRAM DURATION – 47 Required Areas of Compliance

STANDARD 5 – ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS – 9 Required Areas of Compliance

STANDARD 6 – RESEARCH – 2 Required Areas of Compliance

Commission on Dental Accreditation

Proposed Revision to Standard 2-9, Submitted by the Ad Hoc Committee for Consideration by the Commission in Winter 2025

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics

Proposed Revision to Orthodontics and Dentofacial
Orthopedics Standards Related to Faculty Ratios
Orthodontics and Dentofacial Orthopedics RC
CODA Winter 2025

STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

- 2-9** The program **must** ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.

Intent: The program ensures sufficient faculty including non-orthodontic faculty such as qualified didactic and clinical faculty from other disciplines.

- 2-10** For clinic coverage, the program **must** ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program.

CONSIDERATION OF ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RELATED TO ADMINISTRATIVE OVERSIGHT AT MAJOR SITES WHERE EDUCATIONAL ACTIVITY OCCURS

Background: At its Winter 2024 meeting, the Commission considered the New Business report of the Review Committee on Predoctoral Dental Education (PREDOC RC), which included a discussion about the possibility of program directors working remotely and not in-person, on-site at one of the program's approved educational sites. The PREDOC RC recognized the Commission does not have a defined policy or requirement in some discipline-specific Accreditation Standards that stipulates the program director must be in-person, on-site to fulfill the duties as written in the Accreditation Standards. The PREDOC RC believed that CODA should clearly define this expectation for future interpretation of program director qualifications in accordance with the discipline-specific Accreditation Standards. Through a discussion, the PREDOC RC recognized that new technologies and an increasing remote workforce may allow program directors to complete some job tasks remotely. However, tasks such as supervision of faculty and some day-to-day job responsibilities would require the program director to be in-person, on-site at the program's approved educational sites. Additionally, for programs that have multiple approved educational sites that may be geographically separated from the sponsoring institution, including those throughout an individual state or located in different states, it is not clearly defined how much time the program director should spend at each site for supervision over the day-to-day operations, as listed in the discipline-specific Accreditation Standards, or the requirement to delegate site supervision responsibilities. The PREDOC RC believed CODA may need to investigate and review the in-person, on-site work expectations for program directors to determine if changes are needed to the Accreditation Standards for dental education, advanced dental education, and allied dental education programs. Following consideration, the Commission directed an Ad Hoc or Standing Committee to investigate in-person, on-site work expectations for program directors to determine if changes are needed in the discipline-specific Accreditation Standards for dental education, advanced dental education, and allied dental education programs.

Additionally, at its Winter 2024 meeting, the Commission considered the New Business report of the Review Committee on Dental Hygiene Education (DH RC) related to program administrators that may be remotely located from the program's campus. The DH RC considered whether there should be oversight of remote program sites by an on-site individual who reports to the program director. The DH RC noted that some advanced dental education Standards require an on-site supervisor at remote program locations. The Commission noted that the Dental Hygiene Review Committee would monitor trends in remote program locations for dental hygiene education.

Following consideration, at its Winter 2024 meeting, the Commission on Dental Accreditation (CODA) directed an Ad Hoc or Standing Committee to investigate in-person, on-site work expectations for program directors to determine if changes are needed in the discipline-specific Accreditation Standards for dental education, advanced dental education, and allied dental education programs.

Summer 2024: The Ad Hoc Committee, which was comprised of all current CODA Commissioners, met on August 7, 2024 at the ADA Headquarters, in association with the Commission's Summer 2024 meeting. The Ad Hoc Committee reviewed the background materials, which included the Commission's action leading to the Ad Hoc Committee, and the Standards for each discipline related to program director (**Appendix 1**). The Ad Hoc Committee noted that the Advanced Education in

General Dentistry, General Practice Residency Standards, and Pediatric Dentistry Standards include a requirement for a site director/site administrator at all off-campus clinical locations. The Committee discussed the changing environment in dental and dental hygiene education, noting increased establishment of off-campus sites where students spend a majority or all their time, much like a satellite campus. It was noted that while all CODA Standards have a requirement for clinical supervision at all educational activity sites, it was noted that most Standards do not address overall administrative oversight of the program, by the program director or a designee, at all sites where a student spends a majority or all their time. The Committee discussed whether virtual oversight or assignment of a responsible individual would be appropriate at all educational sites. The Committee believed there must be consistency in the educational program at all program sites.

Following consideration, the Ad Hoc Committee concluded that each Review Committee that does not currently have a Standard related to administrative oversight at major educational activity sites (e.g., off-campus sites where students spend a majority or all their time) should review this topic and determine whether a Standard is needed to address the Commission's expectation for administrative oversight, for consideration by the Commission in Winter 2025. In considering this matter, the Commission noted that inclusion of Intent Statements, in conjunction with proposed Standards, could further clarify the flexibility permitted for programs to oversee educational sites in a variety of ways, while ensuring administrative oversight and consistency in the educational program across all sites. At its Summer 2024 meeting, the Commission on Dental Accreditation concurred with the recommendations of the Ad Hoc Committee.

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education is requested to review the orthodontics and dentofacial orthopedics and clinical fellowship training programs in craniofacial and special care orthodontics Accreditation Standards (**Appendix 1**) related to administrative oversight at major educational activity sites (e.g., off-campus sites where students spend a majority or all their time) and determine whether a Standard is needed to address the Commission's expectation for administrative oversight. The Review Committee may determine that Standards already exist, which address overall administrative oversight of the program, by the program director or a designee, at all sites where a student/resident/fellow spends a majority or all their time. Alternately, the Review Committee may determine that Standards require modification or addition, and may propose changes to the Commission for further consideration including possible circulation to the communities of interest for a period of comment.

Recommendation:

Prepared by: Dr. Sherin Tooks

**COMMISSION ON DENTAL ACCREDITATION
STANDARDS RELATED TO PROGRAM DIRECTOR REQUIREMENTS**

Current Standards are in Black Font
New Adopted Standards are in Red Font
Proposed Standards are in Green Font

Discipline	Standard Number	Requirement of the Standard
Predoctoral Dental		
	N/A	
Dental Assisting		
	Standard 2-25	<p>The dental assisting faculty must plan, approve, supervise, and evaluate the student’s clinical experience, and the following conditions must be met:</p> <ul style="list-style-type: none"> a. A formal agreement exists between the educational institution and the facility providing the experience b. The program administrator retains authority and responsibility for the student c. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the dental assisting program. d. The facility accommodates the scheduling needs of the program e. Notification for termination of the agreement ensures that instruction will not be interrupted for currently assigned students f. Expectations and orientation are provided to all parties prior to student assignment
	Standard 3-1	<p>The program must be a recognized entity within the institution’s administrative structure which supports the attainment of program goals.</p> <p>Intent: <i>The position of the program in the institutions administrative structure should permit direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program The administration of the program should include formal provisions for program planning, staffing, management, coordination and evaluation.</i></p>
	Standard 3-2	<p>The program administrator must have a full-time commitment to the institution and an appointment which provides time for program operation, evaluation and revision. The program administrator must have the authority and responsibilities for:</p>

		<p>a. Budget preparation b. Fiscal administration c. Curriculum development and coordination d. Selection and recommendation of individuals for faculty appointment and promotion e. Supervision and evaluation of faculty f. Determining faculty teaching assignments and schedules g. Determining admissions criteria and procedures h. Scheduling use of program facilities i. Development and responsibilities to maintain CODA accreditation compliance and documentation</p> <p>Intent: <i>The program administrator's teaching contact hours and course responsibilities are less than a full-time instructor who does not have administrative responsibilities or as defined by the collective bargaining agreement of the institution or state teachers association. The program administrator's teaching contact hours and course responsibilities allow sufficient time to fulfill assigned administrative responsibilities.</i></p>
	Standard 3-3	<p>The program administrator must be a Dental Assisting National Board "Certified Dental Assistant" or dentist licensed to practice in the state of the program location*, with occupational experience in the application of fourhanded dentistry principles, either as a dental assistant or working with a chairside assistant.</p>
	Standard 3-4	<p>The program administrator must have a baccalaureate degree or higher. The program administrator must have had instruction in educational theory and methodology, e.g., curriculum development, educational psychology, test construction, measurement and evaluation.</p>
	Standard 3-10	<p>Faculty must be ensured a form of governance that allows participation in the program and institution's decision-making process.</p> <p>Intent: <i>There are opportunities for program faculty representation on institution-wide committees and the program administrator is consulted when matters directly related to the program are considered by committees that do not include program faculty.</i></p>
	Standard 3-11	<p>A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member.</p> <p>Intent: <i>An objective evaluation system including student, administration and peer evaluation can identify strengths and weaknesses for each faculty member (to include those at distance sites) including the program administrator. The results of evaluations should be communicated to faculty members on a regular basis to ensure continued improvement.</i></p>

	Standard 4-10	<p>It is preferable and, therefore recommended, that the educational institution provide physical facilities and equipment which are adequate to permit achievement of the program’s objectives. If the institution finds it necessary to contract for use of an existing facility for laboratory, preclinical and/or clinical education, then the following conditions must be met in addition to all existing standards.</p> <p>a. There is a formal agreement between the educational institution and agency or institution providing the facility.</p> <p>b. The program administrator retains authority and responsibility for instruction.</p> <p>c. All students receive instruction and practice experience in the facility.</p> <p>d. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the educational program.</p> <p>e. Availability of the facility accommodates the scheduling needs of the program.</p> <p>f. Notification for termination of the contract ensures that instruction will not be interrupted for currently enrolled students.</p> <p>g. Instruction is provided and evaluated by calibrated dental assisting program faculty.</p> <p>Intent: <i>This standard applies to sites off-campus used for laboratory, preclinical and/or clinical education. All students assigned to a particular facility are expected to receive instruction in that facility. This standard is not applicable to dental offices/clinic sites used for clinical/externship practice experience.</i></p>
Dental Hygiene		
	Standard 3-2	<p>The dental hygiene program administrator must have a full-time appointment as defined by the institution, whose primary responsibility is for operation, supervision, evaluation and revision of the program.</p> <p>Intent: <i>To allow sufficient time to fulfill administrative responsibilities, program administrative hours should represent the majority of hours, and teaching contact hours should be limited.</i></p>
	Standard 3-4	<p>The program administrator must have the authority and responsibility necessary to fulfill program goals including:</p> <p>a) curriculum development, evaluation and revision;</p> <p>b) faculty recruitment, assignments and supervision;</p> <p>c) input into faculty evaluation;</p> <p>d) initiation of program or department in-service and faculty development;</p> <p>e) assessing, planning and operating program facilities;</p> <p>f) input into budget preparation and fiscal administration;</p>

		g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.
Dental Laboratory Technology		
	Standard 3-3	A program administrator who is employed full-time (as defined by the institution) and who is responsible for the day-to-day implementation of the program and must have the authority, responsibility and privileges necessary to manage the program.
	Standard 3-4	The program administrator must: a) have the educational background and occupational experience necessary to understand and fulfill the program goals b) have attained a higher level of education than that presented in the program or be enrolled in a program progressing toward that degree c) current background in educational theory and methodology d) have practical experience as a dental technician e) be certified by the National Board for Certification in Dental Laboratory Technology
	Standard 3-5	Duties: The program administrator must have authority and responsibility necessary to fulfill program goals.
Dental Therapy		
	Standard 3-1	The program director must have a full-time administrative appointment as defined by the institution and have primary responsibility for operation, supervision, evaluation and revision of the Dental Therapy educational program. Intent: <i>To allow sufficient time to fulfill administrative responsibilities, teaching contact hours should be limited for the program director and should not take precedent over administrative responsibilities.</i>
	Standard 3-2	The program director must be a licensed dentist (DDS/DMD) or a licensed dental therapist possessing a master's or higher degree. The director must be a graduate of a program accredited by the Commission on Dental Accreditation and who has background in education and the professional experience necessary to understand and fulfill the program's mission and goals. Intent: <i>The program director's background should include administrative experience, instructional experience, and professional experience in general dentistry. The term of</i>

		<i>interim/acting program director should not exceed a two year period.</i>
	Standard 3-3	The program director must have the authority and responsibility necessary to fulfill program goals including: a) curriculum development, evaluation and revision; b) faculty recruitment, assignments and supervision; c) input into faculty evaluation; d) initiation of program or department in-service and faculty development; e) assessing, planning and operating program facilities; f) input into budget preparation and fiscal administration; g) coordination, evaluation and participation in determining admission criteria and h) procedures as well as student promotion and retention criteria.
Advanced Education in General Dentistry		
	Standard 2-15	The program’s resident evaluation system must assure that, through the director and faculty, each program: a) periodically, but at least three times annually, evaluates and documents the resident’s progress towards achieving the program’s written goals and objectives or competencies for resident training using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions must be taken; and c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits. <i>Intent: While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.</i>
	Standard 3-1	The program must be administered by a director who has authority and responsibility for all aspects of the program. <i>Intent: The program director’s responsibilities include:</i> a) <i>program administration;</i> b) <i>development and implementation of the curriculum plan;</i> c) <i>ongoing evaluation of program content, faculty teaching and resident performance;</i>

		<ul style="list-style-type: none"> d) <i>evaluation of resident training and supervision in affiliated institutions and off-services rotations;</i> e) <i>maintenance of records related to the educational program; and</i> f) <i>resident selection.</i> <p><i>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:</i></p>
	Standard 3-2	Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, must have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.
	Standard 3-3	For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
General Practice Residency		
	Standard 2-5	Residents must be assigned to an anesthesia rotation with supervised practical experience in the following: <ul style="list-style-type: none"> a) preoperative evaluation; b) assessment of the effects of behavioral and pharmacologic techniques; c) venipuncture technique; d) patient monitoring; e) airway management; f) understanding of the use of pharmacologic agents; g) recognition and treatment of anesthetic emergencies; and h) assessment of patient recovery from anesthesia. <p><i>Intent: Program directors should interact with the anesthesia department to determine the rotation length and methods necessary to meet the requirements of the standard. Generally a minimum of 70 hours is considered to provide the appropriate practical experience.</i></p>
	Standard 2-15	The program’s resident evaluation system must assure that, through the director and faculty, each program: <ul style="list-style-type: none"> a) periodically, but at least three times annually, evaluates and documents the resident’s progress towards achieving the program’s written goals and objectives or competencies for resident training using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions must be taken; and

		<p>c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.</p> <p><i>Intent: While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.</i></p>
	Standard 3-1	<p>The program must be administered by a director who has authority and responsibility for all aspects of the program.</p> <p><i>Intent: The program director's responsibilities include:</i></p> <ul style="list-style-type: none"> a) program administration; b) development and implementation of the curriculum plan; c) ongoing evaluation of program content, faculty teaching and resident performance; d) evaluation of resident training and supervision in affiliated institutions and off-services rotations; e) maintenance of records related to the educational program; and f) resident selection. <p><i>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:</i></p> <ul style="list-style-type: none"> 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. <p><i>In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.</i></p>
	Standard 3-2	<p>Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, must have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.</p>
	Standard 3-3	<p>For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.</p>

Dental Anesthesiology		
	Standard 2-10	<p>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.</p> <ul style="list-style-type: none"> 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. <p><i>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.</i></p>
	Standard 2-19	<p>The program’s resident evaluation system must assure that, through the director and faculty, each program:</p> <ul style="list-style-type: none"> 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. <p><i>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.</i></p>
	Standard 3-1	<p>The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-</p>

		<p>sponsoring institution and have authority and responsibility for all aspects of the program.</p> <p>Intent: <i>The program director's responsibilities include:</i></p> <ol style="list-style-type: none"> 1. <i>program administration;</i> 2. <i>development and implementation of the curriculum plan;</i> 3. <i>ongoing evaluation of program content, faculty teaching and resident performance;</i> 4. <i>evaluation of resident training and supervision in affiliated institutions and off-services rotations;</i> 5. <i>maintenance of records related to the educational program;</i> <i>and</i> 6. <i>Resident selection.</i> <p><i>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:</i></p> <ol style="list-style-type: none"> 1. <i>what duties are assigned;</i> 2. <i>to whom they are assigned; and</i> 3. <i>what systems of communication are in place between the program director and individuals who have been assigned responsibilities.</i> <p>In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.</p>
	Standard 3-2	<p>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.</p> <p>Intent: <i>The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology.</i></p>
Dental Public Health		
	Standard 1	<p>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.</p>

	Standard 1-3	For each site where educational activity occurs, there must be an appropriate on-site supervisor who is qualified by education in the curriculum areas for which he/she is responsible.
	Standard 2	<p>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.)</p> <p><i>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.</i></p>
	Standard 2	<p>The program must be administered by one director who is board certified in <u>dental public health</u>. 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.)</p> <p><i>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.</i></p>
	Standard 2	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.
	Standard 2	Documentation of all program activities must be ensured by the program director and available for review.
	Standard 2-1	The program must be directed by a single individual who has at least a 40% appointment to the sponsoring institution.

		<i>Intent: Other activities do not dilute a program director's ability to discharge his/her primary obligations to the educational program.</i>
	Standard 2-1	The program must be directed by a single individual who has at least a 40% appointment to the sponsoring institution <u>and a commitment to teaching and supervision that is uncompromised by additional responsibilities.</u>
	Standard 4	Documentation of all program activities must be ensured by the program director and available for review.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program must have guidelines regarding enrollment of part-time students/residents. Part-time students/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 students/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 students/residents; and (2) there are an equivalent number of months spent in the program.
	Standard 4-4	Directors of one-year programs must review each student's/resident's previous public health training and supplement it, where necessary, to ensure that instruction identified in Standard 4-2 is covered.
	Standard 4-7	The program must include a supervised field experience at a location determined by the program director which requires the students/residents to gain an understanding of one or more of the competencies listed in Standard 4-5. <i>Intent: Supervised field experiences are multi-week or multi-day mentored experiences such as practicums or internships that allow students/residents to enhance their practical understanding in one or more of the competencies listed in Standard 4-5. Supervised field experiences are not meant to include attendance at meetings, conferences, fieldtrips or other didactic sessions.</i>
	Standard 4-8	The program must include a supervised research experience for each student/resident, approved by the program director, that demonstrates application of dental public health principles and sound research methodology and is consistent with the competencies listed in Standard 4-5. (Also see Standard 6)
	Standard 4-8	The program must include a supervised field experience at a location determined by the program director which requires the students/residents to gain an understanding of one or more of the competencies listed in Standard 4-5. <u>The program must document, with a log of activities, the specific dental public health competency(ies) addressed during each field experience.</u>

		<p><i>Intent: Supervised <u>multi-day</u> field experiences are multi-week or multi-day mentored experiences such as practicums or internships that allow students/residents to enhance their practical understanding in one or more of the competencies listed in Standard 4-56. Supervised field experiences are not meant to include attendance at meetings, conferences, fieldtrips or other didactic sessions.</i></p>
	<p>Standard 4-9</p>	<p><u>The program must include a supervised experience at a location determined by the program director which offers an opportunity for the students/residents to gain knowledge regarding the administration of oral healthcare services (management and delivery of care) of a dental program that provides clinical care to underserved and/or vulnerable population(s).</u></p> <p>a) <u>Students'/Residents' with no prior postdoctoral experience in a public health dental care setting must document evidence of a minimum of 80 hours of supervised participation and documentation of the experience and understanding the challenges to delivering oral health services to the population(s) served.</u></p> <p>b) <u>Students/Residents entering the program with equivalent postdoctoral experience in a public health dental care settings serving vulnerable and underserved populations could be exempt from the 80-hour required rotation based on the residency director's evaluation of their experience. The student/resident must fulfill this requirement with submission of a written, guided personal reflection on the challenges delivering oral health care services to underserved and vulnerable populations.</u></p> <p><i><u>Intent:</u> To facilitate the development of Dental Public Health students'/residents' knowledge in the delivery of oral healthcare services to populations, students/residents should deepen their understanding of the provision of clinical care in settings that focus on underserved and/or vulnerable population(s). Experiences are multi-day mentored activities such as practicums or internships or personally providing clinical care, that offer the opportunity for students/residents to enhance their understanding and appreciation of dental care for underserved and/or vulnerable population(s) populations. Personally providing clinical care is not a requirement of this Standard. Clinical facilities may include but are not limited to Community Health Centers, hospitals, schools, clinics that care for vulnerable populations, such as low-income children, persons living with HIV, the homeless, and those with intellectual and/or developmental disabilities. Completion of Standard 4-9 does not fulfill the requirement for Standard 4-8 (Supervised Field Experience).</i></p>
	<p>Standard 4-10</p>	<p>The program must include a supervised research experience for each student/resident, approved by the program director, that demonstrates application of dental public health principles and sound <u>dental public health</u> research methodology, <u>biostatistics and</u></p>

		<u>epidemiology</u> , and is consistent with the competencies listed in Standard 4- 56 . (Also see Standard 6)
	Standard 5 - Evaluation	A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program: <ul style="list-style-type: none"> 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 students/residents an assessment of their performance, at least semiannually; c. Advances students/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 student/resident which is accessible to the student/resident and available for review during site visits.
	Standard 5	Specific written criteria, policies and procedures must be followed when admitting students/residents. <i>Intent: Written non-discriminatory policies are to be followed in selecting students/residents. These policies should make clear the methods and criteria used in recruiting and selecting students/residents and how applicants are informed of their status throughout the selection process. <u>Program directors are encouraged to refer applicants to the Dental Public Health program to the American Board of Dental Public Health for eligibility requirements to obtain Diplomate status.</u></i>
	Standard 5-2	Applicants for one-year dental public health programs must possess an MPH or comparable degree. <i>Intent: <u>For those students/residents admitted with a graduate degree comparable to the MPH, it is expected that the program director document the satisfactory completion of the educational requirements of Standard 4-3. Where deficiencies exist, the student's/resident's program director will create a supplemental curriculum plan to meet those requirements.</u></i>
Endodontics		
	Standard 1-3	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	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.) The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve

		<p>the educational goals of the program and assess the program’s effectiveness in meeting its goals.</p> <p>Documentation of all program activities must be ensured by the program director and available for review.</p>
	Standard 2-1	<p>The sponsoring institution must appoint a program director who: a) is a full-time faculty member and b) whose time commitment is no less than twenty-four hours per week to the advanced dental education program in endodontics.</p>
	Standard 2-1	<p>The sponsoring institution must appoint a program director whose time commitment is no less than twenty-four hours per week to the advanced dental education program in endodontics.</p>
	Standard 2-2	<p>Responsibilities of the program director must include:</p> <ul style="list-style-type: none"> a. Development of mission, goals, and objectives for the program; b. Development and implementation of a curriculum plan; c. Planning for and operation of the facilities used in the endodontic program; d. Student/resident selection unless the program is sponsored by a federal service utilizing a centralized student/resident selection process; e. Ensuring ongoing evaluation of student/resident performance and faculty teaching performance; f. Evaluation of teaching program and faculty supervision in affiliated institutions; g. Maintenance of records related to the educational program, including written instructional objectives and course outlines; h. Overall continuity and quality of patient care as it relates to program; i. Ongoing planning, evaluation and improvement of the quality of the program; j. Preparation of graduates for certification by the American Board of Endodontics; and k. Ensuring formal (written) evaluation of faculty members at least annually to assess their performance in the educational program.
	Standard 2-5	<p>Program directors and full time faculty must be provided time and resources to engage in scholarly pursuits, which may include:</p>

		<ul style="list-style-type: none"> a. Participation in continuing education in endodontics; b. Participation in regional or national endodontic societies; c. Participation in research; and d. Presentation and publication of scientific/clinical studies.
Oral and Maxillofacial Pathology		
	Standard 1	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.
	Standard 1	<p>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.)</p> <p><i>Intent: The director of an advanced dental education program is to be certified by a nationally recognized 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.</i></p>
	Standard 1-4	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	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.
	Standard 2	Documentation of all program activities must be ensured by the program director and available for review.
	Standard 2-1	The program must be directed by a single individual who has a full-time appointment to the sponsoring institution.
	Standard 2-1.1	The program director and faculty of an advanced oral and maxillofacial pathology program must demonstrate a commitment to teaching and supervision that is uncompromised by additional responsibilities.
	Standard 4	Documentation of all program activities must be ensured by the program director and available for review.

	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program must have guidelines regarding enrollment of part-time students/residents. Part-time students/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 students/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 students/residents; and (2) there are an equivalent number of months spent in the program.
	Examples of Evidence Standard 4-1	Examples of evidence to demonstrate compliance may include: <ul style="list-style-type: none"> ● Formal courses taken for University credit; and ● Courses, seminars, conferences, reading assignments, hospital rounds and assignment in the laboratories which are carefully organized; the objectives and content should be carefully planned or reviewed by the program director to avoid deficiencies and unnecessary repetition.
	Intent Standard 4-2.2	Training must include attendance at tumor boards, clinical assessment of patients, selection of appropriate laboratory studies and their interpretation, evaluation of medical and drug status, administration of systemic and local medications, and participation in multi-disciplinary treatment planning. <p><i>Intent: Students/Residents should have the opportunity to manage patients with interesting and unusual diseases. Students/residents should be urged to maintain a log, either photographic and/or written, for cases in which they have had some responsibility. Program directors should periodically evaluate the extent of the students'/residents' clinical experience. Regular conferences and seminars should be scheduled to broaden clinical experience and fill in deficiencies with past clinical teaching cases. A wide variety of clinical situations should also be discussed in regularly scheduled literature reviews or journal clubs.</i></p>
	Standard 5	A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program: <ol style="list-style-type: none"> 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 students/residents an assessment of their performance, at least semiannually; c. Advances students/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 student/resident which is accessible to the student/resident and available for review during site visits.

Oral and Maxillofacial Radiology		
	Standard 1	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.
	Standard 1-2	The program director and faculty must actively assess the outcomes of the oral and maxillofacial radiology program in terms of whether it is achieving its educational objectives.
	Standard 1-4	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	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.) <i>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.</i>
	Standard 2	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.
	Standard 2	Documentation of all program activities must be ensured by the program director and available for review.
	Standard 2-1	The oral and maxillofacial radiology program must be directed by one individual who has a full-time appointment to the sponsoring institution.
	Standard 2-2	The program director and faculty of an advanced oral and maxillofacial radiology program must demonstrate a commitment to teaching and supervision.
	Standard 2-3	The program director and full-time faculty must have adequate time to develop and foster their own professional development.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program must have guidelines regarding enrollment of part-time students/residents. Part-time students/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 students/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 students/residents; and (2) there are an equivalent number of months spent in the program.
	Standard 5	A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program: <ul style="list-style-type: none"> 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. Provide to students/residents an assessment of their performance, at least semiannually; c. Advances students/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 student/resident which is accessible to the student/resident and available for review during site visits.
Oral and Maxillofacial Surgery (Residency)		
	Standard 2	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.) 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.
	Standard 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.
		The responsibilities of the program director must include:
	Standard 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.
	Standard 2-1.2	Ensuring the provision of adequate physical facilities for the educational process.

	Standard 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.
	Standard 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.
	Standard 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.
	Standard 2-1.6	Maintenance of appropriate records of the program, including resident and patient statistics, institutional agreements, and resident records.
	Standard 2-1.8	The program director and teaching staff must lead by example in all aspects of professionalism.
Oral and Maxillofacial Surgery (Fellowship)		
	Standard 2	The program must be administered by a director who is board certified.
	Standard 2-1	Program Director: The program must be directed by a single individual. The responsibilities of the program director must include:
	Standard 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.
	Standard 2-1.2	Ensuring the provision of adequate physical facilities for the educational process.
	Standard 2-1.3	Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.
	Standard 2-1.4	Responsibility for adequate educational resource materials for education of the fellows, including access to adequate learning resources.
	Standard 2-1.5	Responsibility for selection of fellows and ensuring that all appointed fellows meet the minimum eligibility requirements.
	Standard 2-1.6	Maintenance of appropriate records of the program, including fellow and patient statistics, institutional agreements, and fellow records.
Oral Medicine		
	Standard 2-6	Part-time residents must start and complete the program within a single institution, except when the program is discontinued or relocated. <i>Intent: The director of an accredited program may enroll residents on a part-time basis providing that (1) residents are also enrolled on a full-time basis, (2) the educational experiences, including the clinical experiences and</i>

		<i>responsibilities, are equivalent to those acquired by full-time residents and (3) there are an equivalent number of months spent in the program.</i>
	Standard 3-1	The program must be administered by an appointed director who is full-time faculty and who is board certified in oral medicine.
	Standard 3-2	<p>The program director must have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program.</p> <p>Intent: <i>The program director's responsibilities include:</i></p> <ul style="list-style-type: none"> a) <i>selecting residents;</i> b) <i>developing and implementing the curriculum;</i> c) <i>utilizing faculty to offer a diverse educational experience in biomedical, behavioral and clinical sciences;</i> d) <i>facilitating the cooperation between oral medicine, general dentistry, related dental specialties, medicine and other health care disciplines;</i> e) <i>evaluating and documenting resident training, including training in affiliated institutions;</i> f) <i>documenting educational and patient care records as well as records of resident attendance and participation in didactic and clinical programs,</i> g) <i>ensuring quality and continuity of patient care;</i> h) <i>ensuring research opportunities for the residents;</i> i) <i>planning for and operation of facilities used in the program;</i> j) <i>training of support staff at an appropriate level; and</i> k) <i>preparing and encouraging graduates to seek certification by the American Board of Oral Medicine.</i>
	Standard 3-8	The program director and staff must actively participate in the assessment of the outcomes of the educational program.
	Standard 5-5	<p>The program's resident evaluation system must assure that, through the director and faculty, each program:</p> <ul style="list-style-type: none"> a) periodically, but at least two times annually, evaluates and documents the resident's progress toward achieving the program's written goals and objectives or competencies for resident training using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation; and c) maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits. <p>Intent: <i>The program should employ evaluation methods that measure a resident's skills or behavior at a given time. It is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standards 2-10, 2-12 and 2-14.</i></p>

		<i>Where deficiencies are noted, corrective actions are taken. The final resident evaluation or final measurement of educational outcomes may count as one of the two annual evaluations.</i>
Orofacial Pain		
	Standard 2-20	<p>The program’s resident evaluation system must assure that, through the director and faculty, each program:</p> <ul style="list-style-type: none"> a) periodically, but at least two times annually, evaluates and documents the resident’s progress toward achieving the program’s written goals and objectives of resident training or competencies using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions must be taken; and c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits. <p><i>Intent: While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-2.</i></p>
	Standard 3-1	<p>The program must be administered by a director who is board certified or educationally qualified in orofacial pain and has a full-time appointment in the sponsoring institution with a primary commitment to the orofacial pain program.</p>
	Standard 3-2	<p>The program director must have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program.</p> <p><i>Intent: The program director’s responsibilities include:</i></p> <ul style="list-style-type: none"> a. program administration; b. development and implementation of the curriculum plan; c. ongoing evaluation of program content, faculty teaching, and resident performance; d. evaluation of resident training and supervision in affiliated institutions and off-service rotations; e. maintenance of records related to the educational program; and f. resident selection; and g. preparing graduates to seek certification by the American Board of Orofacial Pain.

		<i>In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.</i>
Orthodontics and Dentofacial Orthopedics (Residency)		
	Standard 1-4	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.
	Standard 2	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.) 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.
	Standard 2-1	The program must be directed by one individual.
	Standard 2-2	The program director position must be full-time as defined by the institution.
	Standard 2-3	There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.
	Standard 2-5	Besides maintaining clinical skills, the director must have teaching experience in orthodontics and dentofacial orthopedics. For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.
	Standard 2-14	The program director and faculty must prepare students/residents to pursue certification by the American Board of Orthodontics.
	Standard 2-14.a	The program director must document the number of graduates who become certified by the American Board of Orthodontics.
Orthodontics and Dentofacial Orthopedics (Fellowship)		
	Standard 1-5	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or

		clinical experience in the curriculum areas for which they are responsible.
	Standard 2	The program must be administered by a director who has documented expertise in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics. Additionally, the program director must either be board certified in orthodontics or have previously served as a director in a craniofacial orthodontic fellowship program prior to January 1, 2008.
	Standard 2-1	Program Director: The program must be directed by one individual. The responsibilities of the program director must include:
	Standard 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.
	Standard 2-1.2	Ensuring the provision of adequate physical facilities for the educational process.
	Standard 2-1.3	Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.
	Standard 2-1.4	Responsibility for adequate educational resource materials for education of the students/fellows, including access to adequate learning resources.
	Standard 2-1.5	Responsibility for selection of students/fellows and ensuring that all appointed students/fellows meet the minimum eligibility requirements.
	Standard 2-1.6	Maintenance of appropriate records of the program, including student/fellow and patient statistics, institutional agreements, and student/fellow records.
Pediatric Dentistry		
	Standard 1	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.
	Standard 1-3	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	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.) <i>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</i>

		<i>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.</i>
	Standard 2	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.
	Standard 2-1	The program director must be evaluated annually.
	Standard 2-2 (and sub-parts)	<p>Administrative Responsibilities: The program director must have sufficient authority and time to fulfill administrative program assessment and teaching responsibilities in order to achieve the educational goals of the program including:</p> <p><i>Intent: Program directors with remote programs have resources to visit these programs.</i></p> <p>2-2.1 Student/Resident selection, unless the program is sponsored by federal services utilizing a centralized student/resident selection process.</p> <p>2-2.2 Curriculum development and implementation.</p> <p>2-2.3 Ongoing evaluation of program goals, objectives and content and outcomes assessment.</p> <p><i>Intent: The program uses a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement that relate directly to the stated program goals and objectives.</i></p> <p>2-2.4 Annual evaluations of faculty performance by the program director or department chair; including a discussion of the evaluation with each faculty member.</p> <p>2-2.5 Evaluation of student/resident performance.</p> <p>2-2.6 Participation with institutional leadership in planning for and operation of facilities used in the educational program.</p> <p>2-2.7 Evaluation of student's/resident's training and supervision in affiliated institutions.</p> <p>2-2.8 Maintenance of records related to the educational program, including written instructional objectives, course outlines and student/resident clinical logs (RCLs) documenting the completion of specified procedures and/or patient complexity, including:</p> <ul style="list-style-type: none"> a) nitrous oxide analgesia patient encounters as primary operator b) patient encounters in which sedative agents

		<p>other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used</p> <ul style="list-style-type: none"> c) operating room cases d) clinical procedures (e.g. emergency, trauma, restorative, preventative, orthodontic, multi-disciplinary, etc.) e) patient diversity/complexity (e.g. well-patient, medically complex, special needs, hospital based, etc.) <p><i>Intent: These records are to be available for on-site review: overall program objectives, objectives of student/resident rotations, specific student/resident schedules by semester or year; completed student/resident evaluation forms for current students/residents and recent alumni, self-assessment process, curricula vitae of faculty responsible for instruction. The RCL provides programs with data required for program improvement and gives students/residents and official record of clinical procedures required by regulatory boards and hospitals. The RCL may be comprised of a HIPAA-compliant patient and procedure log and/or a printout of procedure codes, for example, and may be compiled by the program, student/resident, and/or staff.</i></p> <p>2-2.9 Responsibility for overall continuity and quality of patient care.</p> <p>2-2.10 Oversight responsibility for student/resident research.</p> <p>2-2.11 Responsibility for determining the roles and responsibilities of associate program director(s) and their regular evaluation.</p>
	Standard 4	<p>If an institution and/or program enrolls part-time students/residents, the institution/program must have guidelines regarding enrollment of part-time students/residents. Part-time students/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 students/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 students/residents; and (2) there are an equivalent number of months spent in the program.</p>
	Standard 5	<p>A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program:</p> <ul style="list-style-type: none"> 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 students/residents an assessment of their performance, at least semiannually;

		<p>c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and</p> <p>d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.</p>
Periodontics		
	Standard 2	<p>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.)</p> <p>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.</p> <p>Documentation of all program activities must be ensured by the program director and available for review.</p>
	Standard 2-1	<p>The program director must have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following:</p> <ul style="list-style-type: none"> a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences; b. Promote cooperation between periodontics, general dentistry, related dental specialties and other health sciences; c. Select students/residents qualified to undertake training in periodontics unless the program is sponsored by a federal service utilizing a centralized student/resident selection process; d. Develop and implement the curriculum plan; e. Evaluate and document student/resident and faculty performance; f. Document educational and patient care records as well as records of student/resident attendance and participation in didactic and clinical programs; and

		g. Responsibility for the quality and continuity of patient care.
	Standard 2-2	The program director must prepare graduates to seek certification by the American Board of Periodontology. a. The program director must track Board Certification of program graduates.
	Standard 2-9	The program director and faculty must actively participate in the assessment of the outcomes of the educational program.
Prosthodontics		
	Standard 1	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.
	Standard 1-2	For each site, including those at major and minor educational activity sites, there must be an on-site clinical supervisor who is an educationally qualified specialist in the curriculum areas for which he/she is responsible.
	Standard 2	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.) <i>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.</i>
	Standard 2	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.
	Standard 2	Documentation of all program activities must be ensured by the program director and available for review.
	Standard 2-1.1	The program director must have primary responsibility for the organization and execution of the educational and administrative components to the program.
		<i>The program director must devote sufficient time to:</i> <i>a. Participate in the student/resident selection process, unless the program is sponsored by federal services</i>

		<p><i>utilizing a centralized student/resident selection process;</i></p> <ul style="list-style-type: none"> <i>b. Develop and implement the curriculum plan to provide a diverse educational experience in biomedical and clinical sciences;</i> <i>c. Maintain a current copy of the curriculum's goals, objectives, and content outlines;</i> <i>d. Maintain a record of the number and variety of clinical experiences accomplished by each student/resident;</i> <i>e. Ensure that the majority of faculty assigned to the program are educationally qualified prosthodontists;</i> <i>f. Provide written faculty evaluations at least annually to determine the effectiveness of the faculty in the educational program;</i> <i>g. Conduct periodic staff meetings for the proper administration of the educational program; and</i> <i>h. Maintain adequate records of clinical supervision.</i>
	Standard 2-2	The program director must encourage students/residents to seek certification by the American Board of Prosthodontics.
	Standard 4	Documentation of all program activities must be ensured by the program director and available for review.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program must have guidelines regarding enrollment of part-time students/residents. Part-time students/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 students/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 students/residents; and (2) there are an equivalent number of months spent in the program.
	Intent Standard 4-4	<p>Students/Residents must have the didactic/clinical background that supports successful completion of the prosthodontic specialty board examination and fosters life-long learning.</p> <p><i>Intent: Program directors promote prosthodontic board certification. It is expected that students/residents continue their life-long professional development by employing the didactic and clinical knowledge acquired during the program.</i></p>
	Intent Standard 4-32	<p>Students/Residents must have the didactic/clinical background that supports successful completion of the prosthodontic specialty board examination and fosters life-long learning.</p> <p><i>Intent: Program directors should promote prosthodontic board certification to attain the appropriate hospital appointment for the clinical practice of maxillofacial prosthetics. It is expected that students/residents continue their life-long professional development by employing the didactic and clinical knowledge acquired during the maxillofacial program.</i></p>

	Standard 5	<p>A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program:</p> <ul style="list-style-type: none">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 students/residents an assessment of their performance, at least semiannually;c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; andd. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.
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CONSIDERATION OF ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RELATED TO DIVERSITY AND HUMANISTIC CULTURE AND LEARNING ENVIRONMENT

Background: At its Winter 2023 meeting, the Commission on Dental Accreditation (CODA) considered the Report of its Review Committee on Predoctoral Dental Education (PREDOC RC) related to the November 4, 2022 request from Dr. Lawrence F. Hill, president of The National Coalition of Dentists for Health Equity (NCDHE). The Commission directed the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs to consider the proposed revisions to Standards 1-3, 1-4 and 4-4 submitted by The National Coalition of Dentists for Health Equity (TNCDHE), with a future report to the Review Committee and Commission.

At its Summer 2023 meeting, the Standing Committee on Quality Assurance and Strategic Planning (QASP) discussed the February 16, 2023 letter and previously reviewed November 4, 2022 letter and materials from the NCDHE. The February 16, 2023 letter provided short term recommendations that would not require revision of the Accreditation Standards. The QASP members reviewed this topic again and believed that the TNCDHE letter appeared to focus on the enforcement of standards, calibration of site visitors, and diversity of CODA's site visitor volunteers. Following consideration of the QASP report, the Commission on Dental Accreditation directed a formal letter to The National Coalition of Dentists for Health Equity to inform the Coalition of the Commission's second review of its correspondence and actions that were underway by the Commission related to diversity, equity, inclusion and belonging.

On December 1, 2023, the Commission received a letter from TNCDHE (**Appendix 1**). In its letter, TNCDHE provided short-term and long-term suggestions to CODA to improve diversity in all academic dental, allied dental, and advanced dental education programs.

The short-term suggestions from TNCDHE included:

1. Better training of site visit teams on how to assess whether an educational program has implemented a plan to achieve positive results.
2. Ensuring site visit teams are inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Further, when possible, site visit team members should be representative of dental schools with demonstrated success in increasing diversity and assuring a humanistic environment.
3. Redefining the meaning and intent of "diversity" in the Standards, considering the recent Supreme Court decision. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

The long-term suggestions from TNCDHE included:

1. Achieving a humanistic environment, addressing discrimination in policies and practice. Suggested revisions to the Accreditation Standards for Predoctoral Dental Education Programs were provided.
2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.

3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

In Winter 2024, each Review Committee of the Commission provided comment to CODA on TNCDHE letter, which was reviewed by the Commission. Following consideration of Review Committee Reports, the Commission directed establishment of an Ad Hoc Committee composed of all Commissioners who chair the discipline-specific Review Committees in dental, allied dental, and advanced dental education, and additional CODA Commissioners, to study the Accreditation Standards for possible revision related to the letter from The National Coalition of Dentists for Health Equity.

Summer 2024: The Ad Hoc Committee, which was comprised of all current CODA Commissioners, met on August 7, 2024 at the ADA Headquarters, in association with the Commission's Summer 2024 meeting. The Ad Hoc Committee reviewed the background materials, which included the prior work of the Commission on this topic, the letters from TNCDHE, CODA Standards related to diversity and the humanistic culture including proposed revisions, Annual Survey data on dental programs related to diversity, and information from other accrediting agencies. The Committee engaged in extensive discussion related to TNCDHE's most recent letter of December 1, 2023, and the short-term and long-term recommendations of TNCDHE. The Commission noted the Predoctoral Dental Education Review Committee submitted a report to the Commission for consideration at the Summer 2024 meeting, including significant revisions to the Accreditation Standards addressing diversity and the humanistic culture among other proposed changes, which address some of the recommendations of TNCDHE. Additionally, it was noted that the Oral and Maxillofacial Surgery Review Committee submitted a report on proposed revisions related to diversity and the humanistic culture, following a period of public comment, which would also be reviewed at the Summer 2024 meeting. The Committee noted that this is an important topic, but other considerations must also be acknowledged including differences among institutions related to missions, resources, funding, state and federal regulations, and legal considerations. It was noted that some states do not permit initiatives focused on diversity, and the Commission cannot impose Standards that would conflict with state or federal law. As such, the Committee noted the proposed predoctoral dental education Standard revision, which discusses diversity efforts, would be consistent with university policy and state law. The Committee also noted that other dental organizations such as the American Dental Association (ADA) and American Dental Education Association (ADEA) are working to enhance diversity and these agencies should continue to support this effort.

Following consideration, the Ad Hoc Committee concluded that all Review Committees of the Commission should consider the proposed revisions for the Dental Standards 1-2 and 1-3 and revisions for the Oral and Maxillofacial Surgery Standards 1-11 and 2-1.7 (adopted Summer 2024), for possible inclusion of similar Standards within the Review Committee's own discipline(s) to address diversity and the humanistic culture, with a report to the Commission in Winter 2025.

The Commission concurred with the Ad Hoc Committee's recommendation. Additionally, the Commission directed that work continue with further consideration of TNCDHE's December 1, 2023, short-term and long-term recommendations, with additional work to occur prior to the Commission's Winter 2025 meeting. The Commission also directed a letter, which was subsequently sent to The National Coalition of Dentists for Health Equity to provide an update on CODA's review of this matter, noting the topic's complexity and rapidly changing educational and regulatory

environment, which must be monitored, while noting the Commission's commitment to a diverse academic environment.

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education is requested to review the letter from The National Coalition of Dentists for Health Equity (**Appendix 1**), as well as the orthodontics and dentofacial orthopedics and clinical fellowship training programs in craniofacial and special care orthodontics Accreditation Standards, and reference materials including the proposed Dental Standards 1-2 and 1-3 and adopted revisions for Oral and Maxillofacial Surgery Standards 1-11 and 2-1.7 (**Appendix 2**), for possible inclusion of similar Standards to address diversity and the humanistic culture. The Review Committee may determine that Standards already exist, which address diversity and the humanistic culture. Alternately, the Review Committee may determine that Standards require modification or addition and may propose changes to the Commission for further consideration including possible circulation to the communities of interest for a period of comment.

Recommendation:

Prepared by: Dr. Sherin Tooks



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December 1, 2023

Dr. Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
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Dear Dr. Tooks,

Recommendations to increase diversity in dental education and practice via the Commission on Dental Accreditation Standards

The National Coalition of Dentists for Health Equity's mission is to support and promote evidence informed policy and practices that address inequities in oral health. One of our priorities is to advocate for greater diversity among dental students and faculty to better reflect the diversity of the US population in the oral health workforce.

In November of 2022, we wrote to the Commission on Dental Education (CODA), expressing concerns about the lack of diversity in predoctoral dental education and the apparent lack of enforcement of the CODA standards on diversity (hot link to our letter on our website). We observed that despite these standards, no dental schools (as of 2022) had received a recommendation related to diversity over the ten years that the standards had been in place. Our letter recommended new standards, policies, and procedures that would enhance diversity in predoctoral dental education. We were pleased to learn that CODA accepted our letter and referred it to a committee reviewing potential changes in the predoctoral standards and that the committee's report will be considered in the early 2024 CODA meetings.

Since 2022, we have spent additional time reviewing CODA standards for the other academic dental educational programs including dental hygiene, dental therapy and advanced education programs and realized our recommendations should also apply to these other programs. In this letter, we review our original recommendations, and propose additional ones for all educational programs.

We believe that the dental school accreditation standards utilized by CODA serve a vital role in achieving a diverse oral health workforce. However, we also believe that the current CODA predoctoral education standards do not appear to be encouraging academic dental institutions to recruit a more diverse student body or faculty. CODA adopted the new diversity predoctoral education standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that "between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis, Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class increased by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, <https://www.adea.org/HURE/>)" The conclusion we draw is that dental schools are not doing enough to recruit more HURE students to meet the intent of the CODA Standards.

We recognize that the recent Supreme Court decision to abolish the use of race in making admission decisions will prevent academic dental institutions from using race as a determining factor in admissions. The recommendations we make below do not suggest or presume that strategy.

In this letter, we are offering several additional suggestions to CODA to improve the diversity of all academic dental education programs, including predoctoral, dental hygiene, advanced educational programs and dental therapy. Three of these are short term recommendations that are not related to changing accreditation standards, with the understanding that CODA appropriately takes considerable time in changing standards which entails seeking input from many individuals, communities, and entities. In addition, we make another set of suggestions that are long term and include modifications to the "Examples of evidence to demonstrate compliance" for some of the standards. Our recommendations are based on papers found in recent Special Editions of The [Journal of Public Health Dentistry](#) and the [Journal of Dental Education](#).

In particular, the longer-term suggestions build on the recommendations of the paper by Smith, PD, Evans CA, Fleming, E, Mays, KAI Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards, as well as two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, 'Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;' and Formicola, AJ and Evans, C, 'Gies re-visited.' Note that some of these recommendations were included in the previous [letter to CODA](#) sent on November 4, 2022

SHORT-TERM SUGGESTIONS

Suggestion 1: We recommend that site visit teams be better trained on how to assess whether an educational program has implemented a viable plan that achieves positive results. Under the structural diversity section of the Standards, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is appropriate but showing an improvement in the diversity of the dental schools' academic communities based on the school's plans and policies should also be demonstrated.

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

Since site visit teams are different for each school, there can be no consistency in the assessment process unless site visitors are given explicit expectations of what schools should demonstrate to comply with each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards.

Suggestion 2: To be better able to assess whether schools meet diversity and humanistic standards, site visit teams should be inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Wherever possible, site visit team members should also be representative of dental schools that have demonstrated success in increasing diversity and assuring a humanistic environment.

Suggestion 3: Especially in light of the recent Supreme Court decision, CODA should redefine the meaning and intent of the term "diversity" in the Standards documents. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

LONG-TERM SUGGESTIONS

1) Achieving a humanistic environment- Not much is known about how dental schools address discrimination in their humanistic environment policies and practices. Although school policies on anti-discrimination might exist, students, faculty, and staff from underrepresented populations may still experience microaggressions, discrimination, racism, and barriers to socialization and mentorship. It has been suggested that such experiences may be underreported due to numerous factors, including fear of retaliation and/or disbelief that such concerns will be adequately addressed by the dental school. Because there are small numbers of underrepresented students, faculty, and staff in some dental schools, even anonymous humanistic surveys may not reveal these issues.

Suggested new "Examples of evidence to demonstrate compliance with Predoctoral Education Standard 1-3 may include:"

- Policies and procedures (and documentation of their effectiveness) implemented to seek feedback from traditionally underrepresented individuals concerning their experiences with the school's environment.
- Results of feedback that the school has sought from underrepresented students, faculty, and staff about their experiences with the school's environment.
- Documentation of the number and types of problems, complaints, and grievances reported about the school's environment, together with documentation of the school's effectiveness in addressing these issues.

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2) Student Admissions

Despite the historical lack of students and faculty from underrepresented segments of the population enrolled in US dental schools, it appears that dental schools are rarely cited for not meeting Standard 1-4. One reason for this may be that the standard allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not appropriately emphasize certain specific underrepresented segments of the population and/or entirely represent the diversity of the local and regional population surrounding the schools, and/or reflect the national demographics in which the schools' graduates will practice their profession. Additionally, CODA provides no specificity for the level of engagement, with respect to recruitment, that dental schools should have with underrepresented populations

Suggested new "Examples of evidence to demonstrate compliance may include".

- Documentation that the school has implemented policies, procedures, and strategies to attract and retain students, faculty and staff from diverse backgrounds in order to achieve parity with the diversity profiles of the school's local, regional or national populations
- Documentation of longitudinal improvement in the diversity of the school's students, faculty, and staff. Where improvement is absent or minimal, documentation of the evaluation of strategies to improve diversity and of modifications made to these strategies to improve outcomes.

The intent of Standard 1-4 states that "admissions criteria and procedures should ensure the selection of a diverse student body with the potential of successfully completing the program". A problem is that the interpretation of this intent can vary dramatically from school to school. Admissions decisions are made by committees of people, and although there are trainings and processes to address implicit biases toward traditionally underrepresented applicants, the admissions process is still largely subjective. There are unique social and structural issues that exist for underrepresented applicants that must also be considered when assessing their potential for success. Those issues may influence undergraduate education academic achievements including GPA's and standardized tests. The question to admissions committees shouldn't necessarily be which applicant has the higher score, but rather does an applicant demonstrate appropriate academic achievements, despite a history of significant barriers, to successfully negotiate the curriculum.

Suggested new "Examples of evidence to demonstrate compliance may include:"

- Documentation of policies and procedures used to consider the unique social and structural constructs that affect traditionally underrepresented applicants in the admissions decision-making process.

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

- Documentation of procedures used to educate admissions committee members to implicit biases that may exist with respect to the potential of underrepresented applicants to excel in the academic program.
- Documentation of admissions criteria intended to assess not only academic achievements, but also the interest, desire, and commitment of applicants to learn about issues such as cultural competency, community-based practice, and addressing inequities in oral health within the population.

Standards 4-4 for Predoctoral Dental Education programs and Standard 4-2 for Dental Therapy programs state "Admission policies and procedures must be designed to include recruitment and admission of a diverse student population" . There are no accreditation standards for Dental Hygiene or Advanced Educational programs that mandate that these programs have policies and practices to achieve a diverse student population. It is recommended that CODA add these standards with appropriate intent statements and examples of evidence to document compliance.

Generally, with respect to Standards 1-3, 1-4, and 4-4, we recommend that CODA strengthen the accountability that should undergird the standards. There must be accountability around these standards. Accountability must be built into the process of reviewing the standards, supporting site visitors in their work, and making sure that dental schools who fail to meet the standards are required to improve their practices and those dental schools who are exceeding the standards should be encouraged to continue to grow.

3) Inclusive Environments in Dental Education

Underrepresented students have a more difficult time achieving both success and a feeling of belonging in dental educational programs for a myriad of reasons.

To improve retention of students in dental education programs facing academic, social or emotional challenge, it is recommended that CODA strengthen the intent statement for student services (Standard 4-7 for predoctoral programs and Standard 4-12 for the dental therapy programs).

The intent statement should state "programs should have policies and procedures which promote early identification and subsequent mentoring/counseling of students having academic and/or personal issues which have the potential of affecting academic success or the personal well-being of students".

Dental Hygiene and Advanced Education programs have no accreditation standards that address academic or personal support for students having difficulties. It is recommended standards be added.

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

4) Access to Care among Diverse Populations

Access to dental care, and therefore oral and systemic health, is significantly compromised by a number of factors including race, gender, sexual orientation, economic status, education, and neighborhood environment, among other factors.

CODA should strengthen the intent statements with respect to graduates being competent in treating patients in all life stages (predoctoral standard 2-22, dental hygiene standard 2-12 and dental therapy standard 2-20) to assure that foundational knowledge is taught and clinical competence is assessed with respect to changes in oral physiology, the management of the various chronic diseases and associated therapeutics associated with aging, as well as psychological, nutritional and functional challenges manifested in many of these patients.

The intent statement of predoctoral standard 2-17, which addresses student's competence in managing a diverse population, is vague. It is recommended CODA strengthen predoctoral standard 2-17 by stating that "graduates MUST (currently reads should) learn about factors and practices associated with disparities in health status among vulnerable populations, including structural barriers, and must display competency in understanding how these barriers, including prejudices and policies regarding, but not limited to race, gender, sexual preferences, economic status, education and neighborhood environment, affect health and disease and access to care".

There are no standards for dental hygiene or advanced education programs that mandate that graduates be competent in treating a diverse population. CODA should add such standards to these programs.

According to the intent statement of predoctoral Standard 2-26, students working in community health care or service-learning settings are essential to the development of a culturally sensitive workforce. However, the standard merely states that the program makes available such learning environments and that students be urged to avail themselves of such opportunities. CODA should mandate the student's participation in service-learning and/or community-based health centers clinics.

We are pleased to submit these suggestions to CODA and we hope they will be considered by CODA in our mutual efforts to increase the diversity of the dental workforce.

Sincerely,
Dr. Lawrence Hill DDS MPH
President, National Coalition of Dentists for Health Equity

cc:
American Dental Education Association - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer,
American Dental Education Officer

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board

Diverse Dental Society – Dr. Tamana Begay, President

American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director

Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager

Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director;

American Dental Association – Dr. Ray Cohlma, Executive Director; Dr. Jane Grover, Council on Advocacy for Access, and Prevention; Dr. Linda J. Edgar, President

American Dental Hygienists' Association – Jennifer Hill, Interim CEO; JoAnn Gurenlian, RDH, MS, PhD, AAFAAOM, FADHA Director, Education, Research & Advocacy

Community Catalyst – Tera Bianchi, Director of Partner Engagement; Parrish Ravelli, Associate Director, Dental Access Project

National Indian Health Board – Brett Webber, Environmental Health Programs Director; Dawn Landon, Public Health Policy and Programs Project Coordinator

American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Annaliese Cothron, Executive Director

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COMMISSION ON DENTAL ACCREDITATION STANDARDS RELATED TO DIVERSITY AND LEARNING ENVIRONMENT

Current Standards are in Black Font
New Adopted Standards are in Red Font
Proposed Standards are in Green Font

Discipline	Standard Number	Requirement of the Standard
Predoctoral Dental		
	Standard 1-3	<p>The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.</p> <p>Intent: <i>The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.</i></p> <p>Examples of evidence to demonstrate compliance may include:</p> <ul style="list-style-type: none"> • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, 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 student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 1-4	<p>The dental school must have policies and practices to:</p> <ol style="list-style-type: none"> a. achieve appropriate levels of diversity among its students, faculty and staff; b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity. <p>Intent: <i>The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that</i></p>

		<i>include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.</i>
	Standard 2-17	<p>Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.</p> <p>Intent: <i>Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:</i></p> <ul style="list-style-type: none"> • <i>basic principles of culturally competent health care;</i> • <i>basic principles of health literacy and effective communication for all patient populations</i> • <i>recognition of health care disparities and the development of solutions;</i> • <i>the importance of meeting the health care needs of dentally underserved populations, and;</i> • <i>the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi- dimensionally diverse society.</i>
	Standard 2-26	<p>Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.</p> <p>Intent: <i>Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.</i></p>
	Standard 4-4	<p>Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.</p> <p>Intent 4-1 to 4-4: <i>The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non- discriminatory and ensure the quality of the program.</i></p>

	<p><u>Proposed Educational Environment</u></p>	<p>Among the factors that may influence predoctoral curricula are expectations of the parent institution, standing or emerging scientific evidence, new research foci, interfaces with specialty or other dental-related education programs, approaches to clinical education, and pedagogical philosophies and practices. In addition, the demographics of our society are changing, and the educational environment must reflect those changes. People are living longer with more complex health issues, and the dental profession will routinely be expected to provide care for these individuals. Each dental school must also have policies and practices to achieve an appropriate level of diversity among its students, faculty, and staff. While <u>diversity variability</u> of curricula is a strength of dental education, the core principles below promote an environment conducive to change, innovation, and continuous improvement in educational programs. Application of these principles throughout the dental education program is essential to achieving quality.</p>
	<p><u>Proposed Humanistic Learning Environment</u></p>	<p>Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A <u>humanistic pedagogy safe learning environment</u> inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising, and small group interaction. A dental school environment characterized by:</p> <ul style="list-style-type: none"> • <u>physical and psychological safety, free of intimidation, abuse, and retaliation;</u> • respectful <u>and collegial</u> professional relationships between and among faculty, <u>staff</u>, and students; <u>and</u> • <u>establishes</u> a context for the development of interpersonal skills necessary for learning, for <u>and</u> patient care, and for making meaningful contributions to the profession.
	<p><u>Proposed Diversity and Inclusion</u></p>	<p>Diversity <u>and inclusion</u> in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, <u>national origin, gender identity, age, physical abilities/qualities, sexual orientation</u>, religions, and <u>ideologic</u> backgrounds; come from cities-urban, rural areas, and from various geographic regions; and have a wide variety of interests, talents-abilities, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively</p>

		<p>homogeneous environment. Programs must <u>strive to</u> create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural, <u>religious</u>, and socioeconomic lines.</p>
	<p><u>Proposed</u> Definition of Terms</p>	<p>Cultural competence: Having the ability to provide care to patients with diverse backgrounds, values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers’ understanding the relationship between diversity of culture, values, beliefs, behavior, and language and the needs of patients.</p> <p>Dimensions of Diversity: The dimensions of diversity include: structural, curriculum and institutional climate.</p> <p>Diversity - Structural: Structural diversity, also referred to as compositional diversity, focuses on the numerical distribution of students, faculty, and staff from diverse backgrounds in a program or institution.</p> <p>Curriculum: Curriculum diversity, also referred to as classroom diversity, covers both the diversity related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.</p> <p>Diversity - Institutional Climate: Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.</p>
	<p><u>Proposed Standard</u> 1-2</p>	<p>The dental education program must have a stated <u>demonstrate a commitment to a humanistic culture and learning environment that includes: is regularly evaluated.</u></p> <ol style="list-style-type: none"> a. <u>a stated commitment and activities to promote a safe learning environment;</u> b. <u>regular evaluation of the learning environment, with input from faculty, staff, and students;</u> c. <u>actions aimed at enhancing the learning environment based on the results of regular evaluation.</u> <p>Intent: <i>The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of</i></p>

		<p><i>faculty, students, and staff, open communication, leadership, and scholarship.</i></p> <p>Examples of evidence to demonstrate compliance may include:</p> <ul style="list-style-type: none"> • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • <u>Development of a Code of Conduct</u> • <u>Training to recognize and mitigate microaggressions, implicit and explicit bias, racism, gender identity and sexual orientation, hate speech, or other derogatory or harmful behaviors</u> • Student, faculty, and patient <u>staff</u> groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni <u>and staff</u> perceptions of the cultural-<u>learning</u> environment
	<p>Proposed Standard 1-3</p>	<p>The dental school must have policies and practices <u>related to diversity and inclusion consistent with University policies and state law</u> to:</p> <p>a. achieve appropriate levels of diversity among its students, faculty and staff;</p> <p>b. a. engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; and</p> <p>c. b. systematically evaluate comprehensive strategies to improve the institutional climate for dental school's diversity and inclusion.; and</p> <p>d. c. engage in actions aimed at enhancing the program's diversity and inclusion based on results of regular evaluation.</p> <p>Intent: <i>The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulates its expectations regarding diversity, equity, inclusion, and belonging across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity and inclusion in their planning that include, but are not limited to, gender, ethnicity, race, cultural, and socioeconomic factors. gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.</i></p>
	<p>Proposed Standard 2-9</p>	<p><u>Instruction in social and behavioral sciences must be at an in-depth level and include:</u></p> <p>a. <u>patient management, including cultural diversity and interpersonal communications skills;</u></p>

		<ul style="list-style-type: none"> b. <u>intra-professional collaboration, including communicating with other members of the oral health care team;</u> c. <u>inter-professional collaboration, including communicating with other members of the health care team;</u> d. <u>professional conduct, including ethical decision making;</u> e. <u>legal and regulatory concepts related to patient care;</u> f. <u>basic principles of practice management, including models of oral health care delivery, and how to function successfully as the leader of the oral health care team; and</u> g. <u>oral epidemiology, dental public health, and social determinants of health.</u>
	Proposed Standard 2-10	<p><u>Following patient experiences, graduates must demonstrate competence in social and behavioral sciences including:</u></p> <ul style="list-style-type: none"> a. <u>patient management, including cultural diversity and interpersonal communications skills;</u> b. <u>demonstration of intra-professional collaboration, including communicating with other members of the oral health care team;</u> c. <u>demonstration of inter-professional collaboration, including communicating with other members of the health care team</u> d. <u>adherence to professional conduct, including ethical decision making; and</u> e. <u>compliance with legal and regulatory concepts related to patient care.</u>
	Proposed Standard 2-15	<p>Dental education programs <u>The dental education program must make available community-based patient experience opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences interact with and treat patients in varied clinical environments.</u></p> <p>Intent: Service learning experiences and/or e<u>Community-based learning experiences are essential valuable to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.</u></p>
	Proposed Standard 4-1	<p>Specific w<u>Written criteria, policies and procedures, including policies and procedures designed to recruit and admit a diverse student population, must be followed when admitting predoctoral students.</u></p> <p>Intent 4-1 to 4-3 4-4: <u>The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensures the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non- discriminatory and ensure the quality of the program.</u></p>

Dental Assisting		
	Standard 1-7	<p>There must be an active advisory committee to serve as a liaison between the program, local dental and allied dental professionals and the community. Dentists and dental assistants must be equally represented.</p> <p>Intent: <i>The purpose of the advisory committee is to provide a mutual exchange of information for program enhancement, meeting program and community needs, standards of patient care, and scope of practice. Membership should include representation from a variety of practice settings. The program administrator, faculty, students, and appropriate institutional personnel are non-voting participants.</i></p> <p>Examples of evidence to demonstrate compliance may include:</p> <ul style="list-style-type: none"> •Membership responsibilities are defined and terms staggered to provide both new input and continuity •Diverse membership with consideration given to student representation, recent graduate(s), public representation, and a profile of the local dental community. •Responsibilities of program representatives on the committee are defined in writing. •Meeting minutes are maintained and distributed to committee members.
	Standard 2-14	<p>The dental science aspect of the curriculum must include content at the familiarity level in:</p> <ul style="list-style-type: none"> a. Oral pathology b. General anatomy and physiology c. Microbiology d. Nutrition e. Pharmacology to include: <ul style="list-style-type: none"> i. Drug requirements, agencies, and regulations ii. Drug prescriptions iii. Drug actions, side effects, indications and contraindications iv. Common drugs used in dentistry v. Properties of anesthetics vi. Drugs and agents used to treat dental-related infection vii. Drug addiction including opioids and other substances f. Patients with special needs including patients whose medical, physical, psychological, or social conditions make it necessary to modify normal dental routines.
	Standard 2-20	<p>The program must demonstrate effectiveness in creating an academic environment that supports ethical and professional responsibility to include:</p> <ul style="list-style-type: none"> a. Psychology of patient management and interpersonal communication b. Legal and ethical aspects of dentistry

		<p>Intent: <i>Faculty, staff and students 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.</i></p> <p>Examples of evidence may include:</p> <ul style="list-style-type: none"> • Faculty, student, staff membership and participation in dental professional organizations, e.g., American Dental Assistants Association, American Dental Education Association, American Dental Association • Professional Code of Conduct • State Dental Practice Act • Student Handbook • Professional and ethical expectations
	Standard 2-21	<p>The dental assisting program must provide opportunities and encourage students to engage in service and/or community-based learning experiences.</p> <p>Intent: <i>Community-based experiences are essential to develop dental assistants who are responsive to the needs of a culturally diverse population.</i></p> <p>Examples of evidence may include:</p> <ul style="list-style-type: none"> •Service hours •Volunteer activities
Dental Hygiene		
	Standard 1-2	<p>The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.</p> <p>Intent: <i>The program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.</i></p> <p>Examples of evidence to demonstrate compliance may include:</p> <ul style="list-style-type: none"> • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, 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 student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 2-12	Graduates must be competent in providing dental hygiene care for all patient populations including: 1) child 2) adolescent 3) adult 4) geriatric 5) special needs

		<p>Intent: An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, developmental, intellectual or social conditions may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student. Clinical instruction and experiences should include the dental hygiene process of care compatible with each of these patient populations.</p>
	Standard 2-15	<p>Graduates must be competent in interprofessional communication, collaboration and interaction with other members of the health care team to support comprehensive patient care.</p> <p>Intent: Students should understand the roles of members of the health-care team and have interprofessional educational experiences that involve working with other health-care professional students and practitioners. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental Hygienists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).</p>
	Standard 2-19	<p>Graduates must be competent in 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: Dental hygienists should understand and practice ethical behavior consistent with the professional code of ethics throughout their educational experiences.</p>
Dental Laboratory Technology		
	Standard 1-7	<p>There must be an active liaison mechanism between the program and dental professionals in the community.</p> <p>Intent: <i>The purpose of the active liaison mechanism is to provide a mutual exchange of information for improving the program and meeting employment needs of the community.</i> <i>Meetings, either in-person or virtual, should be held at least once per year.</i></p>
	Standard 2-1	<p>Admission of students must be based on specific written criteria, procedures and policies. Minimum admissions requirements must include high school diploma or its equivalent. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability, and employment opportunities for dental laboratory technicians.</p> <p>Intent:</p>

		<i>Because the curriculum is science and technology-oriented and enrollment is limited by facility capacity, special program admissions criteria and procedures may be necessary. The program administrator and faculty, in cooperation with appropriate institutional personnel establish admissions procedures which are non-discriminatory, contribute to the quality of the program, and allow selection of students with potential for successfully completing the program.</i>
	Standard 2-7	<p>The basic curriculum must include content in the subject areas: general studies; physical sciences; dental sciences; legal, ethical and historical aspects of dentistry and dental laboratory technology; infectious disease and hazard control management; and, basic laboratory techniques.</p> <p>Intent: <i>To ensure that foundational knowledge is established early in the program and that subsequent information is provided which is comprehensive and prepares the student to achieve competence in all components of dental laboratory practice. Content identified in each subject need not constitute a separate course, but the subject areas are included within the curriculum.</i></p>
	Standard 2-11	<p>The curriculum must include content in the legal, ethical and historical aspects of dentistry and dental laboratory technology to include:</p> <ul style="list-style-type: none"> a) Organizations that advance certification and continuing education for dental technicians and certification of laboratories. b) Work authorization/prescription of the dentist in accordance with the state dental practice act, consistent with current procedures in dental laboratory technology in the geographic area served by the program. c) Federal and state laws and regulations related to operating a dental laboratory and/or working as a dental laboratory technician. d) HIPAA laws related to health care professionals e) Ethics for health care professionals <p>Intent: <i>The dental laboratory technology curriculum prepares students to assume a professional and ethical standard to understand the basic foundation in which the fundamentals of dental laboratory technology were established.</i></p>
Dental Therapy		
	Standard 1-3	<p>The dental therapy education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.</p> <p>Intent: <i>The dental therapy education program should ensure collaboration, mutual respect, cooperation, and harmonious</i></p>

		<p><i>relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.</i></p> <p>Examples of evidence to demonstrate compliance may include:</p> <ul style="list-style-type: none"> • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, 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 student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 1-4	<p>The program must have policies and practices to:</p> <ol style="list-style-type: none"> a. achieve appropriate levels of diversity among its students, faculty and staff; b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity. <p>Intent: <i>The program should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The program should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Programs could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Programs should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.</i></p>
	Standard 2-14	<p>Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.</p> <p>Intent: <i>Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:</i></p> <ul style="list-style-type: none"> • <i>basic principles of culturally competent health care;</i>

		<ul style="list-style-type: none"> • <i>basic principles of health literacy and effective communication for all patient populations;</i> • <i>recognition of health care disparities and the development of solutions;</i> • <i>the importance of meeting the health care needs of dentally underserved populations, and;</i> • <i>the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.</i> <p><i>Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).</i></p> <p>Examples of evidence to demonstrate compliance may include:</p> <ul style="list-style-type: none"> • student projects demonstrating the ability to communicate effectively with a variety of individuals and groups. • examples of individual and community-based oral health projects implemented by students during the previous academic year • evaluation mechanisms designed to monitor knowledge and performance
	Standard 2-24	<p>Dental therapy education programs must have students engage in service learning experiences and/or community-based learning experiences.</p> <p>Intent: <i>Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.</i></p>
	Standard 4-2	<p>Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.</p> <p>Intent: <i>Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.</i></p>

<p>Advanced Education in General Dentistry</p>		
	<p>Goals 2, 6, 7</p>	<p>2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs. 6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 7. Understand the oral health needs of communities and engage in community service.</p>
	<p>Standard 1-10</p>	<p>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.</p> <p><i>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.</i></p>
	<p>Standard 2-1</p>	<p>The program must provide didactic and clinical training to ensure upon completion of training, the resident is able to:</p> <ul style="list-style-type: none"> a) Act as a primary oral health care provider to include: <ul style="list-style-type: none"> 1) providing emergency and multidisciplinary comprehensive oral health care; 2) obtaining informed consent; 3) functioning effectively within interdisciplinary health care teams, including consultation and referral; 4) providing patient-focused care that is coordinated by the general practitioner; and 5) directing health promotion and disease prevention activities. b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs. c) Manage the delivery of patient-focused oral health care. <p><i>Intent: “Patients with special needs” is defined in the Definition of Terms on page 10 of this document.</i></p> <p><i>Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.</i></p>

General Practice Residency		
	Goals 2, 7, 8	<p>2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.</p> <p>7. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.</p> <p>8. Understand the oral health needs of communities and engage in community service</p>
	Standard 1-10	<p>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.</p> <p><i>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.</i></p>
	Standard 2-1	<p>The program must provide didactic and clinical training to ensure upon completion of training, the resident is able to:</p> <ul style="list-style-type: none"> a) Act as a primary oral health care provider to include: <ul style="list-style-type: none"> 1) providing emergency and multidisciplinary comprehensive oral health care; 2) obtaining informed consent; 3) functioning effectively within interdisciplinary health care teams, including consultation and referral; 4) providing patient-focused care that is coordinated by the general practitioner; and 5) directing health promotion and disease prevention activities. b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs. c) Manage the delivery of patient-focused oral health care. <p><i>Intent: “Patients with special needs” is defined in the Definition of Terms on page 10 of this document.</i></p> <p><i>Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.</i></p>

Dental Anesthesiology		
	Standard 1-10	<p>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.</p> <p><i>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.</i></p>
	Goals 2, 7	<p>2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs.</p> <p>7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.</p>
	Standard 2-1	<p>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.</p>
	Standard 2-6	<p>The following list represents the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:</p> <ul style="list-style-type: none"> a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: <ul style="list-style-type: none"> (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.
Dental Public Health		

	Preface	<p>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, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status.</p> <p>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.</p> <p>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.</p>
	Standard 4-2	<p>Graduates must receive instruction in and be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, practice management, and programs to promote the oral health of individuals and communities.</p> <p><i>Intent: Graduates are expected to 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. Graduates are expected to respect the culture, diversity, beliefs and values in the community.</i></p>
Endodontics		
	Preface	<p>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.</p> <p>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</p>

		<p>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.</p> <p>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.</p>
	Standard 1-1	<p>Graduates must receive instruction in 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.</p> <p><i>Intent: Graduates 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.</i></p>
Oral and Maxillofacial Pathology		
	Preface	<p>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, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status.</p> <p>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.</p> <p>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.</p>

	Standard 4-8.1	<p>Graduates must have an understanding 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.</p> <p><i>Intent: Graduates 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</i></p>
Oral and Maxillofacial Radiology		
	Preface	<p>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.</p> <p>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.</p> <p>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.</p>
	Standard 4-3	<p>Graduates must be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.</p> <p><i>Intent: Graduates 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.</i></p>

Oral and Maxillofacial Surgery (Residency)		
	Preface	<p>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.</p> <p>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.</p> <p>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.</p>
	Standard 4-16	<p>Graduates must receive instruction in the application of the principle of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.</p> <p><i>Intent: Graduates 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.</i></p>
	Standard 1-11	<p>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.</p> <p><u>Examples of evidence to demonstrate compliance may include:</u></p> <ul style="list-style-type: none"> • <u>Nondiscriminatory policies and practices at all organizational levels.</u> • <u>Mission and policy statements which promote diversity and inclusion.</u> • <u>Evidence of training in diversity, inclusion, equity, and belonging.</u>

	Standard 2-1.7	<p>The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.</p> <p><u>Intent:</u> <i><u>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.</u></i></p> <p><u>Examples of evidence to demonstrate compliance may include:</u></p> <ul style="list-style-type: none"> • <u>Established policies regarding ethical behavior by faculty, staff and residents that are regularly reviewed and readily available</u> • <u>Resident, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities</u> • <u>Focus groups and/or surveys directed towards gathering information on resident, faculty, patient, and alumni perceptions of the cultural environment</u>
	Standard 2-1.8	<p>The program director and teaching staff must lead by example in all aspects of professionalism.</p> <p><u>Intent:</u> <i><u>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.</u></i></p> <p><u>Examples of evidence to demonstrate compliance may include:</u></p> <ul style="list-style-type: none"> • <u>Written evaluations from faculty and the chair of the program director and teaching staff.</u> • <u>Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.</u> • <u>External evaluations of culture, climate, and learning environment.</u>

		<ul style="list-style-type: none"> • <u>Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation</u>
	Standard 2-1.9	<p>Lines of communication must be established and ongoing within the program to address culture concerns without the fear of retaliation.</p> <p><u>Examples of evidence to demonstrate compliance may include:</u></p> <ul style="list-style-type: none"> • <u>Written evaluations from faculty that occur at least twice a year.</u> • <u>Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.</u> • <u>Anonymous evaluations of culture, climate, and learning environment.</u> • <u>Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation.</u> • <u>Policies and requirements that promote an optimal educational experience, working culture and environment.</u>
	Standard 4-18.1	<p>The program must provide resident supervision to promote safe and optimal patient care.</p> <p><u>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.</u></p> <p><u>Examples of evidence to demonstrate compliance may include:</u></p> <ul style="list-style-type: none"> • <u>Resident supervision policy</u> • <u>Documented resident responsibility based on OMS benchmarks or similar metrics.</u> • <u>Faculty and resident call schedules</u> • <u>Documentation of didactic and clinical competency or Core Entrustable Professional Activities (EPAs)</u> • <u>Didactic sessions focused on the process of progressive entrustment.</u>
	Standard 4-21 (4-21.1 – 4-21.4)	<p>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.</p> <p><u>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</u></p>

		<p><u>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.</u></p> <p><u>Examples of evidence to demonstrate compliance may include:</u></p> <ul style="list-style-type: none"> • <u>ROAAOMS Wellness Webinar Series</u> • <u>Resident Evaluations of the program</u> • <u>SCORE and/or institutional modules on wellness</u> <p><u>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.</u></p> <p><u>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.</u></p> <p><u>4-21.3 Resident work hours must be monitored and reviewed.</u></p> <p><u>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.</u></p> <p><u>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.</u></p>
<p>Oral and Maxillofacial Surgery (Fellowship)</p>		
<p>Oral Medicine</p>	<p>None</p>	
	<p>Goals 6, 7</p>	<p>6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 7. Understand the oral health needs of communities and engage in community service.</p>

	Standard 1-12	<p>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.</p> <p><i>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.</i></p>
	Standard 2-12	<p>The educational program must provide training to the level of competency for the resident to:</p> <p>a) perform a comprehensive physical evaluation and medical risk assessment on patients who have medically complex conditions and make recommendations for dental treatment plans and modifications;</p>
Orofacial Pain		
	Goals 2, 10	<p>2. Plan and provide interdisciplinary/multidisciplinary health care for a wide variety of patients with orofacial pain.</p> <p>10. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.</p>
	Standard 1-11	<p>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.</p> <p><i>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.</i></p>
	Standard 2-10	<p>The program must provide training to ensure that upon completion of the program, the resident is able to manage patients with special needs.</p> <p><i>Intent: The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident's ability to manage patients with special needs.</i></p>
Orthodontics and Dentofacial Orthopedics (Residency)		

	Preface	<p>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.</p> <p>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.</p> <p>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.</p>
	Standard 1-1	<p>Graduates must receive instruction in 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.</p> <p><i>Intent: Graduates 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.</i></p>
	Standard 4-3.2	<p>An advanced dental education program in orthodontics and dentofacial orthopedics requires extensive and comprehensive clinical experience, which must be representative of the character of orthodontic problems encountered in private practice.</p> <p><i>Intent: The intent is to ensure there is diversity in the patient population so that the students/residents will learn to treat a variety of orthodontic problems from the primary to adult dentition.</i></p>
Orthodontics and Dentofacial Orthopedics (Fellowship)		
	None	
Pediatric Dentistry		Note: The nature of the discipline requires treating infant, child, adolescent and patients with special healthcare needs.

	<p>Preface</p>	<p>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, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status.</p> <p>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.</p> <p>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.</p>
	<p>Standard 4-6</p>	<p>Didactic Instruction: Didactic instruction in behavior guidance must be at the in-depth level and include:</p> <ol style="list-style-type: none"> a. Physical, psychological and social development. This includes the basic principles and theories of child development and the age-appropriate behavior responses in the dental setting; b. Child behavior guidance in the dental setting and the objectives of various guidance methods; c. Principles of communication, listening techniques, and communication with parents and caregivers; d. Principles of informed consent relative to behavior guidance and treatment options; e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the REFERENCE MANUAL; and f. Recognition, treatment and management of adverse events related to sedation and general anesthesia, including airway problems. <p><i>Intent: The term “treatment” refers to direct care provided by the residents/student for that condition or clinical problem. The term “management” refers to provision of appropriate care and /or referral for a condition consistent with contemporary practice and in the best interest of the patient.</i></p>

	4-7	<p>Clinical Experiences: Clinical experiences in behavior guidance must enable students/residents to achieve competency in patient management using behavior guidance:</p> <ul style="list-style-type: none"> a. Experiences must include infants, children and adolescents including individuals with special health care needs, using: <ol style="list-style-type: none"> 1. Non-pharmacological techniques; 2. Sedation; and 3. Inhalation analgesia. b. Students/Residents must perform adequate patient encounters to achieve competency: <ol style="list-style-type: none"> 1. Students/Residents must complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and 2. Students/Residents must complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.
	Standard 4-7	<p>Clinical Experiences: Clinical experiences in behavior guidance must enable students/residents to achieve competency in patient management using behavior guidance:</p> <ul style="list-style-type: none"> a. Experiences must include infants, children and adolescents including individuals with special health care needs, using: <ol style="list-style-type: none"> 1. Non-pharmacological techniques; 2. Minimal Ssedation; and 3. Moderate sedation <u>Inhalation analgesia.</u> b. Students/Residents must perform adequate patient encounters to achieve competency: <ol style="list-style-type: none"> 1. Students/Residents must complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and 2. <u>1.</u> Students/Residents must complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used <u>to sedate pediatric patients or patients with special health care needs.</u> The agents may be administered by any route.
	Standard 4-20	<p>Didactic Instruction: Didactic instruction must be at the understanding level and include:</p> <ul style="list-style-type: none"> a. The design, implementation and management of a contemporary practice of pediatric dentistry, emphasizing

		<p>business skills for proper and efficient practice;</p> <ul style="list-style-type: none"> b. Jurisprudence and risk management specific to the practice of Pediatric Dentistry; c. Use of technology in didactic, clinical and research endeavors, as well as in practice management and telehealth systems; d. Principles of biomedical ethical reasoning, ethical decision making and professionalism as they pertain to the academic environment, research, patient care and practice management; and e. Working cooperatively with consultants and clinicians in other dental specialties and health fields, including interprofessional education activities. <p>Didactic instruction must be at the in-depth level for the following:</p> <ul style="list-style-type: none"> f. The development and monitoring of systems for prevention and management of adverse events and medical emergencies in the dental setting; g. Exposure to the principles of quality management systems and the role of continuous process improvement in achieving overall quality in the dental practice setting; h. Exposure to the principles of ethics and professionalism in dental practice is an integral component of all aspects of this process improvement experience; and i. Employing principles of quality improvement, infection control, and safety, including an understanding of the mechanisms to ensure a safe practice environment. <p><i>Intent: (d) Graduates should 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, (e) The student/resident learns to prevent, recognize and manage common medical emergencies for infants and children through adolescence and when to refer to other health care professionals and (g) Graduates should experience the elements of process improvement and the manner in which to involve the entire team</i></p>
	Standard 4-22	<p>Didactic Instruction: Didactic instruction must be at the in-depth level and include:</p> <ul style="list-style-type: none"> a. Formulation of treatment plans for individuals with special health care needs. b. Medical conditions and the alternatives in the delivery of dental care that those conditions might require. c. Management of the oral health of individuals with special health care needs, i.e.: <ul style="list-style-type: none"> 1. Medically compromised; 2. Physically compromised or disabled; and diagnosed to have developmental disabilities,

		<p>psychiatric disorders or psychological disorders.</p> <p>3. Transition to adult practices</p> <p>Intent: (a) The student/resident learns how and when to modify dental care options as required by a patient's medical condition; and (c) Individuals with special health care needs include those with medical, physical, psychological or social circumstances that require modification in normal dental routines to provide dental treatment.</p>
	Standard 4-23	<p>Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in:</p> <ol style="list-style-type: none"> a. Examination, treatment and management of infants, children, adolescents and individuals with special health care needs; and b. Participation in interprofessional experiences and collaborative care, including craniofacial teams. <p>Intent: Pediatric dentists often remain providers of oral health care for individuals with special health care needs into adulthood and should be able to render basic dental services to adults with special health care needs. These individuals include (but are not limited to) individuals with developmental disabilities, craniofacial anomalies, complex medical problems and significant physical limitations. Management should be understood to include consideration of social, educational, vocational and other aspects of special health care needs.</p>
	Standard 4-28	<p>Didactic Instruction: Didactic instruction must be at the understanding level and include:</p> <ol style="list-style-type: none"> a. The fundamental domains of child advocacy including knowledge about the disparities in the delivery of dental care, issues pertaining to access to dental care and possible solutions; b. The social determinants of health and the impact on general and oral health; c. Services available through healthcare and oral healthcare programs for at-risk populations, such as U.S. governmental programs (e.g., Medicaid and SCHIP); and d. Principles of learning and teaching to diverse audiences. <p>Intent: Pediatric dentists serve as the primary advocates for the oral health of children. The intent of the competency standards is to ensure that the resident is adequately trained to assume this role. Such training includes enhancing knowledge about oral health disparities and available services within the state and federal programs directed at meeting those needs. It also</p>

		<i>includes knowledge about their role as advisors to policy makers and organized dentistry.</i>
	Standard 4-29	Experiences: Experiences must provide exposure of the student/resident to: <ul style="list-style-type: none"> a. Communicating, teaching, and collaborating with groups and individuals on children’s oral health issues; and/or b. Advocating and advising public health policy legislation and regulations to protect and promote the oral health of children; and/or c. Participating at the local, state and/or national level in organized dentistry and child advocacy groups/organizations to represent the oral health needs of children, particularly the underserved.
Periodontics		
	Preface	<p>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.</p> <p>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.</p> <p>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.</p>
	Standard 1-1	Graduates must receive instruction in 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.

		<i>Intent: Graduates 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.</i>
	Standard 2-1.a	The program director must have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following: a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences;
Prosthodontics		
	Preface	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.
	Standard 4-21	Students/Residents must be competent regarding principles of ethical decision making pertaining to academic, research, patient care and practice environments. <i>Intent: Students/Residents should be able 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.</i>