

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

Committee Chair: Dr. Cataldo Leone. Committee Members: Mr. Drew Christianson, Dr. Sillas Duarte (virtual), Ms. Wilhemina Leeuw, Dr. Ana Karina Mascarenhas, Dr. Thomas McConnell, Dr. Scott Phillips, and Dr. Deborah Weisfuse-Lipner. Dr. Kevin Haubrick did not attend the meeting. Commissioner Trainees: Dr. Keith Mays, Dr. Renee McCoy-Collins (virtual, attended a portion of the meeting), Dr. Lisa Nowlin, and Dr. Kanthasamy Ragunathan observed the meeting as Commissioner trainees. Guests (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association (ADEA) attended the policy portion of the meeting. Staff Members: Ms. Kelly Stapleton, manager, Predoctoral Dental Education, and Ms. Attiyya Muhammad, senior project assistant, Commission on Dental Accreditation (CODA). Dr. Sherin Tooks, senior director, CODA, and Ms. Samara Schwartz, senior associate general counsel, CODA, attended a portion of the meeting. The meeting of the Review Committee on Predoctoral Dental Education (PREDOC RC) was held on July 8 – 9, 2024 at the ADA Headquarters, Chicago, Illinois and via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO PREDOCTORAL DENTAL AND DENTAL THERAPY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Dental Education Programs (p. 100): The Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the annual report on the frequency of citings for dental education programs (**Policy Report p. 100**). The PREDOC RC discussed that the highest number of citings overall are found within Standard 2 on Educational Program, with 159 citings. The Committee noted Standard 2-24 h, regarding competency in the replacement of teeth including fixed, removable and dental implant prosthodontic therapies, resulted in 19 citings. The Commission noted Standard 2-9, which requires availability of adequate patient experiences received 14 citings. Standard 2-19, which requires graduates to be competent in practice management received 12 citings. Standard 2-5 which requires methods of student evaluation to measure defined competencies received 10 citings. The highest number of citings for a single area of compliance (with 19 citings) was Standard 2-24 h, regarding competency in the replacement of teeth including fixed, removable and dental implant prosthodontic therapies. Overall, Standard 2-24 a-o totaled 78 citings and is the most frequently cited Standard within dental education.

Standard 5 on Patient Care Services was the second most frequently cited area with 55 citings. The second most frequently cited Standard (with 40 citings total) was Standard 5-3 a-e, which requires programs to conduct a formal system of continuous quality improvement for patient care. There were 21 citings for Standard 1-Institutional Effectiveness, eight (8) citings for Standard 3-Faculty and Staff, 12 citings for Standard 4-Educational Support Services, and six (6) citings for Standard 6-Research Program. Of the 115 site visits conducted since the adoption of the current Accreditation Standards, 58 programs were in compliance with all requirements at the time of the site visit.

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

Informational Report on Frequency of Citings of Accreditation Standards for Dental Therapy Education Programs (p. 101):

The Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the annual report on the frequency of citings for dental therapy education programs noting that three (3) site visits had occurred during the period of reporting (**Policy Report p. 101**). To ensure confidentiality, Frequency of Citings Reports will not be made available in disciplines where a limited number (three or less) of programs have been site visited. Once there are four (4) or more site visits of dental therapy education programs, the non-compliance citings will be analyzed and summarized accordingly.

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

Report of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs (p. 102):

The Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the Report of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs (**Policy Report p. 102**), including the background and history of the Ad Hoc Committee composition, and the Committee's recommendations for revision of the dental education Standards. The PREDOC RC noted the composition of the Ad Hoc Committee included both members of CODA's Review Committee on Predoctoral Dental Education, members nominated by the American Dental Education Association (ADEA) and appointed by the Commission, and members of the Commission. The PREDOC RC noted that extensive proposed revisions were made to the Goals, Definition of Terms, and Standards 1 through 6 of the Accreditation Standards for Dental Education Programs.

The PREDOC RC discussed the proposed revision to move the standard related to faculty calibration to Standard 3 - Faculty & Staff to better align with the intent for programs to provide faculty training focusing on calibration. The PREDOC RC also discussed the proposed revisions of terms from "humanistic environment" to "learning environment". The PREDOC RC noted the proposed revision to define the learning environment aligns with changes of other professional organizations, such as ADEA, to be less subjective and focus on education and student learning. The PREDOC RC also noted that the revision to current Standard 1-3 (proposed Standard 1-2) adds clarity for programs to better focus on the commitment, evaluation, and actions for enhancement of the educational learning environment.

To ensure major changes, including moving standards from one section to another, are visible in the proposed revisions to the Accreditation Standards for Dental Education Programs, the PREDOC RC discussed adding a cover sheet to show a brief summary of the proposed revisions. The PREDOC RC believed an explanation of the proposed changes may help to relay specific rationale to the communities of interest when the proposed revisions are circulated for comment and feedback. Following consideration, the PREDOC RC believed that the proposed revisions found in **Appendix 1**, including the explanation of proposed revisions cover page, should be

circulated to the communities of interest for an initial period of six (6) months to obtain preliminary feedback on the draft document, including a hearing in conjunction with the October 2024 American Dental Association Annual Meeting, with comments to be reviewed at future meetings of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs. It was the belief of the PREDOC RC that a lack of feedback, or positive feedback received during the six-month period of circulation, would indicate that the communities of interest understand and support the revisions as presented, thus additional lengthy circulation of the proposed Standards may not be necessary. Additionally, while Ad Hoc Committee members' terms on the Commission may be expiring, the PREDOC RC believed that the current composition on the Ad Hoc Committee should be retained in order to ensure continuity in the review process for the revised Standards.

Recommendation: It is recommended that the Commission on Dental Accreditation direct the proposed revisions to the Accreditation Standards for Dental Education Programs (**Appendix 1**) be circulated for an initial period of six (6) months to the communities of interest to obtain preliminary feedback on the proposed revisions, including a Hearing in conjunction with the October 2024 American Dental Association Annual Meeting, with comments to be reviewed at future meetings of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs.

It is further recommended that the Commission on Dental Accreditation direct the current membership and composition of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs be retained through completion of the Ad Hoc Committee's charge to review the Accreditation Standards for Dental Education Programs.

NEW BUSINESS

Dental Therapy Site Visit Team Composition: The PREDOC RC discussed the Commission's Site Visitors policy and specifically the site visit team composition for dental therapy education program site visits. Due to the minimal number of dental therapy programs, the PREDOC RC noted it is challenging to find dental therapy educators to serve as CODA site visitors. The Site Visitors policy allows for flexibility such that if a dental therapy educator cannot be identified in accordance with Commission policy, then the site visit team, consisting of three (3) members, may be composed of predoctoral educators (clinical and curriculum site visitors) and allied dentist site visitors. Currently, predoctoral clinical or curriculum site visitors may identify their interest in serving on dental therapy site visits. The PREDOC RC discussed and determined that any predoctoral clinical or curriculum site visitor with appropriate site visit experience may be identified to serve on a dental therapy site visit.

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

**CONSIDERATION OF MATTERS RELATING TO
MORE THAN ONE REVIEW COMMITTEE**

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

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Cataldo Leone
Chair, Review Committee on Predoctoral Dental Education

Commission on Dental Accreditation

Proposed Revisions to Accreditation Standards for Dental Education Programs

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards For Dental Education Programs

Explanation of Proposed Revisions

The explanation below provides a summary of the proposed revisions. This Explanation of Proposed Revisions page will be removed from the final Standards that is approved by the Commission on Dental Accreditation.

Highlights of Proposed Revisions:

Goals, Educational Environment, and Definition of Terms: In regard to the Goals, the Ad Hoc Committee believed that key phrasing currently in place should be bolded, to emphasize that CODA encourages institution to extend their educational programs beyond the minimum requirements, consistent with the institution’s own goals and objectives.

Pertaining to the Educational Environment, the Committee proposed revisions to the humanistic culture to expand broadly the concept of a safe learning environment that includes physical and psychological safety, free of intimidation, abuse, and retaliation. The Committee also modified Student Assessment to encourage adoption of innovations in assessment methods. The Ad Hoc Committee noted language throughout the Standards, which encourages innovative educational methods. The Committee also expanded the educational environment to include “inclusion” as an important component of diversity and proposed additional changes elsewhere in the document.

In the Definition of Terms, the Ad Hoc Committee believed that community-based experiences should replace service learning and be categorized as patient-based or service-based community experiences. The Ad Hoc Committee further clarified the terms surrounding student competence, competency statements, and competency assessments. The Committee also believed that diversity should be classified as structural and institutional climate, again to be further expanded within the Standards. Finally, the Ad Hoc Committee believed that research and strategic planning should be defined, and that health literacy should be eliminated since it was no longer referenced in the Standards.

Standard 1 – Institutional Effectiveness: As with many of the proposed revisions, the Ad Hoc Committee attempted to streamline and clarify the requirements for dental education programs. Within Standard 1, the Committee combined the requirement for a purpose/mission statement (stricken Standard 1-1) with the requirement for an outcomes assessment program (stricken Standard 1-2) to form the proposed Standard 1-1. The Committee also believed there should be a demonstrated commitment to a safe learning environment and revised the Standards accordingly. The Committee noted in several areas of the revisions that diversity and inclusion are an important component to higher education and preparing an individual to work with diverse patient populations; however, the Committee also noted that academic institutions must work within the parameters dictated by laws, and, as such, the Standards related to diversity and inclusion were modified to permit flexibility to programs in achieving these requirements. The Ad Hoc Committee made additional clarifying revisions to support institutional effectiveness.

Standard 2 – Educational Program: Again, within Standard 2, the Ad Hoc Committee attempted to streamline and clarify the Standards which could be subject to differing

1 interpretations. Related to the program length, the Ad Hoc Committee believed an intent
2 statement could further clarify that a program could have policies for students' time away from
3 the program (e.g., vacation or excused absence), while ensuring that students meet all program
4 academic expectations and competencies for graduation within the formal program and in
5 conformance with institutional policies on student attendance.

6
7 The Ad Hoc Committee modified Standard 2 to assure that all educational programs establish
8 competencies that, at minimum, are consistent with the CODA Standards and employ assessment
9 methods to measure the student's readiness for independent practice (proposed Standard 2-
10 3). The Committee also expanded the requirement for curriculum management plan to ensure the
11 curriculum demonstrates integration of biomedical, behavioral and clinical science instruction and
12 incorporates emerging information and technologies (proposed Standard 2-4).

13
14 The Ad Hoc Committee proposed revisions to Critical Thinking, Self-Assessment, and
15 Biomedical Sciences to further clarify and strengthen these Standards. The section on Behavioral
16 Sciences was proposed as the Social and Behavioral Sciences, with the incorporation of
17 components of other Standards to address patient management, intra- and inter-professional
18 collaboration, professional conduct, practice management, and dental public health with social
19 determinants of health. Instructional requirements and competency requirements in social and
20 behavioral sciences were clearly outlined in proposed Standards 2-9 and 2-10.

21
22 Related to the Clinical Sciences, the Ad Hoc Committee had extensive discussions related to the
23 current and future dental professional, and the needs of the graduate who may practice in a variety
24 of settings. The Committee believed that graduates must be competent in providing oral health
25 care to all stages of life, including the defined stages of primary dentition, mixed dentition, adult
26 and geriatric patient populations. To clarify CODA's expectations related to instruction, patient
27 care experiences, and competency assessment related to clinical care, the Ad Hoc Committee also
28 created proposed Standards 2-12, 2-13, and 2-14. Regarding Standard 2-12, the Committee
29 believed that instruction must be provided at an in-depth level in all proposed areas of the new
30 Standard. The Committee also proposed that current Standard 2-9 be stricken with the inclusion
31 of proposed Standard 2-13. The Ad Hoc Committee engaged in several lengthy discussions
32 related to Standard 2-13 and concluded that students must have patient-based instruction and
33 experience in direct patient care within all areas noted in the new Standard. Pertaining to
34 proposed Standard 2-14 regarding the demonstration of competence, the Ad Hoc Committee
35 again had lengthy discussions and determined that a majority of competency assessments in each
36 category of the new Standard must be completed through direct patient care assessments. While
37 the Committee agreed that simulation may also be used to assess competence, the Ad Hoc
38 Committee believed patient care-based competencies should be emphasized. The Committee also
39 noted that recognition and management of patients with special health care needs was
40 incorporated into the proposed Standards 2-12, 2-13, and 2-14, and thus did not require a separate
41 Standard (proposed deletion of current Standard 2-23).

42
43 Standard 3 – Faculty and Staff: The Ad Hoc Committee believed that current Standard 3-1
44 should be divided into a standard related to the number and distribution of faculty, and a separate
45 standard related to the qualifications of those faculty. Additionally, the Ad Hoc Committee
46 moved the requirement from current Standard 2-6 (i.e., comparable instruction through calibration

1 of faculty) to proposed Standard 3-3, which will assure that faculty are calibrated consistent with
2 instruction and assessment of students at all sites. The Ad Hoc Committee believed that
3 institutions must provide ongoing faculty development (proposed Standard 3-4), and that faculty
4 regularly involved in the program (i.e., at least a weekly commitment) must be evaluated through
5 a defined performance review process related to their contributions in the program.
6

7 Standard 4 – Educational Support Services: The Ad Hoc Committee incorporated the
8 components of admission of a diverse student population within its proposed revision to Standard
9 4-1 and proposed that Standard 4-4 be stricken. The Committee also believed that students must
10 be advised of mandatory health and technical standards and proposed a new Standard 4-4 to
11 address this requirement. The Ad Hoc Committee spent considerable time reviewing the Student
12 Services section and concluded that several revisions were warranted, including creation of, and
13 revision to, sections of the Standards for student support services, student due process, and
14 student financial aid. Recognizing that the use of educational activity sites is increasing within
15 dental education, the Ad Hoc Committee proposed a revision to proposed Standard 4-13 to
16 require arrangement for access to health care for students at all sites where educational activity
17 occurs. Additionally, influenza and COVID were added to proposed revised Standard 4-14 as
18 additional immunizations for which students should be encouraged.
19

20 Standard 5 – Patient Care Services: The Ad Hoc Committee moved the requirement of current
21 Standard 5-4 to the proposed Standard 5-1, related to quantitative criteria for student advancement
22 not compromising the delivery of comprehensive patient care. The Committee also believed that
23 all items within the intent statement of proposed Standard 5-2 must be covered in a patients’
24 rights document, rather than serving as an intent statement to the Standard. The Ad Hoc
25 Committee again noted the use of educational activity sites for clinical instruction and believed
26 that all sites owned and/or operated by the program, and all sites where competency is assessed
27 must have a formal system of continuous quality improvement (proposed Standard 5-
28 4). Additionally, active patients at all sites owned and/or operated by the program, and all sites
29 where competency is assessed must have access to professional services at all times (proposed
30 Standard 5-5). The Committee proposed extensive revisions to address management of
31 emergencies and requirements for basic life support or advanced cardiac life support (proposed
32 Standard 5-6). Additionally, the Ad Hoc Committee believed that the Centers for Disease Control
33 and Prevention should serve as the measure upon which all programs are reviewed to ensure
34 adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of
35 hazardous waste (proposed Standard 5-8).
36

37 Standard 6 – Research Program: The Ad Hoc Committee discussed the importance of research
38 for the advancement of dentistry as a learned profession. As such, the Committee proposed
39 revisions to all sub-Standards within Standard 6. The most significant proposed revision occurs
40 in Standard 6-2, in which the Ad Hoc Committee believed that all dental schools must
41 demonstrate evidence of active dental faculty members engaging in research.
42

Accreditation Standards for Dental Education Programs

Commission on Dental Accreditation

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Document Revision History

Date	Item	Action
August 6, 2010	Accreditation Standards for Dental Education Programs	Approved
February 1, 2012	Revised Compliance with Commission Policies section (Complaint	Approved
February 3, 2012	Revision to Standard 2-23 e and 3-2	Approved- Implemented
August 10, 2012	Revised Mission Statement	Approved- Implemented
July 1, 2013	Accreditation Standards for Dental Education Programs	Implemented
July 1, 2013	Revision to Standard 2-23 e and 3-2	Implemented
August 9, 2013	Revised Policy on Accreditation of Off-Campus Sites	Approved- Implemented
January 29, 2014	Revised Policy on Accreditation of Off-Campus Sites	Approved- Implemented
January 30, 2014	Revision to Policy on Complaints (Anonymous)	Approved- Implemented
February 2015	Revision to Standard 4-3 and 5-8	Approved- Implemented
August 2015	Revision to Standard 4-6	Approved
February 5, 2016	Revised Accreditation Status Definitions	Approved- Implemented
July 1, 2016	Revision to Standard 4-6	Implemented
August 5, 2016	Revised Mission Statement	Adopted

1

Date	Item	Action
January 1, 2017	Revised Mission Statement	Implemented
August 4, 2017	Revised Accreditation Status Definition	Implemented
August 4, 2017	Revision to Standard 2-23.e	Approved-Implemented
August 4, 2017	Areas of Oversight at Sites Where Educational Activity Occurs (new Standards 2-6 and 4-6, revisions to Standards 3-1 and 3-2)	Approved
January 1, 2018	Areas of Oversight at Sites Where Educational Activity Occurs (new Standards 2-6 and 4-6, revisions to Standards 3-1 and 3-2)	Implemented
August 3, 2018	Revision to Standards 2-8 and 3-1	Approved
February 8, 2019	Revised Intent Statements Standards 2-20 and 2-24; New Intent Statement Standard 2-9	Approved-Implemented
February 8, 2019	Definition of Terms (Research and Health Literacy); Standard 2-17; Standard 6-Research	Approved
July 1, 2019	Revision to Standards 2-8 and 3-1	Implemented
August 2, 2019	Standard 2-24d and 2-25	Approved
January 1, 2020	Definition of Terms (Research and Health Literacy); Standard 2-17; Standard 6-Research	Implemented
July 1, 2020	Standard 2-24d and 2-25	Implemented
August 7, 2020	Standard 2-24k	Approved
August 6, 2021	Definition of Terms (Should)	Approved-Implemented
August 6, 2021	Revised Mission Statement	Approved
January 1, 2022	Revised Mission Statement	Implemented
July 1, 2022	Standard 2-24k	Implemented

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Accreditation Status Definitions

1. Programs Which Are Fully Operational

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

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

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

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

Revised: 8/17; 2/16; 5/12; 1/99; Reaffirmed: 8/23; 8/18; 8/13; 8/10, 7/05; Adopted: 1/98

2. Programs Which Are Not Fully Operational

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

1 of “initial accreditation.”

2

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

10

11

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

12

Introduction

Accreditation

Accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards. Accreditation standards are developed in consultation with those affected by the standards who represent the broad communities of interest.

The Commission on Dental Accreditation

The Commission on Dental accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related disciplines.

Standards

Dental education programs leading to the D.D.S. or D.M.D. degree must meet the standards delineated in this document to achieve and maintain accreditation.

Standards 1 through 6 constitute *The Accreditation Standards for Dental Education Programs* by which the Commission on Dental Accreditation and its consultants evaluate Dental Education Programs for accreditation purposes. This entire document also serves as a program development guide for institutions that wish to establish new programs or improve existing programs. Many of the goals related to the educational environment and the corresponding standards were influenced by the work of the American Dental Education Association Commission on Change and Innovation and by best practices in accreditation from other health professions.

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

1 Although the standards are comprehensive and applicable to all institutions that offer dental
2 education programs, the Commission recognizes that methods of achieving standards may vary
3 according to the mission, size, type, and resources of sponsoring institutions. Innovation and
4 experimentation with alternative ways of providing required training are encouraged, assuming
5 standards are met and compliance can be demonstrated. The Commission recognizes the
6 importance of academic freedom, and an institution is allowed considerable flexibility in
7 structuring its educational program so that it can meet the *Standards*. No curriculum has
8 enduring value, and a program will not be judged by conformity to a given type. The
9 Commission also recognizes that schools organize their faculties in a variety of ways.
10 Instruction necessary to achieve the prescribed levels of knowledge and skill may be provided
11 by the educational unit(s) deemed most appropriate by each institution.

12
13 The Commission has an obligation to the public, the profession and prospective students to
14 assure that accredited Dental Education Programs provide an identifiable and characteristic core
15 of required education, training, and experience.

16
17 **Format of the Standards**
18 Each standard is numbered (e.g., 1-1, 1-2) and in bold print. Where appropriate, standards are
19 accompanied by statements of intent that explain the rationale, meaning and significance of the
20 standard. This format is intended to clarify the meaning and application of standards for both
21 those responsible for educational programs and those who evaluate these programs for the
22 Commission.

Goals

1
2
3 The assessment of quality in educational programs is the foundation for the *Standards*. In
4 addition to the emphasis on quality education, the *Accreditation Standards for Dental*
5 *Education Programs* are designed to meet the following goals:

- 6 1. to protect the public welfare;
- 7 2. to promote an educational environment that fosters innovation and continuous
8 improvement;
- 9 3. to guide institutions in developing their academic programs;
- 10 4. to guide site visit teams in making judgments regarding the quality of the program and;
- 11 5. to provide students with reasonable assurance that the program is meeting its stated
12 objectives.

13
14 Specific objectives of the current version of the Standards include:

- 15 • streamlining the accreditation process by including only standards critical to the
16 evaluation of the quality of the educational program;
- 17 • increasing the focus on competency statements in curriculum-related standards; and
- 18 • emphasizing an educational environment and goals that foster critical thinking and
19 prepare graduates to be life-long learners.

20
21 To sharpen its focus on the quality of dental education, the Commission on Dental Accreditation
22 includes standards related to institutional effectiveness. Standard 1, “Institutional Effectiveness,”
23 guides the self-study and preparation for the site visit away from a periodic approach by
24 encouraging establishment of internal planning and assessment that is ongoing and continuous.
25 Dental education programs are expected to demonstrate that planning and assessment are
26 implemented at all levels of the academic and administrative enterprise. The *Standards* focus,
27 where necessary, on institutional resources and processes, but primarily on the results of those
28 processes and the use of those results for institutional improvement.

1 The following steps comprise a recommended approach to an assessment process designed to
2 measure the quality and effectiveness of programs and units with educational, patient care,
3 research, and services missions. The assessment process should include:

- 4 1. establishing a clearly defined purpose/mission appropriate to dental education,
5 patient care, research, and service;
- 6 2. formulating goals consistent with the purpose/mission;
- 7 3. designing and implementing outcomes measures to determine the degree of
8 achievement or progress toward stated goals;
- 9 4. acquiring feedback from internal and external groups to interpret the results and develop
10 recommendations for improvement (viz., using a broad-based effort for program/unit
11 assessment);
- 12 5. using the recommendations to improve the programs and units; and
- 13 6. re-evaluating the program or unit purpose and goals in light of the outcomes of this
14 assessment process.

15
16 Implementation of this process will also enhance the credibility and accountability of
17 educational programs.

18
19 It is anticipated that the *Accreditation Standards for Dental Education Programs* will
20 strengthen the teaching, patient care, research, and service missions of schools. These
21 *Standards* are national in scope and represent the minimum requirements expected for a dental
22 education program. **However, the Commission encourages institutions to extend the scope
23 of the curriculum to include content and instruction beyond the scope of the minimum
24 requirements, consistent with the institution's own goals and objectives. [bolded for
25 emphasis]**

26
27 The foundation of these *Standards* is a competency-based model of education through which
28 students acquire the level of competence needed to begin the unsupervised practice of general
29 dentistry. Competency is a complex set of capacities including knowledge, experience, critical
30 thinking, problem-solving, professionalism, personal integrity, and procedural skills that are
31 necessary to begin the independent and unsupervised practice of general dentistry. These
32 components of competency become an integrated whole during the delivery of patient care.
33

34 Professional competence is the habitual and judicious use of communication, knowledge,
35 critical appraisal, clinical reasoning, emotions, values, and reflection in daily practice for the
36 benefit of the individuals and communities served. Accordingly, learning experiences help
37 students blend the various dimensions of competency into an integrated performance for the
38 benefit of the patient, while the assessment process focuses on measuring the student's overall
39 capacity to function as an entry-level, beginning general dentist rather than measuring
40 individual skills in isolation.

1
2 In these *Standards* the competencies for general dentistry are described broadly. The
3 Commission expects each school to develop specific competency definitions and assessment
4 methods in the context of the broad scope of general dental practice. These competencies must
5 be reflective of an evidence-based definition of general dentistry. To assist dental schools in
6 defining and implementing their competencies, the Commission strongly encourages the
7 development of a formal liaison mechanism between the dental school and the practicing dental
8 community.

9
10 The objectives of the Commission are based on the premise that an institution providing a dental
11 educational program will strive continually to enhance the standards and quality of both
12 scholarship and teaching. The Commission expects an educational institution offering such a
13 program to conduct that program at a level consistent with the purposes and methods of higher
14 education and to have academic excellence as its primary goal.

Educational Environment

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 diversity variability 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.

Comprehensive, Patient-Centered Care

The *Standards* reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching and oral health care delivery. ~~Administration, faculty, staff, and students are~~ The program is expected to develop and implement ~~definitions,~~ practices, operations, and evaluation methods so that patient-centered comprehensive care is the norm.

Institutional ~~definitions and~~ operations that support patient-centered care can have the following characteristics or practices:

1. ensure that patients' preferences to the recommended dental procedures, and their social, economic, emotional, physical, and cognitive circumstances are sensitively considered;
2. teamwork and cost-effective use of well-trained allied dental personnel are emphasized;
3. evaluations of practice patterns and the outcomes of care guide actions to improve both the quality and efficiency of care delivery; and
4. general dentists and dental specialists serve as role models for students to help them learn appropriate therapeutic strategies and how to refer patients who need advanced therapies beyond the scope of general dental practice.

Critical Thinking

Critical thinking is foundational to teaching and deep learning in any subject. The components of critical thinking are: the application of logic and accepted intellectual standards to reasoning; the ability to access and evaluate evidence; the application of knowledge in clinical reasoning; and a disposition for inquiry that includes openness, self-assessment, curiosity, skepticism, and dialogue. In professional practice, critical thinking enables the dentist to recognize pertinent information, make appropriate decisions based on a deliberate and open-minded review of the available options, evaluate outcomes of diagnostic and therapeutic decisions, and assess his or her own performance. Accordingly, the dental educational program must develop students who are able to:

- Identify problems and formulate questions clearly and precisely;
- Gather and assess relevant information, weighing it against extant knowledge and ideas, to interpret information accurately and arrive at well-reasoned conclusions;
- Test emerging hypotheses against evidence, criteria, and standards;
- Show intellectual breadth by thinking with an open mind, recognizing and evaluating assumptions, implications, and consequences;
- Communicate effectively with others while reasoning through problems.

Self-Directed Learning and Assessment

The explosion of scientific knowledge makes it impossible for students to comprehend and retain all the information necessary for a lifetime of practice. Faculty must serve as role models demonstrating that they understand and value scientific discovery and life-long learning in their daily interactions with students, patients, and colleagues. In an environment that emphasizes critical thinking and humanistic values, it is essential for students to develop the capacity to self-assess. Self-assessment is indicative of the extent to which students take responsibility for their own learning. Educational programs must depart from teacher-centered and discipline-focused pedagogy to enable and support the students' evolution as independent learners actively engaged in their curricula using strategies that foster integrated approaches to learning. Curricula must be contemporary, appropriately complex and must encourage students to take responsibility for their learning by helping them learn how to learn.

Humanistic Learning Environment

Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic pedagogy safe learning environment inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising, and small group interaction. A dental school environment characterized by:

- physical and psychological safety, free of intimidation, abuse, and retaliation;

- 1 • respectful and collegial professional relationships between and among faculty, staff, and
- 2 students; and
- 3 • establishes a context for the development of interpersonal skills necessary for learning,
- 4 for and patient care, ~~and for making meaningful contributions to the profession.~~
- 5

6 **Scientific Discovery and the Integration of Knowledge**

7 The interrelationship between the basic, behavioral, and clinical sciences is a conceptual
8 cornerstone to clinical competence. Learning must occur in the context of real health care
9 problems rather than within singular content-specific disciplines. Learning objectives that cut
10 across traditional disciplines and correlate with the expected competencies of graduates
11 enhance curriculum design. Beyond the acquisition of scientific knowledge at a particular
12 point in time, the capacity to think scientifically, and to apply the scientific method, including
13 evolving technology (e.g., artificial intelligence), is critical if students are to analyze and solve
14 oral health problems, understand research, and practice evidence-based dentistry.

15 **Evidence-based Care**

16 Evidence-based dentistry (EBD) ~~is an approach to oral health care that requires the judicious-~~
17 ~~integration of systematic assessments of clinically relevant scientific evidence, relating to the~~
18 ~~patient's oral and medical condition and history, with the dentist's clinical expertise and the~~
19 ~~patient's treatment needs and preferences.~~¹ EBD uses thorough, unbiased systematic reviews
20 and critical appraisal of the best available scientific evidence in combination with clinical and
21 patient factors to make informed decisions about appropriate health care for specific clinical
22 circumstances. Curricular content and learning experiences must incorporate the principles of
23 evidence-based inquiry and involve faculty who practice EBD and model critical appraisal for
24 students during the process of patient care. As scholars, faculty contribute to the body of
25 evidence supporting oral health care strategies by conducting research and guiding students in
26 learning and practicing critical appraisal of research evidence.

27 **Student Assessment**

28
29 Dental education programs must conduct regular assessments of students' learning throughout
30 their educational experiences. Such assessment not only focuses on whether the student has
31 achieved the competencies necessary to advance professionally (summative assessment), but
32 also assists learners in developing the knowledge, skills, attitudes, and values considered
33 important at their stage of learning (formative assessment). ~~In an environment that emphasizes-~~
34 ~~critical thinking and humanistic values, it is essential for students to develop the capacity to self-~~
35 ~~assess. Self-assessment is indicative of the extent to which students take responsibility for their~~
36 ~~own learning.~~ To improve curricula, assessment involves a dialogue between and among
37 faculty, students, and administrators that is grounded in the scholarship of teaching and learning.
38 Data from program outcomes, assessment of student learning, and feedback from students and
39 faculty can be used in a process that actively engages both students and faculty. Moreover,

1 programs are encouraged to adopt innovations in assessment methods as they become available
2 (e.g., Entrustable Professional Activities).

3
4
5
6 [†] American Dental Association, <http://www.ada.org/prof/resources/positions/statements/evidencebased.asp>.
7 Accessed Oct 25, 2006.

9 **Application of Technology**

10 Technology enables dental education programs to improve patient care, and to revolutionize all
11 aspects of the curriculum, from didactic courses to clinical instruction. Contemporary dental
12 education programs regularly assess their use of technology and explore new applications of
13 technological advances to enhance student learning and to assist faculty as facilitators of
14 learning and designers of learning environments. Use of technology, including evolving
15 technology (e.g., artificial intelligence), must include systems and processes to safeguard the
16 quality of patient care and ensure the integrity of student performance. Technology has the
17 potential to reduce expenses for teaching and learning and help to alleviate increasing demands
18 on faculty and student time. Use of technology in dental education programs can support
19 learning in different ways, including self-directed, distance and asynchronous learning.

21 **Faculty Professional Development**

22 Faculty and staff development is a necessary condition for change and innovation in dental
23 education. The environment of higher education is changing dramatically, and with it health
24 professions education. Dental education programs can re-examine the relationship between
25 what faculty do and how students learn to change from the sage authority who imparts
26 information to a facilitator of learning and designer of learning experiences that place students
27 in positions to learn by doing. Ongoing faculty and staff development is a requirement
28 encouraged to improve teaching and learning, to foster curricular change, to enhance retention
29 and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the
30 wellspring of a learned profession.

32 **Collaboration with other Health Care Professionals**

33 Access to health care and changing demographics are driving a new vision of the health care
34 workforce. Dental curricula can change to develop a new type of dentist, providing
35 opportunities early in their educational experiences to engage allied colleagues and other health
36 care professionals. Enhancing the public's access to oral health care and the connection of oral
37 health to general health form a nexus that links oral health care providers to colleagues in other
38 health professions. Health care professionals educated to deliver patient-centered care as
39 members of an interprofessional/interdisciplinary team present an opportunity challenge for
40 educational programs. ~~Patient care by all team members will emphasize evidence-based~~
41 ~~practice, quality improvement approaches, the application of technology and emerging~~
42 ~~information, and outcomes assessment.~~ Dental education programs are to seek and take

1 advantage of opportunities to educate dental school graduates who will assume new roles in
2 safeguarding, promoting, and caring for the health care needs of the public.

3

4 **Diversity and Inclusion**

5 Diversity and inclusion in education is essential to academic excellence. A significant amount
6 of learning occurs through informal interactions among individuals who are of different races,
7 ethnicities, national origin, gender identity, age, physical abilities/qualities, sexual orientation,
8 religions, and ideologic backgrounds; come from cities-urban, rural areas, and from various
9 geographic regions; and have a wide variety of interests, talents-abilities, and perspectives. These
10 interactions allow students to directly and indirectly learn from their differences, and to stimulate
11 one another to reexamine even their most deeply held assumptions about themselves and their
12 world. Cultural competence cannot be effectively acquired in a relatively homogeneous
13 environment. Programs must strive to create an environment that ensures an in-depth exchange
14 of ideas and beliefs across gender, racial, ethnic, cultural, religious, and socioeconomic lines.

15

16 **Summary**

17 These principles and the following Standards create an environmental framework intended to
18 foster educational quality and innovation in ways that are unique to the mission, strengths, and
19 resources of each dental school. The Commission believes that implementation of the guidance
20 incorporated in this document will ensure that dental education programs develop graduates who
21 have the capacity for life-long and self-directed learning and are capable of providing evidence-
22 based care to meet the needs their patients and of society.

Definition of Terms Used in Accreditation Standards for Dental Education Programs

Community-based patient experience: Refers to opportunities for dental students to provide patient care in community-based clinics or private practices. ~~Community-based experiences are not intended to be synonymous with community service activities where dental students might go to schools to teach preventive techniques or where dental students help build homes for needy families.~~

Community-based service experience: Refers to non-patient-based experiences and yet provide meaningful interaction with a community such as teaching preventive techniques or where dental students help build homes for needy families.

Comprehensive patient-centered care: The system of patient care ~~in which individual students or providers, examine and evaluate patients; develop and prescribe a treatment plan; perform the majority of care required, including care in several disciplines of dentistry; refer patients to recognized dental specialists as appropriate; and assume responsibility for ensuring through appropriate controls and monitoring that the patient has received total oral care where the patient benefits from an examination and evaluation leading to a thorough treatment plan that is focused on restoring and maintaining overall oral health rather than correcting specific/focused dental problems. This may be accomplished by an individual student or team of students providing a majority of care appropriate to a general dentist and referring to dental specialists as needed. Appropriate controls and monitoring mechanisms are used to ensure the patient has received optimum oral care.~~

Competencies/Competency Statements: Written statements describing the ~~levels of~~ knowledge, skills and values expected of graduates to begin independent, unsupervised dental practice.

Competency Assessments: The mechanisms used to evaluate a student's attainment of knowledge, skills and values required to begin independent, unsupervised dental practice. Competency assessment strategies across the curriculum include a process of formative and summative evaluations. Each competency statement is evaluated through a process consistent for all students, which includes independent, high-stakes assessment measures and defined critical errors.

Competent/Competence: The ~~attainment levels~~ of knowledge, skills and values required by the

1 new graduates to begin independent, unsupervised dental practice.

2
3 **Cultural competence:** Having the ability to provide care to patients with diverse backgrounds,
4 values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and
5 linguistic needs. Cultural competence training includes the development of a skill set for more
6 effective provider-patient communication and stresses the importance of providers'
7 understanding the relationship between diversity of culture, values, beliefs, behavior, and
8 language and the needs of patients.

9
10 ~~**Dimensions of Diversity:** The dimensions of diversity include: structural, curriculum and~~
11 ~~institutional climate.~~

12
13 **Diversity - Structural:** Structural diversity, also referred to as compositional diversity, focuses
14 on ~~the numerical distribution of~~ students, faculty, and staff from diverse backgrounds in a
15 program or institution.

16
17 ~~**Curriculum:** Curriculum diversity, also referred to as classroom diversity, covers both~~
18 ~~the diversity-related curricular content that promote shared learning and the integration~~
19 ~~of skills, insights, and experiences of diverse groups in all academic settings, including~~
20 ~~distance learning.~~

21
22 **Diversity - Institutional Climate:** Institutional climate, also referred to as interactional
23 diversity, focuses on the general environment created in programs and institutions that support
24 diversity as a core value and provide opportunities for informal learning among diverse peers.

25
26 **Evidence-based dentistry (EBD):** An approach to oral health care that requires the judicious
27 integration of systematic assessments of clinically relevant scientific evidence, relating to the
28 patient's oral and medical condition and history, with the dentist's clinical expertise and the
29 patient's treatment needs and preferences regarding their health care.

30
31 **Examples of evidence to demonstrate compliance may include:** Desirable condition, practice
32 or documentation indicating the freedom or liberty to follow a suggested alternative.

33
34 **Must:** Indicates an imperative need or a duty; an essential or indispensable item; mandatory.

35
36 **In-depth:** A thorough knowledge of concepts and theories for the purpose of critical analysis
37 and the synthesis of more complete understanding (highest level of knowledge).

38
39 **Instruction:** Describes any teaching, lesson, rule or precept; details of procedure; directives.

40

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

6
7 **Patients with special health care needs:** Those patients whose medical, physical,
8 psychological, cognitive, or social situations make it necessary to consider a wide range of
9 assessment and care options, including necessary referral, in order to provide dental treatment.
10 These individuals include, ~~but are not limited to~~, people with one or more of the following
11 characteristics: intellectual and developmental disabilities, cognitive impairment, complex
12 medical problems, significant physical limitations, and the vulnerable elderly. Patients with
13 special health care needs may require a modification or accommodation to patient care.

14
15 **Predoctoral:** Denotes training leading to the DDS or DMD degree.

16
17 **Quality assurance improvement:** A cycle ~~of PLAN, DO, CHECK, ACT~~ that involves setting
18 goals, determining outcomes, and collecting data in an ongoing and systematic manner to
19 measure attainment of goals and outcomes. The final step in quality assurance improvement
20 involves identification and implementation of corrective measures designed to strengthen the
21 program.

22
23 ~~**Service learning:** A structured experience with specific learning objectives that combines~~
24 ~~community service with academic preparation. Students engaged in service learning learn~~
25 ~~about their roles as dental professions through provision of patient care and related services in~~
26 ~~response to community-based problems.~~

27
28 **Research:** The process of scientific inquiry involved in the development and dissemination of
29 new knowledge. Research may be broadly defined to include biomedical, translational, clinical,
30 implementation, educational, behavioral, epidemiological, health services, and other forms of
31 scientific inquiry.

32
33 **Should:** Indicates a method to achieve the standard; highly desirable, but not mandatory.

34
35 **Standard:** Offers a rule or basis of comparison established in measuring or judging capacity,
36 quantity, quality, content, and value; criterion used as a model or pattern.

37
38 **Strategic Planning:** A systematic and structured process to define the program's long-term
39 direction, priorities, allocated resources, and decisions, to achieve the program's goals and
40 objectives. The strategic plan involves regular review of the program to ensure effectiveness

1 and student achievement.

2
3 ~~**Research:** The process of scientific inquiry involved in the development and dissemination of~~
4 ~~new knowledge.~~

5
6 ~~**Health literacy:** “The degree to which individuals have the capacity to obtain, process, and~~
7 ~~understand basic health information and services needed to make appropriate health decisions.”~~
8 ~~(Institute of Medicine. 2004. *Health Literacy: A Prescription to End Confusion*. Washington,~~
9 ~~DC: The National Academies Press. <https://doi.org/10.17226/10883>.)~~

10

Accreditation Standards for Dental Education Programs

STANDARD 1-INSTITUTIONAL EFFECTIVENESS

~~1-1 The dental school **must** develop a clearly stated purpose/mission statement appropriate to dental education, addressing teaching, patient care, research and service.~~

Intent:

~~A clearly defined purpose and a mission statement that is concise and communicated to faculty, staff, students, patients and other communities of interest is helpful in clarifying the purpose of the institution.~~

~~1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness at the dental school **must** be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.~~

Intent:

~~Assessment, planning, implementation and evaluation of the educational quality of a dental education program that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students. The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of general dentistry.~~

1-1 The dental school **must**:

- a. have a clearly stated mission statement and strategic plan appropriate to dental education addressing teaching, patient care, research, and service, which is regularly reviewed;
- b. have a broad-based, systematic, and continuous formal outcomes assessment process, with measurable goals and objectives, designed to achieve all aspects of the mission and assess institutional effectiveness and student achievement; and
- c. collect, analyze, and use the outcomes data for program improvement.

~~1-3-1-2~~ The dental education program **must** ~~have a stated~~ demonstrate a commitment to a

- 1 ~~humanistic culture and~~ learning environment that includes: is regularly evaluated.
2 a. a stated commitment and activities to promote a safe learning environment;
3 b. regular evaluation of the learning environment, with input from faculty, staff,
4 and students;
5 c. actions aimed at enhancing the learning environment based on the results of
6 regular evaluation.

7
8 **Intent:**

9 ~~The dental education program should ensure collaboration, mutual respect,~~
10 ~~cooperation, and harmonious relationships between and among administrators,~~
11 ~~faculty, students, staff, and alumni. The program should also support and cultivate~~
12 ~~the development of professionalism and ethical behavior by fostering diversity of~~
13 ~~faculty, students, and staff, open communication, leadership, and scholarship.~~

14
15 **Examples of evidence to demonstrate compliance may include:**

- 16 • Established policies regarding ethical behavior by faculty, staff and students that
17 are regularly reviewed and readily available
18 • Development of a Code of Conduct
19 • Training to recognize and mitigate microaggressions, implicit and
20 explicit bias, racism, gender identity and sexual orientation, hate speech,
21 or other derogatory or harmful behaviors
22 • Student, faculty, and ~~patient~~ staff groups involved in ~~promoting~~
23 ~~diversity,~~ professionalism and/or leadership support for their activities
24 • Focus groups and/or surveys directed towards gathering information on student,
25 faculty, ~~patient, and alumni~~ and staff perceptions of the ~~cultural~~ learning
26 environment

27
28 ~~1-4~~ **1-3** The dental school **must** have policies and practices related to diversity and inclusion
29 consistent with University policies and state law to:

- 30 a. ~~achieve appropriate levels of diversity among its students, faculty and staff;~~
31 ~~b. a.~~ engage in ongoing systematic and focused efforts to attract and retain students,
32 faculty, and staff from diverse backgrounds; ~~and~~
33 ~~e. b.~~ systematically evaluate ~~comprehensive~~ strategies to improve the ~~institutional~~
34 ~~climate for~~ dental school's diversity and inclusion; ~~and~~
35 c. engage in actions aimed at enhancing the program's diversity and inclusion based on
36 results of regular evaluation.

37
38 **Intent:**

39 ~~The dental school should develop strategies to address the dimensions of diversity~~
40 ~~including, structure, curriculum and institutional climate. The dental school should~~

1 *articulates its expectations regarding diversity, equity, inclusion, and belonging*
2 *~~across its academic community in the context of local and national responsibilities,~~*
3 *and regularly assess how well such expectations are being achieved. Schools could*
4 *incorporate elements of diversity and inclusion in their planning that include, but are*
5 *not limited to, gender, ethnicity, race, cultural, and socioeconomic factors. ~~gender,~~*
6 *~~racial, ethnic, cultural and socioeconomic.~~ Schools should establish focused,*
7 *~~significant, and sustained programs to recruit and retain suitably diverse students,~~*
8 *~~faculty, and staff.~~*

9
10 **1-5-1-4** The financial resources **must** be sufficient to support the dental school’s stated
11 ~~purpose/~~mission, goals, and objectives.

12
13 **Intent:**

14 *The institution ~~should have~~ has the financial resources required to develop and sustain*
15 *the program on a continuing basis. The program ~~should have~~ has the ability to*
16 *employ an adequate number of full-time faculty, purchase, and maintain equipment;*
17 *procure supplies, reference material, and teaching aids as reflected in annual*
18 *operating budget. Financial resources ~~should~~ ensure that the program will be in a*
19 *position to recruit and retain qualified faculty. ~~Annual appropriations should and~~*
20 *~~provide for innovations and changes, necessary to reflect current concepts of~~*
21 *~~education in the discipline.~~ The Commission will assess the adequacy of financial*
22 *support on the basis of current ~~appropriations and the stability of~~ sources of funding*
23 *for the program.*

24
25 ~~1-6~~ ~~The sponsoring institution must ensure that support from entities outside of the~~
26 ~~institution does not compromise the teaching, clinical and research components of the~~
27 ~~program.~~

28
29 **~~Examples of evidence to demonstrate compliance may include:~~**

- 30 ~~• Written agreement(s)~~
31 ~~• Contracts between the institution/ program and sponsor(s) (For example:~~
32 ~~contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)~~

33
34
35
36 **1-7 1-5** The authority and final responsibility for curriculum development ~~and approval,~~
37 student selection, faculty selection, and ~~administrative matters~~ program operations
38 **must** rest within the dental program, consistent with the sponsoring institution
39 policies and procedures, and not be influenced by support from outside entities.

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Examples of evidence to demonstrate compliance may include:

- Institutional and/or program bylaws
- Institutional and/or program procedural codes
- Admissions and hiring practices and procedures
- Purchasing policies
- Institutional gift policies
- Written agreement(s)
- Contracts between the institution/ program and sponsor(s) (For example: contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)

~~1-8~~ **1-6** The dental school **must** be a component of a higher education institution that is accredited by a United States Department of Education recognized accrediting agency (i.e., formerly known as a regional accrediting agency) and has within its scope the accreditation of doctoral degree granting programs.

~~1-9~~ **1-9** ~~The dental school **must** show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems.~~

1 ~~2-5-2-3~~ The dental education program **must**:

- 2 a. establish competency statements that, at a minimum, are consistent with
3 the Commission on Dental Accreditation Standards, and
4 b. employ student ~~evaluation~~ assessment methods that measure ~~its defined~~
5 the competencies defined for graduation and readiness for independent
6 dental practice.

7
8 **Intent:**

9 ~~Assessment of student performance should measure not only retention of factual-~~
10 ~~knowledge, but also the development of skills, behaviors, and attitudes needed for~~
11 ~~subsequent education and practice. The education program should assess-~~
12 ~~problem-solving, clinical reasoning, professionalism, ethical decision-making-~~
13 ~~and communication skills. The evaluation of competence is an ongoing process~~
14 ~~that requires a variety of assessments~~ performed independently by each
15 individual student ~~that can measure not only the acquisition of knowledge and~~
16 ~~skills but also assess the process and procedures which will be necessary for-~~
17 entry-level practice to begin independent dental practice.

18
19 **Examples of evidence to demonstrate compliance may include:**

- 20 ~~• Narrative descriptions of student performance and professionalism in courses-~~
21 ~~where teacher-student interactions permit this type of assessment~~
22 ~~• Objective structured clinical examination (OSCE)~~
23 ~~• Clinical skills testing~~

24
25 ~~2-6~~ ~~Students must receive comparable instruction and assessment at all sites-~~
26 ~~where required educational activity occurs through calibration of all-~~
27 ~~appropriate faculty.~~

28
29 **Examples of Evidence to demonstrate compliance may include:**

- 30 ~~• On-going faculty training~~
31 ~~• Calibration Training Manuals~~
32 ~~• Periodic monitoring for compliance~~
33 ~~• Documentation of faculty participation in calibration-related activities~~

34
35 ~~2-7~~ ~~Biomedical, behavioral and clinical science instruction must be integrated and-~~
36 ~~of sufficient depth, scope, timeliness, quality and emphasis to ensure-~~
37 ~~achievement of the curriculum's defined competencies.~~

1 ~~2-8-2-4~~ The dental ~~school~~ education program **must** have a curriculum management plan that
2 ensures:

- 3 a. an ongoing curriculum review and evaluation process which includes input
4 from faculty, ~~students~~, administration and ~~other appropriate sources~~ students,
5 including student evaluation of instruction;
- 6 b. evaluation of all courses with respect to the defined ~~competencies of the~~
7 ~~school to include student evaluation of instruction~~ competency statements;
- 8 c. elimination of unwarranted repetition, ~~and~~ outdated material, ~~and~~
9 ~~unnecessary material~~;
- 10 d. ongoing evaluation of sequencing of curriculum content;
- 11 e. integration of biomedical, behavioral, and clinical science instruction; and
- 12 f. incorporation of emerging information and technologies, ~~and achievement of~~
13 ~~appropriate sequencing~~;
- 14 g. ~~incorporation of emerging didactic and clinical technologies to support the~~
15 ~~dental education program curriculum.~~

16
17 ~~2-9~~ The dental school ~~must~~ ensure the availability of adequate patient experiences
18 that afford all students the opportunity to achieve its stated competencies within a
19 reasonable time.

20
21 **Intent:**

22 *The comprehensive care experiences provided for patients by students should be*
23 *adequate to ensure competency in all components of general dentistry practice.*

24
25 **Critical Thinking**

26
27 ~~2-10-2-5~~ Graduates **must** be competent in the use of critical thinking, ~~and problem-solving,~~
28 including accessing and critically appraising scientific literature, popular media, and
29 consumer information, as it relates to providing evidence-based patient care. ~~their use~~
30 ~~in the comprehensive care of patients, scientific inquiry and research methodology.~~

31
32 **Intent:**

33 *The educational program introduces students to critical thinking regarding*
34 *interpretation of available information (e.g., scientific evidence, websites,*
35 *social media, artificial intelligence, marketing), as it pertains to patient care.*
36 *Throughout the curriculum, the educational program should use teaching and*
37 *learning methods that support the development of critical thinking and*
38 *problem solving skills.*

39
40 **Examples of evidence to demonstrate compliance may include:**

- 41 • Explicit discussion of the meaning, importance, and application of critical

1 thinking

- 2 • Use of questions by instructors that require students to analyze problem
- 3 etiology, compare and evaluate alternative approaches, provide rationale for
- 4 plans of action, and predict outcomes
- 5 • Prospective simulations in which students perform decision-making
- 6 • Retrospective critiques of cases in which decisions are reviewed to identify
- 7 errors, reasons for errors, and exemplary performance
- 8 • Writing assignments that require students to analyze problems and discuss
- 9 alternative theories about etiology and solutions, as well as to defend decisions
- 10 made
- 11 • Asking students to analyze and discuss work products to compare how
- 12 outcomes correspond to best evidence or other professional standards
- 13 • Demonstration of the use of active learning methods, such as case analysis and
- 14 discussion, critical appraisal of scientific evidence in combination with clinical
- 15 application and patient factors, and structured sessions in which faculty and
- 16 students reason aloud about patient care

17 Self-Assessment

18
19
20 ~~2-11-2-6 Graduates~~ **Students must** demonstrate the ability to self-assess through reflective

21 practice, including the development of professional competencies and the

22 demonstration of professional values and capacities associated with self-directed,

23 lifelong learning.

24 **Intent:**

25 *The ~~E~~educational program ~~should~~ prepares students to assume responsibility for their*

26 *own learning. The education program ~~should~~ teaches students how to learn and apply*

27 *evolving and new knowledge over a complete career as a health care professional.*

28 *Lifelong learning skills include student assessment of learning needs.*

29 **Examples of evidence to demonstrate compliance may include:**

- 30 • Students routinely assess their own progress toward overall competency and
- 31 individual competencies as they progress through the curriculum
- 32 • Students identify learning needs and create personal learning plans
- 33 ~~• Students participate in the education of others, including fellow students,~~
- 34 ~~patients, and other health care professionals, that involves critique and~~
- 35 ~~feedback.~~

36 Biomedical Sciences

- 1 ~~2-12 2-7~~ Biomedical science instruction ~~in dental education~~ **must** ensure ~~an~~ in-depth
2 ~~Understanding foundation knowledge~~ of basic biological principles, ~~consisting of a core of~~
3 ~~information on the fundamental~~ including:
4 a. structures, functions and interrelationships of the body systems, with emphasis
5 on the oro-facial complex, and
6 b. abnormal biological conditions, including systemic and craniofacial disorders.

7
8 **Intent:**

9 Biological science instruction includes etiology, epidemiology, differential
10 diagnosis, pathogenesis, prevention, treatment, and prognosis as it relates to
11 patient care.

- 12
13 ~~2-13~~ The biomedical knowledge base ~~must~~ emphasize the oro-facial complex as an
14 ~~important anatomical area existing in a complex biological interrelationship with the~~
15 ~~entire body.~~

- 16
17 ~~2-14~~ In-depth information on abnormal biological conditions ~~must~~ be provided to
18 ~~support a high level of understanding of the etiology, epidemiology, differential~~
19 ~~diagnosis, pathogenesis, prevention, treatment and prognosis of oral and oral~~
20 ~~related disorders.~~

- 21
22 ~~2-15 2-8~~ Graduates **must** be competent in the application of biomedical sciences
23 ~~knowledge~~ in the delivery of patient care.

24
25 **Intent:**

26 Biological science knowledge should be of sufficient depth and scope for graduates
27 to apply advances in modern biology to clinical practice and to integrate new
28 medical knowledge and therapies relevant to oral health care.

29
30
31 **Social and Behavioral Sciences**

- 32
33 2-9 Instruction in social and behavioral sciences **must** be at an in-depth level and
34 include:
35 a. patient management, including cultural diversity and interpersonal communications
36 skills;
37 b. intra-professional collaboration, including communicating with other members of
38 the oral health care team;
39 c. inter-professional collaboration, including communicating with other members of
40 the health care team;
41 d. professional conduct, including ethical decision making;

- e. legal and regulatory concepts related to patient care;
- f. 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
- g. oral epidemiology, dental public health, and social determinants of health.

2-10 Following patient experiences, graduates **must** demonstrate competence in social and behavioral sciences including:

- a. patient management, including cultural diversity and interpersonal communications skills;
- b. demonstration of intra-professional collaboration, including communicating with other members of the oral health care team;
- c. demonstration of inter-professional collaboration, including communicating with other members of the health care team
- d. adherence to professional conduct, including ethical decision making; and
- e. compliance with legal and regulatory concepts related to patient care.

~~2-16 Graduates **must** be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving and maintaining oral health.~~

~~2-17 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.~~

Intent:

~~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:~~

- ~~• basic principles of culturally competent health care;~~
- ~~• basic principles of health literacy and effective communication for all patient populations~~
- ~~• recognition of health care disparities and the development of solutions;~~
- ~~• the importance of meeting the health care needs of dentally underserved populations, and;~~
- ~~• the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi—~~

1 *dimensionally diverse society.*

2
3 **Practice Management and Health Care Systems**

4
5 ~~2-18— Graduates **must** be competent in applying legal and regulatory concepts related to the~~
6 ~~provision and/or support of oral health care services.~~

7
8 ~~2-19— Graduates **must** be competent in applying the basic principles and philosophies of~~
9 ~~practice management, models of oral health care delivery, and how to function~~
10 ~~successfully as the leader of the oral health care team.~~

11
12 ~~2-20— Graduates **must** be competent in communicating and collaborating with other~~
13 ~~members of the health care team to facilitate the provision of health care.~~

14
15 **Intent:**

16 *In attaining competence, students should understand the roles of members of the*
17 *health care team and have educational experiences, particularly clinical experiences,*
18 *that involve working with other healthcare professional students and practitioners.*
19 *Students should have educational experiences in which they coordinate patient care*
20 *within the health care system relevant to dentistry.*

21
22
23 **Ethics and Professionalism**

24
25 ~~2-21— Graduates **must** be competent in the application of the principles of ethical~~
26 ~~decision making and professional responsibility.~~

27
28 **Intent:**

29 *Graduates should know how to draw on a range of resources, among which are*
30 *professional codes, regulatory law, and ethical theories. These resources should*
31 *pertain to the academic environment, patient care, practice management and*
32 *research. They should guide judgment and action for issues that are complex, novel,*
33 *ethically arguable, divisive, or of public concern.*

34
35 **Clinical Sciences**

36
37 ~~2-22— Graduates **must** be competent to access, critically appraise, apply, and~~
38 ~~communicate scientific and lay literature as it relates to providing evidence-~~
39 ~~based patient care.~~

40
41 **Intent:**

1 ~~The education program should introduce students to the basic principles of~~
2 ~~clinical and translational research, including how such research is conducted,~~
3 ~~evaluated, applied, and explained to patients.~~

4
5 ~~2-23~~ 2-11 Graduates **must** be competent in providing oral health care ~~within the~~
6 ~~scope of general dentistry to all patients in all stages of life, including~~
7 ~~children with primary dentition, children with mixed dentition, adults, and~~
8 ~~geriatric patients.~~

9
10 ~~2-24~~ At a minimum, graduates **must** be competent in providing oral health care within the
11 ~~scope of general dentistry, as defined by the school, including:~~
12 a. ~~patient assessment, diagnosis, comprehensive treatment planning, prognosis, and~~
13 ~~informed consent;~~
14 b. ~~screening and risk assessment for head and neck cancer;~~
15 c. ~~recognizing the complexity of patient treatment and identifying when referral is~~
16 ~~indicated;~~
17 d. ~~health promotion and disease prevention, including caries management;~~
18 e. ~~local anesthesia, and pain and anxiety control, including consideration of the~~
19 ~~impact of prescribing practices and substance use disorder;~~
20 f. ~~restoration of teeth;~~
21 g. ~~communicating and managing dental laboratory procedures in support of patient~~
22 ~~care;~~
23 h. ~~replacement of teeth including fixed, removable and dental implant prosthodontic~~
24 ~~therapies;~~
25 i. ~~periodontal therapy;~~
26 j. ~~pulpal therapy;~~
27 k. ~~oral mucosal, temporomandibular, and osseous disorders;~~
28 l. ~~hard and soft tissue surgery;~~
29 m. ~~dental emergencies;~~
30 n. ~~malocclusion and space management; and~~
31 o. ~~evaluation of the outcomes of treatment, recall strategies, and prognosis~~

32
33 **Intent:**

34 ~~Graduates should be able to evaluate, assess, and apply current and emerging~~
35 ~~science and technology. Graduates should possess the basic knowledge,~~
36 ~~skills, and values to practice dentistry, independently, at the time of~~
37 ~~graduation. The school identifies the competencies that will be included in~~
38 ~~the curriculum based on the school's goals, resources, accepted general~~
39 ~~practitioner responsibilities and other influencing factors. Programs should~~
40 ~~define overall competency, in order to measure the graduate's readiness to~~
41 ~~enter the practice of general dentistry.~~

1
2 2-12 Instruction in clinical sciences **must** be at an in-depth level and include:
3

4 a. Diagnosis and Treatment Planning

- 5 1. patient assessment;
6 2. history taking;
7 3. clinical examination;
8 4. radiographic examination;
9 5. caries risk assessment;
10 6. hard and soft tissue pathology assessment;
11 7. oral cancer risk assessment and screening;
12 8. periodontal risk assessment; and
13 9. treatment planning, including referrals when indicated.

14
15 b. Prevention and Wellness

- 16 1. health promotion and disease prevention;
17 2. prophylaxis;
18 3. oral hygiene instruction;
19 4. dental sealants;
20 5. space maintenance; and
21 6. nutrition.

22
23 c. Oral Health Care

- 24 1. Operative Dentistry, to include direct and indirect restorations;
25 2. Fixed Prosthodontics, to include fixed partial dentures;
26 3. Removable Prosthodontics, to include partial and complete dentures;
27 4. Implant Dentistry, to include placement and restoration of dental implants;
28 5. Endodontics, to include pulpal therapy, non-surgical and surgical root canal
29 therapy, endodontic retreatment;
30 6. Periodontics, to include non-surgical and surgical periodontal therapy, and
31 periodontal maintenance;
32 7. Oral & Maxillofacial Surgery, to include exodontia, alveoloplasty, mucosal and
33 osseous disorders;
34 8. Orthodontics, to include diagnosis and treatment of malocclusion, and;
35 9. Management and Control of Chronic and Acute Pain, including diagnosis and
36 treatment of orofacial pain/temporomandibular joint disorders, anxiety control,
37 local anesthesia, and conscious sedation.

38
39 d. Practice and Profession

- 40 1. obtaining informed consent;
41 2. recognition and management of patients with special health care needs,
42 including dental/medical/behavioral complexities requiring modification of
43 treatment or referral;
44 3. communicating with dental laboratories/laboratory technicians and evaluating
45 the resultant restorations and appliances;
46 4. digital dentistry and emerging clinical technologies;

5. management of dental and medical emergencies;
6. prescribing practices, including screening, brief intervention, and referral for treatment (SBIRT) for substance use disorders;
7. use of standards of care/clinical guidelines;
8. infection prevention and control practices;
9. assessment of treatment outcomes; and
10. recall strategies.

2-13 Patient-based instruction and experiences in clinical sciences must include direct care provided by the student, for the following:

a. Diagnosis and Treatment Planning

1. patient assessment;
2. history taking;
3. clinical examination;
4. radiographic examination;
5. caries risk assessment;
6. hard and soft tissue pathology assessment;
7. oral cancer risk assessment and screening;
8. periodontal risk assessment; and
9. treatment planning, including referrals when indicated.

b. Prevention and Wellness

1. health promotion and disease prevention;
2. prophylaxis;
3. oral hygiene instruction;
4. dental sealants;
5. analysis of space maintenance needs; and
6. nutritional counseling.

c. Oral Health Care

1. Operative Dentistry, to include direct and indirect restorations;
2. Fixed Prosthodontics, to include fixed partial dentures;
3. Removable Prosthodontics, to include partial and complete dentures;
4. Implant Dentistry, to include restoration of dental implants;
5. Endodontics, to include pulpal therapy, non-surgical root canal therapy;
6. Periodontics, to include non-surgical periodontal therapy, and periodontal maintenance;
7. Oral & Maxillofacial Surgery, to include exodontia;
8. Orthodontics, to include diagnosis of malocclusion; and
9. Pain Control, to include anxiety control and local anesthesia.

d. Practice and Profession

1. obtaining informed consent;
2. recognition and management of patients with special health care needs, including dental/medical/behavioral complexities requiring modification of

- 1 treatment or referral;
- 2 3. communicating with dental laboratories/laboratory technicians and evaluating
- 3 the resultant restorations and appliances;
- 4 4. digital dentistry and emerging clinical technologies;
- 5 5. management of dental emergencies;
- 6 6. prescribing practices, including screening for substance use disorder;
- 7 7. infection prevention and control practices;
- 8 8. assessment of treatment outcomes; and
- 9 9. recall strategies.

10
11 **Intent:**

12 Patient experiences are critical to the educational preparation of students to enter
13 practice as a general dentist. Programs may achieve sufficient patient experiences in a
14 number of ways, including rotations to sites where educational activity occurs related to
15 the clinical program, and other methods.

16
17 **2-14** Graduates must demonstrate competence in the following areas within the scope of
18 general dentistry, with the majority of competency assessments in each category (i.e., a-
19 d) completed through direct patient care assessments:

20
21 a. Diagnosis and Treatment Planning

- 22 1. patient assessment;
- 23 2. history taking;
- 24 3. clinical examination including hard and soft tissue pathology assessment;
- 25 4. radiographic examination;
- 26 5. caries risk assessment;
- 27 6. oral cancer risk assessment and screening
- 28 7. periodontal risk assessment; and
- 29 8. treatment planning, including referrals when indicated.

30
31
32 b. Prevention and Wellness

- 33 1. health promotion and disease prevention;
- 34 2. prophylaxis;
- 35 3. oral hygiene instruction;
- 36 4. dental sealants; and
- 37 5. nutritional counseling.

38
39 c. Oral Health Care

- 40 1. Operative Dentistry, to include direct and indirect restorations;
- 41 2. Prosthodontics, to include replacement of teeth using fixed, removable or dental
42 implant prosthodontic therapies;
- 43 3. Endodontics, to include pulpal therapy and non-surgical root canal therapy;
- 44 4. Periodontics, to include non-surgical periodontal therapy;
- 45 5. Oral & Maxillofacial Surgery, to include exodontia;
- 46 6. Orthodontics, to include diagnosis of malocclusion; and

1 7. Pain Control, to include anxiety control and local anesthesia.

2
3 d. Practice and Profession

- 4 1. obtaining informed consent;
5 2. recognition and management of patients with special health care needs,
6 including dental/medical/behavioral complexities requiring modification of
7 treatment or referral;
8 3. communicating with dental laboratories/laboratory technicians and evaluating
9 the resultant restorations and appliances; management of medical and dental
10 emergencies;
11 4. prescribing practices, including screening for substance use disorder;
12 5. infection prevention and control practices; and
13 6. assessment of treatment outcomes and recall strategies.

14
15 ~~2-23~~ ~~Graduates **must** be competent in assessing and managing the treatment of patients~~
16 ~~with special needs.~~

17
18 **Intent:**

19 ~~An appropriate patient pool should be available to provide experiences that may~~
20 ~~include patients whose medical, physical, psychological, or social situations make it~~
21 ~~necessary to consider a wide range of assessment and care options. As defined by the~~
22 ~~school, these individuals may include, but are not limited to, people with~~
23 ~~developmental disabilities, cognitive impairment, complex medical problems,~~
24 ~~significant physical limitations, and the vulnerable elderly. Clinical instruction and~~
25 ~~experience with the patients with special needs should include instruction in proper~~
26 ~~communication techniques including the use of respectful nomenclature, assessing the~~
27 ~~treatment needs compatible with the special need, and providing services or referral as~~
28 ~~appropriate.~~

29
30 ~~2-25~~ 2-15 Dental education programs The dental education program **must** make
31 available community-based patient experience opportunities and encourage
32 students to engage in service learning experiences and/or community-based
33 learning experiences interact with and treat patients in varied clinical
34 environments.

35
36 **Intent:**

37 ~~Service learning experiences and/or e~~Community-based learning experiences are
38 ~~essential~~ valuable to the development of a culturally competent oral health care
39 workforce. The interaction and treatment of diverse populations in a community-
40 based clinical environment adds a special dimension to clinical learning experience
41 and engenders a life-long appreciation for the ~~value of~~ community service.

STANDARD 3- FACULTY AND STAFF

3-1 The number, and distribution ~~and qualifications~~ of faculty and staff **must** be sufficient to meet the dental school's stated ~~purpose~~/mission, goals and objectives, at all sites where required educational activity occurs.

3-2 The faculty member responsible for the specific discipline **must** be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing process of the ~~individual faculty as defined by the~~ program/institution.

Intent: Faculty ~~should have~~ has knowledge and experience at an appropriate level for the curriculum areas for which they are responsible. The collective faculty of the dental school ~~should have~~ has competence in all areas of the dentistry covered in the program.

3-3 Faculty **must** be calibrated to ensure consistency in instruction and assessment of students at all sites where educational activity occurs.

Intent: Calibration is consistent with areas in which a faculty provides instruction and/or assessment of students.

Examples of Evidence to demonstrate compliance may include:

- On-going faculty training
- Calibration training materials
- Documentation of faculty participation in calibration-related activities
- Periodic monitoring for compliance

~~3-2-3-4~~ The dental school/institution **must** ~~show evidence of~~ provide an ongoing faculty development ~~process~~ program.

Intent:

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

Examples of evidence to demonstrate compliance may include:

- Program/Institutional faculty development offerings and numbers of faculty participating
- Participation in faculty development activities related to teaching and learning
- Attendance at ~~regional and national~~ professional meetings ~~that address education~~

- 1 • Mentored experiences for new faculty
- 2 • ~~Scholarly productivity~~
- 3 • ~~Maintenance of existing and development of new and/or emerging clinical-~~
- 4 ~~skills~~
- 5 • ~~Documented understanding of relevant aspects of teaching methodology~~
- 6 • ~~Curriculum design and development~~
- 7 • ~~Curriculum evaluation~~
- 8 • ~~Student/Resident assessment~~
- 9 • ~~Cultural Competency~~
- 10 • ~~Ability to work with students of varying ages and backgrounds~~
- 11 • ~~Use of technology in didactic and clinical components of the curriculum~~
- 12 • ~~Records of Calibration of Faculty~~

13

14 ~~3-3-3-5~~ Faculty **must** be ensured a form of governance that allows participation in the

15 school's decision-making processes.

16

17 ~~3-4 3-6~~ A defined evaluation process **must** exist that ensures objective measurement of the

18 performance of ~~each~~ faculty member regularly involved in teaching, patient care,

19 scholarship and service in regard to their area(s) of contribution to the program.

20

21 **Intent:**

22 Faculty who have at least a weekly commitment are considered regularly involved with

23 the program.

24

25 ~~3-5-3-7~~ The dental school **must** have a stated process for promotion and tenure (where

26 tenure exists) that is clearly communicated to the faculty.

STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Admissions

4-1 ~~Specific w~~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.

4-2 Admission of students with advanced standing **must** be based on the ~~same~~ comparable standards of achievement required by students regularly enrolled in the program.

4-3 Students with advanced standing **must** receive an individualized assessment and an appropriate curriculum plan that results in the same standards of competence for graduation required by students regularly enrolled in the program.

Intent: Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant's past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline.

Acceptance of advanced standing students ~~cannot exceed /residents will not result in an increase of~~ the program's approved total number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for students/~~residents~~ in the conventional program and be held to the same academic standards. Advanced standing students/~~residents~~, to be certified for completion, are expected to demonstrate the same standards of competence as those in the conventional program.

Examples of evidence to demonstrate compliance may include:

- Policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

~~4-4 Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population.~~

Intent 4-1 to 4-3 4-4:

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,

1 *should* establish admissions procedures that are non- discriminatory and ensure the
2 quality of the program.

3
4 **4-4** The dental school **must** advise prospective students of mandatory health and
5 technical standards that will ensure that prospective students are qualified to undertake
6 dental studies.

7 8 **Facilities and Resources**

9
10 **4-5-4-5** The dental school **must** provide adequate and appropriately maintained facilities and
11 learning resources to support the purpose/mission of the dental school and which are in
12 conformance with applicable regulations.

13 14 15 **Written Agreements**

16
17 **4-6-4-6** Any site not owned by the sponsoring institution where required educational activity
18 occurs **must** have a written agreement that clearly defines the roles and responsibilities
19 of the parties involved.

20 21 22 **Students Services**

23
24 **4-7** Student support services **must** include the following:
25 a. ~~Personal wellness, academic and career counseling of students;~~
26 b. academic counseling,
27 c. career counseling, and
28 d. financial aid counseling
29 b. ~~—assuring student participation on appropriate committees;~~
30 e. ~~—providing appropriate information about the availability of financial aid and~~
31 ~~health services;~~
32 d. ~~—developing and reviewing specific written procedures to ensure due~~
33 ~~process and the protection of the rights of students;~~
34 e. ~~—student advocacy;~~
35 f. ~~—maintenance of the integrity of student performance and evaluation~~
36 ~~records; and~~
37 g. ~~—Instruction on personal debt management and financial planning.~~

38 39 **Intent:**

40 *All policies and procedures should protect the students and provide avenues for appeal*
41 *and due process. Policies should ensure that student records accurately reflect the*
42 *work accomplished and are maintained in a secure manner. Students should have*
43 *available the necessary support to provide career information and guidance as to*
44 *practice, post-graduate and research opportunities.*

1
2 **4-8** Students **must** be assured participation on appropriate committees.

3
4 **4-9** The program **must** maintenance the integrity of student performance and evaluation
5 records.

6
7 **4-10** The program **must** have policies and procedures that ensure mechanisms for students
8 to report mistreatment and grievances without retaliation.

9
10 **Student Due Process**

11
12 **4-11** The program **must** have written policies and procedures to ensure:

- 13 a. academic due process;
14 b. misconduct disciplinary due process; and
15 c. guidance on navigating due process resources.

16
17 **Intent:**

18 Due process includes individual student review of performance and/or behavior that
19 leads to an appropriate decision. All policies and procedures protect the students and
20 provide avenues for appeal.

21
22 **Student Financial Aid**

23
24 ~~4-8~~ **4-12** At the time of acceptance, sStudents **must** be advised of the total expected cost of
25 their dental education and the availability of financial aid, at the time of acceptance and
26 throughout enrollment.

27
28 **Intent:**

29 Financial information *should* includes estimates of living expenses and educational
30 fees, an analysis of financial need, and the availability of financial aid.

31
32 ~~4-5~~ The institution **must** be in compliance with all federal and state regulations
33 relating to student financial aid and student privacy.

34
35 **Health Services**

36
37 ~~4-6~~ The dental school **must** advise prospective students of mandatory health standards that
38 will ensure that prospective students are qualified to undertake dental studies.

39
40 ~~4-11~~ **4-13** There **must** be a mechanism an established arrangement for ready access
41 to health care for students while they are enrolled in dental school,
42 including for all sites where educational activity occurs.

1
2
3
4
5
6
7
8
9
10
11

Intent:

At all sites where educational activity occurs, including distant clinical educational activity sites, the program assures that students will have access to health care services. Medical insurance alone does not assure access to health care services.

~~4-12~~ **4-14** Students **must** be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, ~~and~~ hepatitis ~~B~~, **influenza, and COVID**, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.

STANDARD 5 - PATIENT CARE SERVICES

5-1 The dental school **must** have a stated commitment to patient-centered care that ensures the use of quantitative criteria for student advancement and graduation does not compromise the delivery of comprehensive patient care.

~~5-1~~ **5-2** The dental school **must** have a published formal policy addressing ~~the meaning of and commitment to patient-centered care and distribute the written~~ the rights of patients, that is visible ~~policy~~ to each patient, student, faculty, and staff, ~~and patient and~~ includes:

Intent:

~~A written statement of patient rights should include:~~

- a. *considerate, respectful and confidential treatment;*
- b. *continuity and completion of treatment;*
- c. *access to complete and current information about his/her condition;*
- d. *advance knowledge of the cost of treatment;*
- e. *informed consent;*
- f. *explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;*
- g. *treatment that meets the standard of accepted care in the profession.*

~~5-2~~ **5-3** Patient care **must** be evidenced-based, integrating the best research evidence and patient values. The dental school **must** demonstrate a commitment to evidence-based patient care.

Intent:

The dental school should uses evidence to evaluate new treatments, technology, and products and to guide diagnosis and treatment decisions.

Examples of Evidence to Demonstrate Compliance May Include:

- Policies and procedures related to evidence-based patient care
- Committee meeting minutes reflecting review of current literature
- Contemporary guidelines of care

1
2 ~~5-3~~ **5-4** The dental school **must** conduct a formal system of continuous quality improvement
3 for the patient care program, at sites that it owns and/or operates and all sites where
4 competency is assessed, that demonstrates evidence of:

- 5 a. standards of care that are patient-centered, focused on comprehensive care and
6 written in a format that facilitates assessment with measurable criteria;
7 b. an ongoing review and analysis of compliance with the defined standards of care;
8 c. an ongoing review of a representative sample of patients and patient records
9 to assess the appropriateness, ~~necessity~~ and quality of the care provided;
10 d. mechanisms to determine the cause(s) of treatment deficiencies; and
11 e. implementation of corrective measures as appropriate.

12
13 **Intent:**

14 *Dental education programs ~~should~~ create and maintain databases for monitoring and*
15 *improving patient care and serving as a resource for research and evidence- based*
16 *practice.*

17
18 ~~5-4 The use of quantitative criteria for student advancement and graduation **must not**~~
19 ~~compromise the delivery of comprehensive patient care.~~

20
21 **5-5** The dental school **must** ensure that active patients have access to professional
22 services at all times for the management of dental emergencies, at sites that it
23 owns and/or operates and all sites where competency is assessed.

24
25 ~~5-6 All students, faculty and support staff involved in the direct provision of patient-~~
26 ~~care **must** be continuously certified in basic life support (B.L.S.), including-~~
27 ~~cardiopulmonary resuscitation, and be able to manage common medical-~~
28 ~~emergencies. At sites that it owns and/or operates and all sites where competency~~
29 ~~is assessed, the dental education program **must**:~~
30 a. have a written and distributed plan to manage medical emergencies;
31 b. ensure that all students, faculty, and support staff involved in the direct provision of
32 patient care are continuously certified in basic life support (B.L.S.) or advanced
33 cardiac life support (A.C.L.S.); and
34 c. ensure that faculty involved in the direct provision of patient care are able to
35 manage common medical emergencies.

36
37 **5-7** Written policies and procedures **must** be in place to ensure the safe use of
38 ionizing radiation, which include criteria for patient selection, frequency of
39 exposing radiographs on patients, and retaking radiographs consistent with
40 current, accepted dental practice.

41
42 **5-8** The dental school **must** establish and enforce a mechanism to ensure adequate

1 preclinical/clinical/laboratory asepsis, infection and biohazard control, and
2 disposal of hazardous waste, ~~consistent with accepted dental practice in~~
3 ~~accordance with Centers for Disease Control and Prevention (CDC) guidelines.~~

4
5 **5-9** The dental school's policies and procedures **must** ensure ~~that~~ the confidentiality
6 and protection of information pertaining to ~~the health status of~~ each individual
7 patient is strictly maintained.

STANDARD 6 - RESEARCH PROGRAM

6-1 Research, ~~the process of scientific inquiry involved in the development and dissemination of new knowledge,~~ **must** be an integral component of the ~~purpose/~~mission, goals and objectives of the dental school.

Intent:

~~Research is the process of scientific inquiry involved in the development and dissemination of new knowledge. The institution dental school should develops and sustain a research program on a continuing basis. The dental school should develops strategies to address the research mission and regularly assess how well such expectations are being achieved. Annual evaluations should provide evidence of innovations and advances which reflect research leadership within research focus areas of the institution.~~

Examples of evidence to demonstrate compliance may include:

- Established research areas and ongoing funded support of the research activities
- Commitment to research reflected in ~~institution~~ the mission statement, strategic plan, and financial support
- Evidence of regular ongoing research programmatic review
- Extramural grant and/or foundation support of the research program
- Other evidence of the global impact of the research program

6-2 The dental school ~~faculty, as appropriate to meet the school's purpose/mission, goals and objectives,~~ **must** engage in research or other forms of scholarly activity. must demonstrate evidence of active dental faculty member engagement in research.

Intent:

~~Schools should~~ The dental school ~~establishes~~ focused, significant, and sustained research programs to recruit and retain faculty suitable to the institution's research themes, and or scholarly activity. ~~The program should~~ dental school ~~employs~~ an adequate number of full-time dental ~~faculty with time dedicated to the research mission of the institution.~~ Dental faculty are encouraged to establish inter-disciplinary collaborations consistent with the dental school's research mission. ~~Financial resources should~~ ensure that the program dental school ~~will be in a position to recruit and retain qualified~~ research ~~faculty.~~

Examples of evidence to demonstrate compliance may include:

- Faculty roster of full-time equivalents dental faculty dedicated to research
- Extramural funding of dental faculty

- 1 • Documentation of research dental faculty recruitment efforts
- 2 • Dental faculty research mentorship programs
- 3 • Peer reviewed scholarly publications (manuscripts, abstracts, books, etc.) based
- 4 on original research
- 5 • Presentation at scientific meetings and symposia
- 6 • Other evidence of the impact of the research program and research
- 7 productivity

8
9 **6-3** —~~Dental education programs~~ The dental education program must provide make
10 available opportunities; and encourage, ~~and support~~ students to participation
11 participate in research and other scholarly activities mentored by faculty.

12
13 **Intent:**

14 *The dental education program ~~should~~ provides students with opportunities to*
15 *experience research including, but not limited to, biomedical, translational,*
16 *clinical, implementation, educational, behavioral, epidemiological, health services,*
17 *and other forms of scientific inquiry. ~~biomedical, translational, educational,~~*
18 *epidemiologic and clinical research. Such activities ~~should~~ align with clearly*
19 *defined research mission and goals of the ~~institution~~ dental school. The dental*
20 *education program ~~should~~ introduces students to the principles of research and*
21 *provide elective opportunities beyond basic introduction, including how such*
22 *research is conducted and evaluated, and where appropriate, conveyed to patients*
23 *and other practitioners, and applied in clinical settings.*

24 **Examples of evidence to demonstrate compliance may include:**

- 25 • Formal presentation of student research at school or university events
- 26 • Scholarly publications with student authors based on original research
- 27 • Presentation at scientific meetings
- 28 • Research abstracts and table clinics based on student research