Summer 2023 CODA Meeting

**Agenda Book 2:** Reports Requiring Action

**Book 2 Contains:**
- CODA Open Session Agenda with Bookmarks
- All Review Committee Meeting Minutes and New Business Items (if applicable)
- All Commission-only Reports (p. 1900 items)
- Consent Agenda Items
COMMISSION ON DENTAL ACCREDITATION
FRIDAY, AUGUST 11, 2023
Chicago, Illinois and Video Conference

Call to Order: Friday, August 11, 2023
9:00 a.m. Central Daylight Time, Open Session

Dr. Sanjay M. Mallya, presiding

I. Roll Call: Dr. Evanthia Anadioti, Dr. Victor Badner, Dr. Keith Beasley, Dr. Joel Berg, Dr. Carolyn Brown, Dr. Indraneel Bhattacharyya, Ms. Margaret Bowman-Pensel, Dr. Ngoc Chu, Dr. Joseph Cohen, Dr. Scott DeRossi, Dr. Scott DeVito, Dr. Maxine Feinberg (vice chair), Dr. Joseph Giovannitti, Dr. Amid Ismail, Dr. Barbara Krieg-Menning, Dr. George Kushner, Dr. Brent Larson, Dr. Cataldo Leone, Dr. Frank Licari, Dr. Paul Luepke, Dr. Sanjay Mallya (chair), Ms. Lisa Mayer, Dr. Keith Mays, Ms. Martha McCaslin, Dr. Garry Myers, Dr. Monica Nenad, Dr. Miriam Robbins, Dr. Nancy Rosenthal, Dr. Timmothy Schwartz, Ms. Lonni Thompson, Dr. Marshall Titus, Dr. Deborah Weisfuse, and Mr. Noah Williams.

Commissioner Trainees: Dr. Cornelius Pitts, Dr. Cherae Farmer-Dixon, Dr. LaShun James, Dr. Jessica Lee, Dr. Jeffery Price, Dr. Kenneth Sadler, and Dr. Glenn Sameshima,

Commission Staff: Dr. Sherin Tooks, ex-officio (director), Ms. Jamie Asher Hernandez, Ms. Katie Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner, Ms. Kelly Stapleton and Ms. Marjorie Hooper. Ms. Cathryn Albrecht, senior associate general counsel, CODA.

Trustee Liaison: Dr. James Boyle, III, Third District Trustee, Board of Trustees Liaison to CODA, American Dental Association (ADA).

Guests: Dr. Debora Matthews, chair, and Mr. Frederic Duguay, director, Commission on Dental Accreditation of Canada (CDAC).

II. Adoption of the Agenda

Dr. Mallya

III. Conflict of Interest Statement, Fiduciary Reminder, and Reminder of Professional Conduct Policy and Prohibition Against Harassment

Ms. Albrecht

IV. Approve Minutes from Winter 2023 Meeting

Dr. Mallya

V. Mail Ballot Approved Since Last Commission Meeting

Dr. Mallya

- Report of the Standing Committee on Nominations to CODA – NADL Nominee for DLT RC, Closed 5/16/2023
- Report of the Standing Committee on Nominations to CODA – AAOM Nominees for OM, Closed 5/16/2023

VI. Consent Agenda

Dr. Mallya
VII. **Report of the Review Committee on Predoctoral Dental Education:** Dr. Cataldo Leone, Chair, Dr. Charles Berry, Mr. Drew Christianson, Mr. David Cushing, Ms. Wilhemina Leeuw, Dr. Ana Karina Mascarenhas, Dr. Thomas McConnell, Dr. Deborah Weisfuse-Lipner, and Dr. Linda Wells.

A. Informational Report on Frequency of Citings of Accreditation Standards for Dental Education Programs (p. 100)
B. Informational Report on Frequency of Citings of Accreditation Standards for Dental Therapy Education Programs (p. 101)
C. Consideration of Proposed Revision to Standard 2-24 of the Accreditation Standards for Dental Education Programs (p. 102)
D. Informational Report of the Standing Committee on International Accreditation (p. 103)

**Policy Report**

**Review Committee Minutes and New Business**

VIII. **Report of the Review Committee on Postdoctoral General Dentistry Education:** Dr. Miriam Robbins, Chair, Dr. Jayson Huber, Dr. Edward O’Connor, Dr. Sally Placa, Dr. Steven Rhodes, Dr. Frank Romano, Dr. Eric Sung, Mr. Glenn Unser, and Dr. Michelle Ziegler.

A. Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in Advanced Education in General Dentistry (p. 200)
B. Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in Advanced Education in General Dentistry (p. 201)
C. Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in General Practice Residency (p. 202)
D. Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in General Practice Residency (p. 203)
E. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 204)

**Policy Report**

**Review Committee Minutes**

IX. **Report of the Review Committee on Dental Assisting Education:** Ms. Martha McCaslin, Chair, Ms. Julie Bera, Ms. Kimberly Bland, Ms. Dorothea Cavallucci, Ms. Heather Ferris, Ms. Christy Ross, Dr. Preeti Sahasi, Dr. Debra Schneider, Ms. Melissa Siegel, and Ms. Diana Williams.

A. Informational Report on Frequency of Citings of Accreditation Standards for Dental Assisting Education Programs (p. 300)
B. Consideration of Proposed Revisions to Standard 3-6 of the Accreditation Standards for Dental Assisting Education Programs (p. 301)

**Policy Report**

**Review Committee Minutes and New Business**
X. **Report of the Review Committee on Dental Hygiene Education**: Dr. Monica Nenad, Chair, Ms. Denise Avrutik, Dr. Linda Boyd, Ms. Mara Crow, Dr. Marcia Ditmyer, Ms. Patricia Guenther, Ms. Carrie Hobbs, Dr. Lorie Holt, Dr. Tariq Javed, Dr. Barbara Krieg-Menning, Dr. Nancy Rosenthal, Dr. Paul Francis Tayag Ayson, and Ms. Maiga Van Haalen.

A. Informational Report on Frequency of Citings of Accreditation Standards for Dental Hygiene Education Programs (p. 400)
B. Informational Report on Frequency of Citings of Accreditation Standards for Dental Hygiene Education Programs (p. 401)
C. Consideration of the Report of the Ad Hoc Committee to Develop Dental Hygiene Enrollment Guidelines and Review Accreditation Standards for Dental Hygiene Education Programs (p. 402)

**Policy Report**

**Review Committee Minutes**

XI. **Report of the Review Committee on Dental Laboratory Technology Education**: Ms. Lonnie Thompson, Chair, Ms. LaShun James, Ms. Sandra Kotowske, Mr. Steven Pigliacelli, and Dr. Arpana Verma.

A. Informational Report on Frequency of Citings of Accreditation Standards for Dental Laboratory Technology Education Programs (p. 500)
B. Informational Report on Frequency of Citings of Accreditation Standards for Dental Laboratory Technology Education Programs (p. 501)

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**Review Committee Minutes and New Business**

XII. **Report of the Review Committee on Dental Public Health Education**: Dr. Victor Badner, Chair, Dr. Bruce Dye, Dr. Maya Popova, Dr. Shannon Smith-Stephens, and Dr. Robert Weyant.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Dental Public Health (p. 600)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 601)

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XIII. **Report of the Review Committee on Endodontics Education**: Dr. Garry Myers, Chair, Dr. Carolyn Brown, Dr. Linda Casser, Dr. Gerald Glickman, Dr. Scott McClanahan, and Dr. Josanne O’Dell.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Endodontology (p. 700)
B. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Endodontology (p. 701)
C. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 702)

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IX. Report of the Review Committee on Oral and Maxillofacial Pathology Education: Dr. Neel Bhattacharyya, Chair; Dr. Ashley Clark, Dr. Kathryn Korff, Dr. Renee Reich, and Ms. Lisa Mayer.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Education Programs in Oral and Maxillofacial Pathology (p. 800)
B. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Education Programs in Oral and Maxillofacial Pathology (p. 801)
C. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 802)

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XV. Report of the Review Committee on Oral and Maxillofacial Radiology Education: Dr. Sanjay Mallya, Chair, Dr. Boris Bacanurschi, Dr. KC Chan, Dr. Karen Parker-Davidson, and Dr. Sindhura Anamali Reddy.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Education Programs in Oral and Maxillofacial Radiology (p. 900)
B. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology (p. 901)
C. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 902)

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XVI. Report of the Review Committee on Oral and Maxillofacial Surgery Education: Dr. George Kushner, Chair, Dr. Vasiliki Karlis, Dr. John Manahan, Dr. Pushkar Mehra, Dr. Jan Mitchell, and Dr. Faisal Quereshy.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (p. 1000)
B. Informational Report on Frequency of Citings of Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery (p. 1001)
C. Consideration of Proposed Revisions to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organizations and Authority to Operate (p. 1002)
D. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (p. 1003)
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Review Committee Minutes and New Business

XVII. Report of the Review Committee on Orthodontics and Dentofacial Orthopedics Education:
Dr. Brent Larson, Chair, Mr. David Cushing, Dr. Sarandeep Huja, Dr. Howard Lieb, Dr. Steven Lindauer, and Dr. Emile Rossouw.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p.1100)
B. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p.1101)
C. Informational Report on Frequency of Citings of Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (p. 1102)
D. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1103)

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XVIII. Report of the Review Committee on Pediatric Dentistry Education: Dr. Joel Berg, Chair, Dr. James Boynton; Dr. Kevin Haubrick; Dr. Ana Keohane; Dr. Tad Mabry; and Dr. Anupama Tate.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (p. 1200)
B. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (p. 1201)
C. Consideration of Proposed Revisions to Anesthesia Standards of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (p. 1202)
D. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1203)

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XIX. Report of the Review Committee on Periodontics Education: Dr. Paul Luepke (Chair), Dr. Wayne Kye, Dr. A.C. Liles, III, Dr. Angela Palaiologou-Gallis, Dr. Vishal Shah, and Dr. Dimitris Tatakis.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Periodontics (p. 1300)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1301)

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XX. Report of the Review Committee on Prosthodontics Education: Dr. Evanthia Anadioti, Chair; Dr. Scott DeVito; Dr. Joseph Hagenbruch; Dr. Sang Lee; Dr. Dean Morton; and Dr. David Felton.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Prosthodontics (p. 1400)
B. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Prosthodontics (p. 1401)
C. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1402)

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XXI. Report of the Review Committee on Dental Anesthesiology Education: Dr. Joseph Giovannitti, Chair, Ms. LaShun James, Dr. Gerard Kugel, Dr. Mana Saraghi, and Dr. Philip Yen.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 1500)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1501)

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XXII. Report of the Review Committee on Oral Medicine Education: Dr. Scott DeRossi, Chair, Ms. Jennifer Barber, Dr. Michael DeBellis, Dr. Lina Mejia, and Dr. Thomas Sollecito.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral Medicine (p. 1600)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1601)

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XXIII. Report of the Review Committee on Orofacial Pain Education: Dr. Joseph Cohen, Chair, Dr. Steve Bender, Dr. Reny de Leeuw, Dr. Bessie Katsilometes, and Dr. Robert Windsor.

A. Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain (p. 1700)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain Related to Patients With Special Needs (p. 1701)
C. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1702)

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XXIV. Miscellaneous Affairs – Consideration of Matters Relating to More than One Review Committee

A. Informational Report on Review Committee and Commission Meeting Dates (p.1800) (All Review Committees) Dr. Rosenthal

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XXV. Miscellaneous Affairs – Matters for the Commission as a Whole

A. Report of the Standing Committee on Finance (p. 1900) Commission Report Dr. Mallya

B. Report of the Standing Committee on Quality Assurance and Strategic Planning (p. 1901) Commission Report Dr. Mallya


F. Report of the Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards (p. 1905) Commission Report Ms. Mayer


H. Report of the Ad Hoc Committee on Alternative Site Visit Methods (p. 1907) Commission Report Dr. Licari

I. Report of the Ad Hoc Committee on Professional Development and Mega Issues (p. 1908)
Commission Report  Dr. DeRossi

J. Informational Report of the Standing Committee on International Accreditation (p. 1909)

Commission Report  Dr. Licari

K. Report on Appointment of Commissioners and Appeal Board Members (p. 1910)

Commission Report  Dr. Mallya

L. Election of Chair and Vice Chair of the Commission (p. 1911)

Commission Report  Dr. Mallya

M. Report of the Commission on Dental Accreditation of Canada (CDAC) (p. 1912)

CDAC Report  Dr. Matthews & Mr. Duguay

N. Update on USDE and Higher Education Accreditation Issues  Dr. Tooks

O. Survey of Meeting (verbal)  Dr. Tooks

XXVI. New Business

XXVII. Adjourn
CONSENT AGENDA

Mail Ballots Approved Since the Last Commission Meeting:

- None

Review Committee Reports:

- None
REPORT OF THE REVIEW COMMITTEE ON PREDOCTORAL DENTAL EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Cataldo Leone. Committee Members: Dr. Charles Berry, Mr. Drew Christianson, Mr. David Cushing (attended virtually), Dr. Ana Karina Mascarenhas, Ms. Wilhemina Leeuw, Dr. Thomas McConnell, Dr. Deborah Weisfuse-Lipner, and Dr. Linda Wells. Commissioner Trainees: Dr. Cherae Farmer-Dixon, Dr. Cornelius Pitts (attended virtually), Dr. Kenneth Sadler, and Mr. Noah Williams observed the meeting as Commissioner trainees. Commissioner: Dr. Maxine Feinberg, chair, CODA (attended virtually). Guests (Open Session Only, Virtual): Ms. Sheila Brear, chief learning officer, American Dental Education Association attended the policy portion of the meeting. Staff Members: Ms. Kelly Stapleton, manager, Predoctoral Dental Education, and Mr. Nick Brattoli, senior project assistant, CODA. Dr. Sherin Tooks, senior director, CODA and Ms. Cathryn Albrecht, 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 10 – 11, 2023 at the ADA Headquarters, Chicago, Illinois and via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO PREDOCTORAL DENTAL EDUCATION 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. The PREDOC RC discussed that the highest number of citings overall are found within Standard 2 on Educational Program (110 citings) and Standard 5 on Patient Care Services (42 citings). The Committee noted Standard 2-19 which requires graduates to be competent in practice management resulted in 11 citings. Standard 2-9 requiring the availability of adequate patient experiences resulted in 10 citings. The highest number of citings for a single area of compliance (with 13 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 44 citings and is the most frequently cited Standard within dental education.

Standard 5 on Patient Care Services was the second more frequently cited area with 42 citings. The second most frequently cited Standard (with 32 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 17 citings for Standard 1 – Institutional Effectiveness, six (6) citings for Standard 3 – Faculty and Staff, six (6) citings for Standard 4 – Educational Support Services, and two (2) citings for Standard 6 – Research Program. Trends are noted with regard to Standards 2 and 5, as noted above. Of the 96 site visits conducted since the adoption of the current Accreditation Standards, 50 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. 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.

Consideration of Proposed Revision to Standard 2-24 of the Accreditation Standards for Dental Education Programs (p. 102): The Review Committee on Predoctoral Dental Education (PREDOC RC) considered two (2) proposed revisions to Standard 2-24 of the Accreditation Standards for Dental Education Programs. The first revision, submitted by Dr. Amid Ismail, Dean of Temple University Kornberg School of Dentistry, suggested a change to 2-24 h, regarding competency in the replacement of teeth including fixed, removable, and dental implant prosthodontic therapies, to define and clarify the experiences that graduates must complete with patients to be competent in each procedure (Appendix 1, Policy Report p. 102). The second revision, submitted by Dr. Hong Chen, co-chair of the American Academy of Orofacial Pain Resident and Academy Training Committee, suggested a change to 2-24 k to add orofacial pain to ensure graduates of dental education programs demonstrate minimal clinical competency in managing dental patients with orofacial pain (Appendix 2, Policy Report p. 102).

The PREDOC RC noted that the suggested revisions for 2-24 h and k should be reviewed by the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs as the Ad Hoc Committee is currently reviewing all dental education standards. The PREDOC RC discussed the suggestion of 2-24 h regarding defining the patient experiences and competency requirements that must be completed on a patient and whether defining competency assessment methods should be under the purview of the Commission through its Accreditation Standards or the educational program. Nonetheless, the PREDOC RC recommends the Ad Hoc Committee consider both proposals in its review of the Accreditation Standards for Dental Education Programs.

Recommendation: It is recommended that the Commission on Dental Accreditation direct the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs to consider the two (2) proposed revisions to Standard 2-24 submitted by Dr. Amid Ismail of Temple University Kornberg School of Dentistry and Dr. Hong Chen of the American Academy of Orofacial Pain, (Appendix 1 and 2, Policy Report p. 102, respectively) with a future report to the Review Committee and Commission.
Informational Report of the Standing Committee on International Accreditation (p. 103): The Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the report of the Standing Committee on International Accreditation. The Standing Committee considered two (2) international programs: 1) Saveetha Institute of Medical and Technical Sciences, Chennai, India, and 2) Instituto Tecnológico y de Estudios Superiores de Monterrey, Monterrey, Nuevo Leo, Mexico, during its meeting on Friday, April 7, 2023. The Standing Committee on International Accreditation directed formal letters be sent to the programs reviewed, as applicable, in accordance with the actions taken by the Committee.

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

NEW BUSINESS

Matters Related to Dental Education Programs: The Review Committee on Predoctoral Dental Education (PREDOC) discussed the connection between Dental Standard 2-9 and Dental Standard 2-24 in relation to students having sufficient patient experiences in specific procedures before completing a competency assessment. The PREDOC RC acknowledged that there are challenges for dental education programs to make available patients needing dental care in all areas of Standard 2-24 a-o, specifically challenges related to fixed partial dentures. The PREDOC RC discussed changes in technology, research, and patient care needs, while also acknowledging the importance of graduating practicing dentists who are competent in managing all procedures and are ethically responsible to manage and provide the appropriate patient care.

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 SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PREDOCTORAL DENTAL EDUCATION AND DENTAL THERAPY EDUCATION

Due to an ongoing need for additional site visitors, the Review Committee on Predoctoral Dental Education considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Dr. Cataldo Leone
Chair, Review Committee on Predoctoral Dental Education
REPORT OF THE REVIEW COMMITTEE ON POSTDOCTORAL GENERAL DENTISTRY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Miriam Robbins. Committee Members: Dr. Jayson Huber, Dr. Edward O’Connor, Dr. Steven Rhodes, Dr. Eric Sung, Mr. Glenn Unser, and Dr. Michelle Ziegler. Dr. Frank Romano participated in the meeting virtually and Dr. Sally Jo Placa was unable to attend the meeting. Guest (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education and Ms. Bridget Blackwood, senior project assistant, Commission on Dental Accreditation (CODA). Dr. Sherin Tooks, director, CODA and Ms. Cathryn Albrecht, senior associate general counsel, CODA, attended a portion of the meeting. The meeting of the Review Committee on Postdoctoral General Dentistry Education (PGD RC) was held on July 13-14, 2023 at ADA Headquarters, Chicago, Illinois.

CONSIDERATION OF MATTERS RELATED TO POSTDOCTORAL GENERAL DENTISTRY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in Advanced Education in General Dentistry (p. 200): The Review Committee on Postdoctoral General Dentistry Education (PGD RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry (AEGD) approved and adopted August 3, 2018 and noted that 68 site visits had been conducted between August 3, 2018 and August 4, 2022. Analysis of the data in indicated that a total of 31 citings of non-compliance were made. Of these, 6 were related to Standard 1 – Institutional and Program Effectiveness; 17 were related to Standard 2 – Educational Program; 4 were related to Standard 3 – Faculty and Staff; and 4 were related to Standard 5 – Patient Care Services. No citings were related to Standard 4 – Educational Support Services. Analysis of the data indicates that the most frequently cited areas of non-compliance, with 3 citations each, were in Standards 1-9 (outcomes assessment process) and 3-9 (adequacy of allied dental personnel and clerical staff). The second most frequently cited standards with 2 each were 2-2d (advanced training in endodontic therapy), 2-3 (written curriculum plan), and 5-3 (continuous quality improvement process). The PGD RC noted this serves as the final report on the frequency of citings for the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry implemented on August 3, 2018. Revised Accreditation Standards were adopted August 5, 2022 with immediate implementation.

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

Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in Advanced Education in General Dentistry (p. 201): The PGD RC considered the frequency of citings of the Accreditation Standard for Advanced Dental
Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in General Practice Residency (p. 202): The Review Committee on Postdoctoral General Dentistry Education (PGD RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency (GPR) adopted and implemented August 3, 2018 and noted that 71 site visits had been conducted between August 3, 2018 and August 4, 2022. Analysis of the data indicated that a total of 47 citings of non-compliance were made. Of these, 9 were related to Standard 1 – Institutional and Program Effectiveness; 23 were related to Standard 2 – Educational Program; 7 were related to Standard 3 – Faculty and Staff; 5 were related to Standard 4 – Educational Support Services; 4 were related to Standard 4-Educational Support Services, and 4 were related to Standard 5 – Patient Care Services. Further analysis of the data indicated that the most frequently cited areas of non-compliance, with 4 citations was 2-19 a (resident evaluations). The second most frequently cited areas of non-compliance with 3 citations each, were in Standards 1-5 (written agreements), 1-9 (outcomes assessment), and 2-2c (advanced training in periodontal therapy). The PGD RC noted this serves as the final report on the frequency of citings for the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency implemented on August 3, 2018. Revised Accreditation Standards were adopted August 5, 2022 with immediate implementation.

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

Informational Report on Frequency of Citings of Accreditation Standards For Advanced Dental Education Programs in General Practice Residency (p. 203): The PGD RC considered the frequency of citings of the Accreditation Standard for Advanced Dental Education Programs in General Practice Residency (GPR) approved and implemented August 5, 2022 and noted that since that date, 10 GPR site visits have been conducted utilizing the August 2022 Standards. The report indicates that a total of five (5) citings of non-compliance were made. Of these, three (3) were related to Standard 2 – Educational Program, and two (2) were related to Standard 5 – Patient Care Services. Analysis of the data indicates that the most frequently cited area of non-compliance, with 2 citations, was Standard 5-4 (basic life support recognition/certification). The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

Recommendation: This report is informational in nature and no action is required.
Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 204): At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate
educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the
Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 204) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 204), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the PGD RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as the addition of requirements related to authority to operate, confer a certificate and, as applicable, confer a degree.

The PGD RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate.
The PGD RC acknowledged that the inclusion of the proposed definition and revisions in the Advanced Education in General Dentistry and General Practice Residency Accreditation Standards may impact programs sponsored by community health centers, or other healthcare organizations. Therefore, the PGD RC believed it is critical to circulate the proposed revisions to the communities of interest to provide the opportunity for review and comment. The PGD RC recommended the revisions be circulated for a period of one (1) year. Further, the PGD RC noted that all programs that could be affected by the proposed revisions should carefully review the revisions and comment accordingly.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1 for Advanced Education in General Dentistry and Appendix 2 for General Practice Residency, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

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

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

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF POSTDOCTORAL GENERAL DENTISTRY EDUCATION**

Due to an ongoing need for additional site visitors, the Review Committee on Postdoctoral General Dentistry Education (PGD RC) considered site visitor nominations at this meeting. The Committee’s recommendations on the nominations 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. Miriam Robbins
Chair, Review Committee on Postdoctoral General Dentistry Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1-1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are struck

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1-1 FOR ADVANCED EDUCATION IN GENERAL DENTISTRY, ORAL MEDICINE, AND OROFACIAL PAIN:

Each sponsoring or co-sponsoring United States-based educational institution, hospital or health care organization must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1-1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in General Practice Residency
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are struck.

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1-1 FOR GENERAL PRACTICE
RESIDENCY AND DENTAL ANESTHESIOLOGY:

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON DENTAL ASSISTING EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Ms. Martha McCaslin. Committee Members: Ms. Julie Bera, Ms. Kimberly Bland, Ms. Christy Ross, Dr. Preeti Sahasi (attended virtually), Dr. Debra Schneider, and Ms. Diana Williams. Ms. Melissa Siegel was unable to attend the meeting. Guests (Open Session Only, Virtual): Ms. Rebecca Stolberg, vice president, Allied Dental Education and Faculty Development, American Dental Education Association (ADEA), attended the policy portion of the meeting. Commission Staff: Ms. Jamie Asher Hernandez, manager, Allied Dental Education, Ms. Katie Navickas, manager, Allied Dental Education, and Mr. Daniel Sloyan, coordinator, Allied Dental Education, Commission on Dental Accreditation (CODA). Dr. Sherin Tooks, senior director, CODA, and Ms. Zaira Limon Perez, senior project assistant, Allied Dental Education, CODA, attended a portion of the meeting. The meeting of the Review Committee on Dental Assisting Education (DA RC) was held on July 13-14, 2023 at the American Dental Association Headquarters Building, Chicago, Illinois.

CONSIDERATION OF MATTERS RELATED TO DENTAL ASSISTING EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Dental Assisting Education Programs (p. 300): The Review Committee on Dental Assisting Education (DA RC) considered the annual report of the frequency of citings of Accreditation Standards for Dental Assisting Education Programs and noted the most frequently cited areas of non-compliance for site visits conducted between July 1, 2020 through October 31, 2022.

The data indicates that a total of 361 citings of non-compliance were made. Of these, 39 (10.8%) were related to Standard 1–Institutional Effectiveness; 247 (68.42%) were related to Standard 2–Educational Programs; 33 (9.14%) were related to Standard 3–Administration, Faculty and Staff; 26 (7.2%) were related to Standard 4–Educational Support Services; 15 (4.16%) were related to Standard 5–Health and Safety Provisions; and 1 (0.28%) was related to Standard 6–Patient Care Services.

Analysis of the data indicates the most frequently cited areas of non-compliance are within Standard 2–Educational Programs. Standard 2-7, e, requiring written documentation of each course in the curriculum be provided to students at the start of each course and include specific criteria for final course grade calculation, was cited most frequently and represents 4.9% (12) of all Standard 2 citations. Second most cited is Standard 2-9, o, related to the skills/functions that students demonstrate knowledge of, in a laboratory/preclinical setting prior to performing these skills/functions in a clinical setting, to include identify and respond to dental and medical emergencies, was cited 10 times (4.05%). The subset of citations within Standard 1–Institutional Effectiveness were most frequent in Standard 1-7 (11) related to the dentists and dental assistants being equally represented on the advisory committee, and represent 28.2% all of Standard 1–Institutional Effectiveness citations.

Recommendation: This report is informational in nature and no action is required.
Consideration of Proposed Revisions to Standard 3-6 of the Accreditation Standards for Dental Assisting Education Programs (p. 301): At its Winter 2023 meeting, the Review Committee on Dental Assisting Education (DA RC) and Commission on Dental Accreditation (CODA) reviewed the August 11, 2022 request from Ms. Marcy Owens, dental assisting program director, Tennessee College of Applied Technology at Knoxville, to consider a proposed revision to Standard 3-6 of the Accreditation Standards for Dental Assisting Education Programs.

The proposed revision suggested that Dental Assisting Standard 3-6 be revised or repealed to eliminate the baccalaureate degree requirement for faculty providing didactic instruction. If not repealed, Ms. Owens believed Standard 3-6 should be revised to require that dental assisting faculty have three (3) years of chairside experience in the dental assisting field, a current state professional license as either a Dental Assistant, Dentist, or Dental Hygienist, and that dental assistants and dental hygienists teaching in dental assisting programs hold the Certified Dental Assistant (CDA) credential through the Dental Assisting National Board (DANB).

At its Winter 2023 meeting, the DA RC reviewed the proposed revisions to Dental Assisting Standard 3-6 and engaged in a discussion related to faculty qualifications. The DA RC determined that Standard 3-6 warranted revision to require that faculty providing didactic instruction obtain a baccalaureate degree within two (2) years of the date of initial hire as a didactic faculty. The DA RC believed that there should be a defined period to obtain the degree, rather than an open-ended deadline to ensure that faculty obtain degrees within a reasonable timeframe. For example, a faculty who is initially hired as a clinical instructor and subsequently becomes a didactic instructor must obtain the baccalaureate degree within two (2) years of the date of initial assignment as a didactic instructor. Likewise, a faculty who is initially hired as a didactic instructor must have earned the baccalaureate degree within two (2) years of hire; further, if this faculty leaves and returns to a teaching position in the institution later, the faculty must earn the baccalaureate degree within two (2) years from their initial appointment date as a didactic faculty at that institution. Following discussion, the DA RC recommended the proposed revision to Standard 3-6 of the Accreditation Standards for Dental Assisting Education Programs (Appendix 1, Policy Report 301) be circulated to the communities of interest for six (6) months, for review and comment, with a Hearing conducted in conjunction with the March 2023 American Dental Education Association (ADEA) Annual Session, with comments reviewed at the Commission’s Summer 2023 meetings. At its Winter 2023 meeting, the Commission concurred with the DA RC recommendation and directed circulation of the proposed revision to Dental Assisting Standard 3-6 for a period of six (6) months.

As directed by the Commission, the proposed revision to Standard 3-6 of the Accreditation Standards for Dental Assisting Education Programs (Appendix 1, Policy Report 301) was circulated for comment through June 1, 2023. No (0) comments were received at the Spring 2023 Virtual Hearing on Standards (Appendix 2, Policy Report 301). Additionally, the Commission office received 46 written comments prior to the June 1, 2023 deadline via the Comment Portal (Appendix 3, Policy Report 301). One (1) comment was incorrectly submitted through a different Standards Comment Portal but was included in Appendix 3, Policy Report.
301. In addition, there were two (2) comments received in the Commission office via email, and the senders were informed they must use the Comment Portal; therefore, those comments were resubmitted via the Comment Portal subsequent to the June 1, 2023 deadline (Appendix 4, *Policy Report 301*). There were also two (2) written comments received via the Comment Portal after the June 1, 2023 deadline (Appendix 4, *Policy Report 301*).

The DA RC reviewed and discussed the comments received, including those comments that were submitted after the June 1, 2023 deadline. The Committee noted that some institutions require a degree as part of the institution’s own faculty hiring process, and many institutions require a degree at least one level higher than the degree to be awarded to the students by the program. As such, the DA RC believed that faculty should hold a degree when providing didactic instruction. The Committee reviewed and discussed the written comments noting concern with the proposed revision to Standard 3-6, noting the concerns focused on either the length of time for a baccalaureate degree or the need to hold a degree at all. The Committee believed that there should be a level of standard for faculty members who teach in a CODA-accredited dental assisting education program. Additionally, the Committee noted that the mentoring process of new faculty who do not have a degree is extensive, time consuming, and takes faculty away from other faculty responsibilities and their own teaching.

Following lengthy discussion, the Committee confirmed that a degree requirement is necessary; however, following consideration of the comments received, the DA RC believed the number of years to achieve the baccalaureate degree for a didactic instructor could be altered to provide faculty additional time to achieve the degree. Therefore, the Committee proposed to change the time frame for achieving the baccalaureate degree from the proposed two (2) years to three (3) years. The Committee felt the change in the timeframe of achieving the degree to three (3) years will encourage applicants to pursue the degree and potentially teach at the same time. It was also noted that this revision would provide faculty transitioning into a program administrator role the ability to achieve the baccalaureate degree requirement for dental assisting program administrators, which could promote faculty career ladderizing and address the concern of faculty shortages.

In conclusion, the DA RC recommended that the Commission adopt the proposed revision to Dental Assisting Standard 3-6 (*Appendix 1*), with immediate implementation. The DA RC believed that given the feedback and positive impact on programs, there is no implementation period needed.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt and direct immediate implementation of the proposed revision to Standard 3-6 of the Accreditation Standards for Dental Assisting Education Programs (*Appendix 1*) and all related documents.
NEW BUSINESS

Review of the Criteria for Selection of Dental Assisting Site Visitors: The DA RC discussed the criteria for selection of dental assisting site visitors. The Committee discussed whether to change the criteria, “equivalent of three (3) years full-time dental assisting teaching experience.” After much discussion about the number of years of teaching experience and whether the experience should be full-time and part-time, the Committee believed the criteria is appropriate as written. The DA RC believed that Commission site visitors need to have adequate teaching experience in order to understand dental assisting education and assess other programs based on CODA’s Standards. No changes were made to the criteria for selection of dental assisting site visitors at this time. The Committee determined that the criteria would be reviewed again at the next DA RC meeting in Winter 2024.

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

Consideration of Proposed Revision to Standard 2-7 of the Accreditation Standards for Dental Assisting Education Programs: The DA RC discussed revision to Dental Assisting Standard 2-7 as the term “competency statement” within the Standard (2-7, e) appeared confusing to programs and site visitors. It was noted that inclusion of course objectives and competency statements on the same line was confusing. After discussion about the definitions of competency statements, course objectives and course competencies, it was determined that the term “competency statements” should be removed from Dental Assisting Standard 2-7, e and “course competencies” should be added as a separate item from course objectives, for clarity, as noted below (Underline indicates Addition; Strikethrough indicates Deletion). Due to the clarifying nature of the change, the DA RC believed this change did not warrant public comment and could be adopted with immediate implementation.

2-7 Written documentation of each course in the curriculum must be provided to students at the start of each course and include:
   a. The course title, number, description, faculty presenting course and contact information
   b. Course objectives including competency statements
   c. Course competencies
   d. Content outline including topics to be presented
   e. Course schedule including learning and evaluation mechanisms for didactic, laboratory, and clinical learning experiences
   f. Specific criteria for final course grade calculation

Examples of evidence to demonstrate compliance may include:
   • Course syllabus
   • Rubrics for grade calculation
   • Institutional grading policies
   • Competencies
• Course schedules to include activities, assignments, and evaluations for each date the course meets.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt and direct immediate implementation of the proposed revisions, noted above, to Standard 2-7 of the Accreditation Standards for Dental Assisting Education Programs and all related documents.

**Discussion Related to the Decline (Closure, Discontinuance, Teach-Out) in CODA-Accredited Dental Assisting Programs:** The DA RC discussed the decline in CODA-accredited dental assisting programs due to program closure, program discontinuance, and teach-out. At the Summer 2022 DA RC meeting, the Committee recommended to the Commission on Dental Accreditation to direct the Standing Committee on Documentation and Policy Reviews to review and revise, as needed, the policy and procedure for reporting program closure/discontinuance/teach-out reports to provide the Commission with information as to the reasons why dental assisting programs discontinue CODA-accreditation. Since revision of the policy, the Commission has collected information from CODA-accredited dental assisting programs that have reported closure/discontinuance/teach-out. The DA RC discussed the information, noting programs have found it difficult to hire faculty with the current faculty requirements in the Accreditation Standards for Dental Assisting Education Programs; many states do not require graduation from a CODA-accredited dental assisting program to practice as a dental assistant; institutions can operate non-CODA-accredited dental assisting programs; and institutions find it costly to operate a CODA-accredited dental assisting program.

After lengthy discussion, the DA RC believed that an Ad Hoc Committee should be formed and include members of the DA RC and CODA Commissioners who are dentists and dental educators to further review the issue of CODA-accredited dental assisting program voluntary discontinuance of accreditation. The DA RC also believed that requesting data from other dental associations could be helpful to study this topic.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct the formation of an Ad Hoc Committee of available members of the Dental Assisting Review Committee and Commissioners who are dentists and dental educators to further study the trend of voluntary withdrawal of CODA accreditation by CODA-accredited dental assisting education programs, with a report for further consideration by the Dental Assisting Review Committee and Commission in Winter 2024.

**Consideration of Standard 2-1 of the Accreditation Standards for Dental Assisting Education Programs:** The DA RC discussed Dental Assisting Standard 2-1 related to the requirement for a high-school diploma or its equivalent for admission into a CODA-accredited dental assisting education program. The Committee believed that, in the past, high school students were able to enroll in CODA-accredited dental assisting programs and receive a certificate of completion from the CODA-accredited dental assisting program upon graduation.
from high school. The DA RC discussed the rationale for the requirement of a high-school diploma or its equivalent and determined the need for more data regarding how changing this standard may impact dental assisting programs. The DA RC noted that in some states students cannot perform dental assisting skills and functions until they reach a certain age, which is often post-secondary. Additionally, the DA RC noted that CODA-accredited dental assisting programs may admit students through advanced standing policies and procedures when those students have completed equivalent didactic, laboratory and/or preclinical content prior to admission to the CODA-accredited program. Further, CODA-accredited programs must remain at the post-secondary level of instruction due to CODA’s scope of recognition by the United States Department of Education as an accrediting agency. Following discussion, the DA RC believed there should be no change at this time related to Standard 2-1 Admissions and that this Standard should be further reviewed at the next DA RC meeting in Winter 2024.

**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 SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL ASSISTING EDUCATION**

Due to an ongoing need for additional site visitors, the Review Committee on Dental Assisting Education considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

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

Respectfully submitted,

Ms. Martha McCaslin
Chair, Review Committee on Dental Assisting Education
At its Winter 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Dental Assisting Education Programs be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2023, for review at the Summer 2023 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from February 10, 2023 to June 1, 2023.

This document will be considered by the Commission in Summer 2023.

Additions are **Underlined**

*Strikethroughs* indicate Deletions
STANDARD 3 – ADMINISTRATION, FACULTY AND STAFF

Faculty

3-6 Faculty providing didactic instruction must have earned at least a baccalaureate degree within three years of the date of initial hire as a didactic faculty.

Intent:
*Military program faculty with a rank of staff sergeant, E5, or non-commissioned officer are exempt.

Examples of evidence to demonstrate compliance may include:
• Transcript(s)
REPORT OF THE REVIEW COMMITTEE ON DENTAL HYGIENE EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Monica Nenad. Committee Members: Ms. Denise Avrutik, Dr. Linda Boyd, Dr. Marcia Ditmyer (attended virtually), Ms. Patricia Guenther, Ms. Carrie Hobbs, Dr. Lorie Holt, Dr. Tariq Javed, Dr. Nancy Rosenthal, Dr. Paul Francis Tayag Ayson, and Ms. Maiga Van Haalen. Ms. Mara Crow and Dr. Barbara Krieg-Menning were unable to attend the meeting. Guests (Open Session Only, Virtual): Dr. JoAnn Gurenlian, director, Education and Research, American Dental Hygienists’ Association, and Ms. Rebecca Stolberg, vice president, Allied Dental Education and Faculty Development, American Dental Education Association. Staff Members: Ms. Katie Navickas, manager, Allied Dental Education, Ms. Jamie Asher Hernandez, manager, Allied Dental Education, and Mr. Daniel Sloyan, coordinator, Allied Program Reviews, Commission on Dental Accreditation (CODA). Dr. Sherin Took, senior director, CODA, and Ms. Zaira Perez-Lemon senior project assistant, Allied Dental Education, CODA, attended a portion of the meeting. The meeting of the Review Committee on Dental Hygiene Education (DH RC) was held on July 10-11, 2023 at the ADA Headquarters, Chicago, Illinois.

Informational Report on Frequency of Citings of Accreditation Standards for Dental Hygiene Education Programs (p. 400): The Review Committee on Dental Hygiene Education (DH RC) considered the annual report of the frequency of citings of Accreditation Standards for Dental Hygiene Education Programs and noted the most frequently cited areas of non-compliance for site visits conducted between January 1, 2009 and June 30, 2022.

The data indicated that a total of 2,363 citings of non-compliance were made. Of these, 178 (7.5%) were related to Standard 1–Institutional Effectiveness; 1,216 (51.4%) were related to Standard 2–Educational Program; 431 (18.2%) were related to Standard 3–Administration, Faculty and Staff; 205 (8.7%) were related to Standard 4–Educational Support Services; 102 (4.3%) were related to Standard 5–Health and Safety Provisions; and 231 (9.8%) were related to Standard 6–Patient Care Services.

The most frequently cited areas of non-compliance are within Standard 2–Educational Program. The subsets of Standard 2-12 were cited most frequently and received a total of 304 citations. Standard 2-12 requires graduate competence in providing dental hygiene care for various patient types including patients with special needs. Citations within Standard 2-12 patient types were distributed as follows: child (60), adolescent (73), adult (43), geriatric (64), and special needs patients (64). Continued monitoring of Standard 2-12 and standards related to patient care and tracking is indicated and future revisions may be warranted. Standard 2-7, which describes the course documentation components provided to students, was cited a total of 192 times. Within Standard 3–Administration, Faculty and Staff, Standard 3-7, a) requiring current knowledge of the specific subject(s) faculty are teaching, and b) requiring educational methodology for faculty, received 63 and 79 citations, respectively.
The revised Accreditation Standards for Dental Hygiene Education Programs was implemented on July 1, 2022. Therefore, this report concludes the Frequency of Citings for the January 2009 Accreditation Standards for Dental Hygiene Education Programs.

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

**Informational Report on Frequency of Citings of Accreditation Standards for Dental Hygiene Education Programs (p. 401):** The Commission on Dental Accreditation approved the Accreditation Standards for Dental Hygiene Education Programs on February 12, 2021, with implementation on July 1, 2022. Since that implementation date, 17 site visits have been conducted by visiting committees of the Commission utilizing the July 1, 2022 Standards.

The Review Committee on Dental Hygiene Education (DH RC) considered the annual report of the frequency of citings to include the July 1, 2022 Accreditation Standards for Dental Hygiene Education Programs and noted the most frequently cited areas of non-compliance for site visits conducted between July 1, 2022 through October 31, 2022.

The data indicated that a total of 54 citings of non-compliance were made during the period of reporting. Of these, 3 (5.6%) were related to Standard 1-Institutional Effectiveness; 23 (42.59%) were related to Standard 2-Educational Program; 12 (22.2%) were related to Standard 3-Administration, Faculty and Staff; 9 (16.7%) were related to Standard 4-Educational Support Services; 5 (9.3%) were related to Standard 5-Health and Safety Provisions; and 3 (5.6%) related to Standard 6-Patient Care Services.

The most frequently cited areas of non-compliance were within Standard 2-Educational Program. The subsets of Standard 2-12 were cited most frequently and received a total 10 citations. Standard 2-12 requires graduate be competence in providing dental hygiene care for various patient types. Citations within Standard 2-12, patient types, were distributed as follows: child (2), adolescent (2), adult (1), geriatric (2), and special needs patients (3). Continued monitoring of Standard 2-12 and standards related to patient care is indicated. Within Standard 3–Administration, Faculty and Staff, Standard 3-6, d, evidence of faculty calibration for clinical evaluation received three (3) citations. Standard 3-2, the dental hygiene program administrator must have a full-time appointment as defined by the institution, whose primary responsibility is for operation, supervision, evaluation and revision of the program, received two (2) citations.

The Commission will continue to receive reports annually summarizing the updated data on frequency of citings of individual Standards.

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

**Consideration of the Report of the Ad Hoc Committee to Develop Dental Hygiene Enrollment Guidelines and Review Accreditation Standards for Dental Hygiene Education Programs (p. 402):** At its Winter 2023 meeting, the Commission on Dental Accreditation (CODA) considered the Report of the Review Committee on Dental Hygiene Education (DH RC), which included a new business item related to the Committee’s discussion regarding the
interpretation of dental hygiene Standard 2-8 and Standard 3-6, and discussion by the DH RC related to enrollment increases in dental hygiene education programs. Following consideration, the DH RC recommended that an Ad Hoc meeting of the available members of the DH RC in Spring 2023 would allow further discussion of these matters and, as appropriate, submission of a report to the DH RC and Commission for further consideration in Summer 2023. At its Winter 2023 meeting, the Commission concurred with the recommendation of the DH RC and directed the Ad Hoc Committee of the DH RC to further discuss the Dental Hygiene Standards related to general education courses and faculty qualifications, and reporting mechanisms related to enrollment increases, with a report for further consideration by the Dental Hygiene Review Committee and Commission in Summer 2023. The report of the Ad Hoc Committee is found in Policy Report p. 402.

Dental Hygiene Standard 2-8: At this meeting, the DH RC reviewed the report of the Ad Hoc Committee and continued its discussion related to Standard 2-8, particularly related to the intent statement which states: “General education, social science, and biomedical science courses included in the curriculum should be equivalent to those offered in four-year colleges and universities.” and the Standard 2-8b intent statement, which states: “The subjects are to be of the scope and depth comparable to college transferable liberal arts course work.”

The DH RC continued to share its earlier perspective that whether provided as a separate course or within the dental hygiene curriculum, the learning outcomes of content in general education, social science and biomedical science should be equivalent to college transferable courses to assure foundation knowledge in these general education courses as applied to dental hygiene courses. Following discussion, the DH RC concluded that revision of Standard 2-8 is not warranted at this time; however, the Committee will continue to monitor program compliance with this Standard.

Dental Hygiene Standard 3-6: At this meeting, the DH RC considered the discussion of the Ad Hoc Committee. It was again noted that for some courses in the dental hygiene curriculum may be difficult to find appropriate and current content to demonstrate current knowledge in the subjects taught; for example, embryology and dental anatomy. However, the DH RC reiterated that faculty must have current knowledge in the subjects they are teaching, as well as education methodology background consistent with teaching assignments and teaching modality (i.e., didactic, hybrid, clinic, distance education).

The Review Committee affirmed that site visitors and programs should use professional judgement as to what is “current” when reviewing education methodology and continuing education. It was also noted that the new Allied Biosketch has helped programs document the faculty’s compliance in these areas. The DH RC concluded that revision of Standard 3-6 is not warranted at this time; however, the Committee will continue to monitor program compliance with this Standard.

Enrollment Increases in Dental Hygiene Education Programs: At this meeting, the DH RC reviewed the Ad Hoc Committee’s proposed new Guidelines for Requesting an Increase in
Enrollment in a Dental Hygiene Education Program (Appendix 1, Policy Report p. 402). The DH RC believed that the enrollment guidelines would assist programs in documenting sufficient resources to increase enrollment. Additionally, the enrollment guidelines provide a uniform method of receipt of information for review by the DH RC Chair, and DH RC, as appliable. No further changes were recommended related to the proposed new guidelines. The DH RC concluded that the guidelines should be adopted by the Commission, with immediate implementation to permit dental hygiene programs to use these guidelines for future enrollment increases. The proposed Guidelines for Requesting an Increase in Enrollment in a Dental Hygiene Education Program are found in Appendix 1.

**Recommendations:** It is recommended that the Commission on Dental Accreditation direct there be no revision to Standard 2-8 of the Accreditation Standards for Dental Hygiene Education Programs at this time.

It is further recommended that the Commission on Dental Accreditation direct there be no revision to Standard 3-6 of the Accreditation Standards for Dental Hygiene Education Programs at this time.

It is further recommended that the Commission on Dental Accreditation adopt, with immediate implementation, the proposed new Guidelines for Requesting an Increase in Enrollment in a Dental Hygiene Education Program (Appendix 1).

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

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

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

Due to an ongoing need for additional site visitors, the Review Committee on Dental Hygiene Education considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

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

Respectfully submitted,

Dr. Monica Nenad
Chair, Review Committee on Dental Hygiene Education
Proposed New
Guidelines for Requesting an Increase in Enrollment in a Dental Hygiene
Education Program

(Additions are underlined)

TIMING OF REQUESTS AND RESPONSE: An increase in enrollment in dental hygiene education programs must be reported to the Commission. Upon submission of the enrollment increase report, a substantial increase in program enrollment as determined by preliminary review by the discipline-specific Review Committee Chair will require prior approval by CODA.

RATIONALE FOR GUIDELINES: These Guidelines were drafted to focus upon adequacy of programmatic resources in support of additional student enrollees. Enrollment increases are tracked to ensure over time total enrollment does not exceed the resources of the program.

The Commission must review the request prior to implementation. It should be noted that the requirement for prior approval for an increase in enrollment is commensurate with the Commission’s Program Change policy under which previous enrollment increases were reported.

Programs should be cognizant of the impending need for enrollment increases through short- and long-term planning and proactively request permission for the increase. The Commission will not consider retroactive permanent requests. Additionally, the Commission will not consider inter-cycle requests unless there are documented extenuating circumstances.

Requests should be sent to the Commission on Dental Accreditation (see Mechanics, below) for initial review by the Review Committee Chair and, as needed, by the Dental Hygiene Education Review Committee and subsequent review and approval by the Commission. The Dental Hygiene Education Review Committee will review the request at the next regularly scheduled meeting. Reports submitted by May 1 will be considered at the Summer Commission meeting, and reports submitted by November 1 will be considered at the Winter Commission meeting.

POLICY ON MISSED DEADLINES: So that the Commission may conduct its accreditation program in an orderly fashion, all institutions offering programs accredited by the Commission are expected to adhere to deadlines for requests for program information. Programs/institutions must meet established deadlines to allow scheduling of regular or special site visits and for submission of requested information. Program information (i.e. self-studies, progress reports, annual surveys or other kinds of accreditation-related information requested by the Commission) is considered an integral part of the accreditation process. If an institution fails to comply with the Commission's request, or a prescribed deadline, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will...
immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

Revised: 2/16; Reaffirmed: 8/20; 8/15; 8/10, 7/07, 7/01, 5/88

FORMAT: The report must be clear and concise and must follow the “Required Documentation” and “Mechanics” sections illustrated within this guideline. Reports that fail to adhere to the stated guidelines may be returned to the program.

REQUIRED DOCUMENTATION (10 areas): Program directors must ensure that the proposed enrollment increases does not jeopardize the program’s ability to meet the Accreditation Standards.

In order to build and maintain calibration of evaluating requests for reportable enrollment increases, the following documentation must be submitted with the request for enrollment increase:

1. Date the program plans to increase enrollment.
2. Indicate the current enrollment in each year of the program and the projected enrollment in each year of the program.
3. Indicate whether the proposed increase in enrollment is temporary or a permanent increase.
4. The ratio of teaching faculty to students before and after the proposed increase, including changes in faculty assignments, hiring plans, and new faculty biosketches with teaching assignments, as applicable, including Dental Hygiene Self-Study Example Exhibit 8.
5. A schedule for all courses within the program, before and after the proposed increase is in effect documenting assignments of the faculty (didactic, preclinical, laboratory and clinical), including Dental Hygiene Self-Study Example Exhibit 11.
6. Support staff available to students after the proposed enrollment increase.
7. Financial resources to support the increased enrollment.
8. Facility resources: classroom, laboratory, preclinical and clinical space, faculty space, student work/study areas, computer access, etc.
9. A description of the availability of adequate patient experiences to ensure the program’s goals and objectives for training to competencies will be achieved following the increased enrollment. Submit current (past two years) and projected numbers of patients by procedure type, including an accounting for the increased student enrollment. Additionally, provide minimum, mean, and maximum patient experiences by procedure type, for the preceding graduating class.
10. Explanation of how any off-campus sites may be involved in the proposed enrollment increase. Note: If new off-campus sites may be involved in the
enrollment increase being reported, the Policy and Guidelines for Off-Campus Sites must also be followed.

Supportive documentation must be submitted to demonstrate continued compliance with Standards following the change. A signed Verification Page must accompany the report. Omission of any of these ten (10) documentation areas may postpone Commission action on the request for increase in enrollment.

The Commission has directed that program materials be submitted electronically through a secure CODA electronic submission portal or by email, solely. Paper copies and/or electronic copies mailed to the Commission office will not be accepted.

MECHANICS: The following guidelines must be observed when preparing your report. Electronic Submission Guidelines are available and must be strictly followed. Failure to comply with these guidelines will constitute an incomplete report. Electronic Submission Guidelines are available on the CODA website at this link: https://coda.ada.org/policies-and-guidelines/electronic-submission-guidelines

1. Cover page must include
   a. date of report
   b. name and address of the institution;
   c. program title;
   d. name, title, telephone number, e-mail address, and signature of individual preparing the request (this is typically the program director);
   e. name, title, and signature of the chief executive officer of the institution (the chief executive officer of the institution sponsoring the program must be copied on the letter transmitting the request to the Commission).

   The report must include a signed cover/verification page and must conform to the Commission’s electronic submission guidelines.

2. If documentation is extensive, a list of what is provided should be included. The actual items can be provided in one (1) separate document that conforms to the electronic submission guidelines.

Institutions/Programs are expected to follow Commission policy and procedure on privacy and data security, including those related to compliance with the Health Insurance Portability and Accountability Act (HIPAA). The Commission’s statement on HIPAA, as well as the Privacy and Data Security Summary for Institutions/Programs (PDF), are found in the Policies/Guidelines section of the Commission’s website at

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https://coda.ada.org/policies-and-guidelines/hipaa-compliance. Programs that fail to comply with CODA’s policy will be assessed an administrative fee of $4000.

POLICY ON PREPARATION AND SUBMISSION OF DOCUMENTS TO THE COMMISSION: All institutions offering programs accredited by the Commission are expected to prepare documents that adhere to guidelines set forth by the Commission on Dental Accreditation, including required verification signatures by the institution’s chief executive officer, the institution’s chief academic officer, and program director. These documents may include, but are not limited to, self-study, responses to site visit/progress reports, initial accreditation applications, reports of program change, and transfer of sponsorship and exhibits. The Commission’s various guidelines for preparing and submitting documents, including electronic submission, can be found on the Commission’s website or obtained from the Commission staff.

In addition, all institutions must meet established deadlines for submission of requested information. Any information that does not meet the preparation or submission guidelines or is received after the prescribed deadlines may be returned to the program, which could affect the accreditation status of the program.

Electronic Submission of Accreditation Materials: All institutions will provide the Commission with an electronic copy of all accreditation documents and related materials, which conform to the Commission’s Electronic Submission Guidelines. Electronic submission guidelines can be found on the Commission’s website or obtained from the Commission staff. Accreditation documents and related materials must be complete and comprehensive.

Documents that fail to adhere to the stated Guidelines for submission will not be accepted and the program will be contacted to submit a corrected document. In this case, documents may not be reviewed at the assigned time which may impact the program’s accreditation status.

Compliance with Health Insurance Portability and Accountability Act (HIPAA) (Excerpt): The program’s documentation for CODA must not contain any patient protected health information (PHI) or sensitive personally identifiable information (PII). If the program submits documentation that does not comply with the policy on PHI or PII, CODA will assess an administrative processing fee of $4,000 per program submission to the institution; a program’s resubmission that continues to contain PHI or PII will be assessed an additional $4,000 administrative processing fee.

Revised: 8/20; Adopted 1/20 (Formerly Policy on Electronic Submission of Accreditation Materials, Commission Policy and Procedure Related to Compliance with the Health Insurance Portability and Accountability Act [HIPAA] and Policy on Preparation and Submission of Reports to the Commission)

ANNOUNCEMENT OF REVIEW RESULTS: The Commission’s actions to approve or deny the request for reportable enrollment increases in predoctoral education programs, as are other

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accreditation actions, will be transmitted to the institutions/programs within 30 days following the Winter (January/February) or Summer (July/August) meetings.

**DENIAL OF REQUESTS:** Requests will be denied if the program cannot ensure continued compliance with the Accreditation Standards as demonstrated by documentation of the major program resource areas identified in the Guidelines for Enrollment Increases in Predoctoral Dental Education Programs.

**OTHER CHANGES IN ENROLLMENT:** Decreases in enrollment on a one-time-only basis or on a permanent basis must be reported to the Commission, but do not require prior approval. In the case of one-time-only decreases, programs are advised to maintain clinical experiences for the enrollment number for which they are approved.

**ASSISTANCE:** If you have questions, it is preferred that you contact staff via email. CODA staff emails can be found on the CODA website at the following link:  
https://coda.ada.org/about-coda/coda-staff

Staff can also be contacted at 312-440-2695.
Commission on Dental Accreditation
Privacy and Data Security Reminders

Protect sensitive personally identifiable information (“PII”) such as social security numbers, drivers’ license numbers, credit card numbers, account numbers, etc.

Security Reminder: Personally Identifiable Information

Before submitting any documents to CODA or to a CODA site visitor, an institution must:

- Review for PII and patient identifiers.
- Fully and appropriately redact any PII and patient identifiers.
- Make sure the redacted information is unreadable in hard copy and electronic form. You must use appropriate redaction methods to ensure personal information cannot be read or reconstructed.

CODA does not accept PII or patient identifiers in any materials submitted by a program.

Security Reminder: Patient Identifiers

Before submitting any information about a patient to CODA or to a CODA site visitor, you must thoroughly redact all 18 patient identifiers listed on the next page.

Examples of information about a patient:

- Dental records
- Rosters of procedures (procedure logs)
- Chart review records (chart audit records)
- Information from affiliated teaching institutions, to include items listed above
- Brochures with patient images and/or information
- Presentations with patient images and/or information
- Course materials (exams, lecture materials) with patient images and/or information

If even one identifier is readable, do not submit the information to CODA.

CODA does not accept documents containing PII or patient identifiers from institutions. Any PHI/PII that is necessary for CODA accreditation may only be reviewed by CODA site visitors when they are on-site at the institution.

When redacting identifiers, you must ensure that the information is unreadable and cannot be reconstructed in both hard copy and electronic form. For example, certain information redacted on a hard copy can become readable when the hard copy is scanned. Instead, it may be effective
to use opaque cover-up tape on the hard copy, scan, and then ensure the redacted information on the scanned version is not visible/readable through the redaction.
Commission on Dental Accreditation

Privacy and Data Security Requirements for Institutions

(Rev. 8/2021)

1. **Sensitive Information.** To protect the privacy of individuals and to comply with applicable law, the Commission on Dental Accreditation (“CODA” or “the Commission”) **prohibits all programs/institutions from disclosing in electronic or hard copy documents** provided to CODA other than on-site during a site visit, any of the following information (“Sensitive Information” or “PII”):
   - Social Security number
   - Credit or debit card number or other information (e.g., expiration date, security code)
   - Drivers’ license number, passport number, or other government issued ID
   - Account number with a pin or security code that permits access
   - Health insurance information, such as policy number or subscriber I.D.
   - Medical information, such as information about an individual’s condition, treatment, or payment for health care
   - Mother’s maiden name
   - Taxpayer ID number
   - Full date of birth
   - Any data protected by applicable law (e.g., HIPAA, state data security law)
   - Biometric data, such as fingerprint or retina image
   - Username or email address, in combination with a password or security question that permits access to an online account

2. **Patient Identifiers.** Before submitting information about a patient to CODA other than on-site during a site visit, a program/institution **must remove the following data elements** of the individual, and of relatives, household members, and employers of the individual (the “Patient Identifiers”):
   1. Names, including initials
   2. Address (including city, zip code, county, precinct)
   3. Dates, including treatment date, admission date, age, date of birth, or date of death [a range of dates (e.g., May 1 – 31, 2015) is permitted provided such range cannot be used to identify the individual who is the subject of the information]
   4. Telephone numbers
   5. Fax numbers
   6. E-mail addresses
   7. Social Security numbers
   8. Medical record numbers

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9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers (e.g., finger and voice prints)
17. Full face photographic images and comparable images
18. Any other unique identifying number, characteristic, or code:
   • that is derived from information about the individual
   • that is capable of being translated so as to identify the individual, or
   • if the mechanism for re-identification (e.g., the key) is also disclosed

In addition, the information provided to CODA cannot be capable of being used alone or in combination with other information to identify the individual.

3. **Redaction.** When removing any Sensitive Information or Patient Identifier from paper or electronic documents disclosed to CODA, programs/institutions shall fully and appropriately remove the data such that the data cannot be read or otherwise reconstructed. Covering data with ink is not an appropriate means of removing data from a hard copy document and may sometimes be viewable when such documents are scanned to an electronic format.

4. **Administrative fee.** If the program/institution submits any documentation that does not comply with the directives noted above, CODA will assess an administrative fee of $4000 to the program/institution; a resubmission that continues to contain prohibited data will be assessed an additional $4000 fee.
   - CODA Site Visitors and Commission volunteers are only authorized to access Sensitive Information and Patient Identifiers:
     - Onsite during a site visit, and
     - That are necessary for conducting the accreditation site visit
   - CODA Site Visitors and Commission volunteers may not download or make hard copies or electronic copies of Sensitive Information or Patient Identifiers.

**NOTE:** If a document includes fictitious information, which may otherwise appear to be Sensitive Information or Patient Identifiers, the program is expected to clearly mark the document as “Fictitious Example”.

Guidelines for Requesting DH Enrollment Increases

Adopted DATE
REPORT OF THE REVIEW COMMITTEE ON DENTAL LABORATORY TECHNOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Ms. Lonni Thompson. Committee Members: Ms. LaShun James and Ms. Sandra Kotowske. Mr. Steven Pigliacelli and Dr. Arpana Verma were unable to attend the meeting. Guests (Open Session Only, Virtual): Ms. Rebecca Stolberg, vice president, Allied Dental Education and Faculty Development, American Dental Education Association (ADEA), attended the policy portion of the meeting. Staff Members: Ms. Jamie Asher Hernandez, manager, Allied Dental Education, Ms. Katie Navickas, manager, Allied Dental Education, Mr. Daniel Sloyan, coordinator, Allied Dental Education, and Ms. Zaira Limon Perez, senior project assistant, Allied Dental Education, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Dental Laboratory Technology Education (DLT RC) was held on July 10, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL LABORATORY TECHNOLOGY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Dental Laboratory Technology Education Programs (p. 500): The Review Committee on Dental Laboratory Technology Education (DLT RC) considered the annual report of the frequency of citings of Accreditation Standards for Dental Laboratory Technology Education Programs and noted the most frequently cited areas of non-compliance for site visits conducted between January 1, 2014 and December 31, 2021. During this time, 15 dental laboratory technology site visits were conducted. An analysis of the data indicated a total of 23 citings of non-compliance. Of these, 4 (17.4%) were related to Standard 1–Institutional Effectiveness; 10 (43.5%) were related to Standard 2–Educational Program; 6 (26.1%) were related to Standard 3–Administration, Faculty and Staff; 1 (4.3%) was related to Standard 4–Educational Support Services; and 2 (8.7%) were related to Standard 5–Health and Safety Provisions. Due to the limited number of site visits and a total of 23 citings of non-compliance, a trend in the data cannot be identified. The Commission approved revised Accreditation Standards for Dental Laboratory Technology Education Programs at its February 12, 2021 meeting with an implementation date of January 1, 2022. Therefore, this report concludes the Frequency of Citings for the Accreditation Standards for Dental Laboratory Technology Education Programs implemented January 2014.

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

Informational Report on Frequency of Citings of Accreditation Standards for Dental Laboratory Technology Education Programs (p. 501): The Review Committee on Dental Laboratory Technology Education (DLT RC) considered the annual report of the frequency of citings of Accreditation Standards for Dental Laboratory Technology Education Programs and noted the most frequently cited areas of non-compliance for site visits conducted between
January 1, 2022 and October 31, 2022. During this time, no (0) dental laboratory technology site visits were conducted. Therefore, there are no (0) citings presented as there were no (0) dental laboratory technology site visits conducted by visiting committees of the Commission utilizing the January 2022 Standards. To ensure confidentiality, Frequency of Citings Reports will not be made available where a limited number (three or less) of programs have been site visited.

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

**NEW BUSINESS**

**Dental Laboratory Technology Site Visitor Recruitment:** The Review Committee on Dental Laboratory Technology Education (DLT RC) discussed the ongoing, urgent need for DLT site visitors and DLT National Association of Dental Laboratories (NADL) Representative site visitors as there are several upcoming DLT site visits in the next few years. The DLT RC confirmed that CODA staff will continue to send a call for nominations for DLT site visitors and DLT NADL Representative site visitors to NADL and the DLT communities.

**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 SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL LABORATORY TECHNOLOGY**

No site visitor nominations were considered at this meeting.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

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

Respectfully submitted,

Ms. Lonni Thompson
Chair, Review Committee on Dental Laboratory Technology Education
REPORT OF THE REVIEW COMMITTEE ON DENTAL PUBLIC HEALTH EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Victor Badner. Committee Members: Dr. Bruce Dye, Dr. Maya Popova, and Dr. Robert Weyant. Dr. Shannon Smith-Stephens was unable to participate. Guests (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, Dr. Frances Kim, executive director, American Association of Public Health Dentistry (AAPHD), Dr. Susan McKernan, secretary-treasurer, American Board of Dental Public Health (ABDPH), and Dr. Mary Tavares, director, ABDPH, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, Ms. Yesenia Ruiz, manager, Advanced Dental Education, Dr. Sherin Tooks, senior director, Ms. Bridget Blackwood, senior project assistant, and Ms. Michele Kendall, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Dental Public Health Education (DPH RC) was held on July 14, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL PUBLIC HEALTH EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Dental Public Health (p. 600): The Review Committee on Dental Public Health Education (DPH RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Dental Public Health implemented August 3, 2018. The DPH RC noted that ten (10) dental public health site visits have been conducted from August 3, 2018 through October 31, 2022 and no (0) areas of non-compliance were cited. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 601). At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.
Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to
Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

**Charter/License to Operate and Offer Instruction**: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate.
Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 601) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 601), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the DPH RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as proposed revision to Standards related to institutional sponsors to include health care organizations and a new requirement related to authority to operate, confer a certificate and, as applicable, confer a degree.

The DPH RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the DPH RC believed that the inclusion of the proposed definition and revisions in the Dental Public Health Accreditation Standards should have no impact on dental public health education programs. The DPH RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.
CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

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

No site visitor nominations were considered at this meeting. While there were no site visitor nominations to consider at this meeting, the DPH RC discussed the need to recruit dental public health site visitors, as well as methods for doing so, including recruiting individuals at national meetings, and announcing a call for nominations through the dental public health listserv.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Victor Badner
Chair, Review Committee on Dental Public Health Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Dental Public Health
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health
Service (IHS), Veterans Health Administration system (VA), or academic health center/medical
center/ambulatory care center (both public and private) that is accredited by an agency
recognized by the United States Department of Education or accredited by an accreditation
organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval.
to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

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

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON ENDODONTICS EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Garry Myers. Committee Members: Dr. Carolyn Brown, Dr. Linda Casser, Dr. Gerald Glickman, Dr. Scott McClanahan, and Dr. Josanne O’Dell. Guests (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Commission Staff: Ms. Yesenia Ruiz, manager, Advanced Dental Education, and Ms. Peggy Soeldner, manager, Advanced Dental Education, Commission on Dental Accreditation (CODA). Dr. Sherin Tooks, senior director, CODA, attended a portion of the meeting. The meeting of the Review Committee on Endodontics Education (ENDO RC) was held on July 10, 2023, via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO ENDODONTICS EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Endodontics (p. 700): The Review Committee on Endodontics Education (ENDO RC) considered the annual report on the frequency of citings of Accreditation Standards for Advanced Dental Education Programs in Endodontics implemented January 1, 2014. The ENDO RC noted that there was one (1) citing during the period covered by this report (January 1, 2014, through June 30, 2022), which was in the area of non-surgical and surgical endodontic treatment and retreatment. The revised Accreditation Standards for Advanced Dental Education Programs in Endodontics was adopted on February 12, 2021 and implemented on July 1, 2022. Therefore, this report concludes the Frequency of Citings for the January 2014 Accreditation Standards for Advanced Dental Education Programs in Endodontics

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Endodontics (p. 701): The Review Committee on Endodontics Education (ENDO RC) considered the annual report on the frequency of citings of Accreditation Standards for Advanced Dental Education Programs in Endodontics implemented on July 1, 2022. The ENDO RC noted there had been three (3) citings during the period covered by this report, in the areas of hours devoted in clinical care (Standard 4-6), active participation in endodontics interdisciplinary seminars and conferences (Standard 4-13), and eligible applicants to the advanced dental education program (Standard 5). Due to the limited number of citings, no analysis can be performed at this time.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 702): At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.
The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

**Institutional Sponsor (Health Care Organizations):** The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.
The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the
Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 702) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 702), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** The Review Committee on Endodontics Education (ENDO RC) considered the proposed revision to the Accreditation Standards related to the Definition of Terms for Health Care Organization and to chartering and licensure to operate. Following consideration, the ENDO RC recommended that the proposed revisions be circulated to the communities of interest for a period of one (1) year, with further consideration by the ENDO RC and Commission in Summer 2024.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.
CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

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

Due to an ongoing need for additional site visitors, the Review Committee on Endodontics Education (ENDO RC) considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Garry Myers
Chair, Review Committee on Endodontics Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Endodontics
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

**Health Care Organization:** A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDOdontics, ORAL AND MAXilloFACIAL PATHOLOGY, ORAL AND MAXilloFACIAL RADIology, ORTHodontICS AND DENToFACIAL ORTHOPEDICS, ORAL AND MAXilloFACIAL SURGERY, PEDiatric DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).
Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

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

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL PATHOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Neel Bhattacharyya. Committee Members: Dr. Ashley Clark, Dr. Kathryn Korff, Dr. Renee Reich, and Ms. Lisa Mayer. Guests (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education; Ms. Yesenia Ruiz, manager, Advanced Dental Education; Ms. Bridget Blackwood, senior project assistant, and Ms. Michele Kendall, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Oral and Maxillofacial Pathology Education (OMP RC) was held on July 13, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL AND MAXILLOFACIAL PATHOLOGY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology (p. 800): The Review Committee on Oral and Maxillofacial Pathology Education (OMP RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology implemented January 1, 2014 and noted 14 oral and maxillofacial pathology site visits have been conducted between January 1, 2014 through August 5, 2021. One (1) area of non-compliance was cited during the reporting period, which was under Standard 4-5.3 related to trainees actively participating in the gross and microscopic examination of surgical and necropsy specimens. This will serve as the final report on the frequency of citing for the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology implemented on January 1, 2014. Revised Accreditation Standards were adopted August 5, 2021 with immediate implementation.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology (p. 801): The Review Committee on Oral and Maxillofacial Pathology Education (OMP RC) considered the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology implemented August 6, 2021 and noted two (2) oral and maxillofacial pathology site visits have been conducted between August 6, 2021 through October 31, 2022. To ensure confidentiality, Frequency of Citings reports will not be made available where a limited number (three or less) of programs have been site visited. Once there are four (4) or more site visits of oral and maxillofacial pathology programs, the non-compliance citings will be analyzed and summarized accordingly.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 802):
At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input.
from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

**Charter/License to Operate and Offer Instruction:** The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs **must** be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): **Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.** The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or
federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 802) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 802), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the OMP RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as proposed revision to Standards related to institutional sponsors to include health care organizations and a new requirement related to authority to operate, confer a certificate and, as applicable, confer a degree.

The OMP RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the OMP RC believed that the inclusion of the proposed definition and revisions in the Oral and Maxillofacial Pathology Accreditation Standards should have no impact on oral and maxillofacial pathology education programs. The OMP RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

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

Matters related to more than one review committee are included in a separate report.
CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE
COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORAL AND
MAXILLOFACIAL PATHOLOGY EDUCATION

No site visitor nominations were considered at this meeting.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Neel Bhattacharyya
Chair, Review Committee on Oral and Maxillofacial Pathology Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are strucken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

**Health Care Organization:** A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs
conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Sanjay Mallya. Committee Members: Dr. Boris Bacanurschi, Dr. King Chong Chan, Dr. Karen Parker-Davidson, and Dr. Sindhura Anamali Reddy. Guests (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education; Ms. Yesenia Ruiz, manager, Advanced Dental Education; Ms. Bridget Blackwood, senior project assistant, and Ms. Michele Kendall, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Oral and Maxillofacial Radiology Education (OMR RC) was held on July 10, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology (p. 900): The Review Committee on Oral and Maxillofacial Radiology Education (OMR RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology implemented August 2, 2019 and noted that one (1) oral and maxillofacial radiology site visit was conducted from August 2, 2019 through October 31, 2022. To ensure confidentiality, Frequency of Citings reports will not be made available where a limited number (three or less) of programs have been site visited. Once there are four (4) or more site visits of oral and maxillofacial radiology programs, the non-compliance citings will be analyzed and summarized accordingly.

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

Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology (p. 901): At its Summer 2022 meeting, the Review Committee on Oral and Maxillofacial Radiology Education (OMR RC) considered a proposed revision to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology submitted by the American Association of Oral and Maxillofacial Radiologists (AAOMR) related to assurance that graduates are familiar with intended applications and limitations of artificial and augmented intelligence-based approaches in dentomaxillofacial imaging. The OMR RC discussed artificial and augmented intelligence (AI), noting that it is a growing field with applications in dentistry and oral and maxillofacial radiology. Further, the committee considered the potential uses of AI including clinical data-driven decision making, identification of radiologic anatomy and disease manifestations, as well as image enhancement to reduce artifacts and noise. In addition, the OMR RC noted that as the use of AI-based systems increases, oral and maxillofacial radiologists will need to be familiar with the basic principles of artificial intelligence (AI)/machine learning (ML), the accuracy and performance of AI-based systems and models, the common training errors and evaluation
methods for these systems, and the liabilities associated with detection and identification of dentomaxillofacial pathoses.

The OMR RC concluded that the addition of this concept within the Accreditation Standards is appropriate and determined that graduates of oral and maxillofacial radiology programs must have an understanding of the intended applications and limitations of artificial and augmented intelligence-based approaches in dentomaxillofacial imaging. In doing so, the Committee believed that programs would receive additional clarity from an intent statement indicating that graduates “will be prepared to serve as a resource to the referring clinician with respect to guiding and discussing optimal application of artificial and augmented intelligence-based approaches in radiology practice.” The OMR RC noted that the addition of a new Standard 4-16 would necessitate renumbering of the subsequent standard.

The OMR RC recommended the proposed addition of a new Standard 4-16 to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology (Appendix 1, Policy Report p. 901) be circulated to the communities of interest for review and comment for a period of one (1) year, with Hearings conducted in conjunction with the October 2022 American Dental Association and March 2023 American Dental Education Association meetings, with comments reviewed at the Commission’s Summer 2023 meetings.

As directed by the Commission, the proposed new Standard 4-16 within the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology was circulated for comment through June 1, 2023. No (0) comments were received at the virtual hearing in conjunction with the ADA meeting and no (0) comments were received at the virtual hearing in conjunction with the ADEA meeting. The Commission office received one (1) written comment prior to the June 1, 2023 deadline (Appendix 2, Policy Report p. 901).

**Summer 2023 Review Committee Meeting:** At this meeting, the Oral and Maxillofacial Radiology Review Committee considered the proposed new Standard 4-16 within the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology and the written comment received prior to the June 1, 2023 deadline, noting the written comment was supportive of the addition of the proposed Standard 4-16. Upon conclusion of the discussion, the OMR RC determined the new Standard 4-16 should be approved as circulated and recommended an implementation date of July 1, 2024.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed new Standard 4-16 within the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology (Appendix 1) and related documents for implementation July 1, 2024.

**Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 902):** At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.
The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input.
from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs **must** be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs
conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 902) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 902), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the OMR RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as proposed revision to Standards related to institutional sponsors to include health care organizations and a new requirement related to authority to operate, confer a certificate and, as applicable, confer a degree.

The OMR RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the OMR RC believed that the inclusion of the proposed definition and revisions in the Oral and Maxillofacial Radiology Accreditation Standards should have little to no impact on oral and maxillofacial radiology education programs. The OMR RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 2, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.
CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION

No site visitor nominations were considered at this meeting.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Sanjay Mallya
Chair, Review Committee on Oral and Maxillofacial Radiology Education
At its Summer 2022 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2023, for review at the Summer 2023 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from August 5, 2022 to June 1, 2023.

This document will be considered by the Commission in Summer 2023.

Additions are Underlined; Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology
STANDARD 4 – CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of Evidence to demonstrate compliance may include:
- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or “searching publication databases and appraisal of the evidence”)
  - Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

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

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

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

If an institution and/or program enrolls part-time students/residents, the institution/program must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis must ensure that: (1) the educational experiences, including the clinical experiences and
responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

PROGRAM DURATION

4-1 The duration of an advanced oral and maxillofacial radiology program must be a minimum of 24 months full-time or its equivalent.

4-2 Students/residents must be enrolled on, at least, a half-time basis.

ETHICS AND PROFESSIONALISM

4-3 Graduates must be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

CLINICAL ORAL AND MAXILLOFACIAL RADIOLOGY

4-4 Students/Residents must assume major responsibility for interpretations and consultative reports on an adequate number of imaging studies of sufficient variety to be competent, as graduates, in clinical oral and maxillofacial radiology.

4-5 Clinical oral and maxillofacial radiology case conferences must be held an average of, at least, once every two weeks.

Intent: The intent is to ensure that graduates understand and can explain the underlying principles of interpretation of disease processes.

4-6 Students/residents must participate in regularly scheduled literature reviews.

Intent: Graduates will have an in-depth knowledge of the current literature in oral and maxillofacial radiology.

ORAL AND MAXILLOFACIAL DIAGNOSTIC IMAGING TECHNIQUES

4-7 Training in oral and maxillofacial diagnostic imaging techniques must be provided to the students/residents with adequate instruction and supervision.
Graduates must be competent in the procedures performed in oral and maxillofacial radiology including, but not limited to: (a) intraoral, (b) panoramic, (c) cephalometric and other skull projections, and (d) cone-beam computed tomography/volumetric imaging.

Graduates must have an in-depth knowledge of other imaging techniques applicable to oral and maxillofacial radiology, including, but not limited to: (a) multi-slice/detector computed tomography, (b) magnetic resonance imaging, (c) diagnostic ultrasonography, and (d) nuclear medicine imaging techniques.

**Intent:** Programs will provide students/residents with an in-depth knowledge of the technical procedures to acquire these studies but not necessarily experience in independent acquisition of these studies.

Graduates must understand administrative procedures associated with the directorship of an oral and maxillofacial radiology facility.

**Intent:** Graduates of oral and maxillofacial radiology programs will be prepared to assume the administrative responsibilities to direct a radiology facility.

**ASSOCIATED MEDICAL SCIENCES**

The program must provide advanced education in head and neck anatomy, and oral and maxillofacial pathology.

**EVALUATION AND RADIOLOGIC MANAGEMENT OF PATIENTS**

The program must provide students/residents with an understanding of and experience in the clinical manifestations of head and neck diseases and head and neck manifestations of systemic diseases as an important facet of the training and practice of oral and maxillofacial radiology.

Students/Residents must attend head and neck tumor board or a similar institutional interdisciplinary conference which includes radiology on a regular basis, but at least monthly.

Graduates must be competent in designing appropriate radiologic studies.

**Intent:** Graduates of oral and maxillofacial radiology programs will be prepared to serve as a resource to the referring clinician with respect to selecting the optimum examination.

The clinical training of oral and maxillofacial radiology students/residents in the routine activities of a screening/emergency or treatment planning clinics must be minimized.

Oral and Maxillofacial Radiology Standards
4-16 **Graduates must** understand intended applications and limitations of artificial and augmented intelligence-based approaches in dentomaxillofacial imaging.

*Intent:* Graduates of oral and maxillofacial radiology programs will be prepared to serve as a resource to the referring clinician with respect to guiding and discussing optimal application of artificial and augmented intelligence-based approaches in radiology practice.

**MEDICAL RADIOLOGY**

4-1617 The program **must** provide for a meaningful period of education in medical radiology in an active, hospital-based radiology department or other similar facility of, at least, three months duration, or its part-time equivalent.

*Intent:* The practice of oral and maxillofacial radiology calls for the association, cooperation and frequent consultation with medical radiologists (general, head and neck, and/or neuroradiology). An understanding of the broad scope of radiology is important.

**RADIATION AND IMAGING PHYSICS**

4-1718 **Graduates must** understand radiation physics including the basic imaging physics of: (a) analog and digital oral and maxillofacial radiography; (b) cone-beam computed tomography/volumetric imaging; (c) multi-slice computed tomography; (d) magnetic resonance imaging; (e) diagnostic ultrasonography; (f) nuclear medicine; and (g) image enhancement analysis concepts associated with diagnostic imaging.

**RADIATION BIOLOGY**

4-1819 **Graduates must** have an in-depth knowledge of the biological effects of ionizing radiations.

*Intent:* Graduates will be able to describe both the biological changes and the clinical consequences of exposure to ionizing radiations.

**RADIATION PROTECTION**

4-1920 **Graduates must** have an in-depth knowledge of radiation protection and/or hygiene.

*Intent:* Graduates will be prepared to eliminate unnecessary exposure of patients, operators and the general public.

**TEACHING EXPERIENCE**

4-2021 A program in oral and maxillofacial radiology **must** include an organized teaching experience for students/residents with formal evaluation.
The amount of time devoted by the student/resident to teaching experience must be carefully evaluated and not exceed ten percent (10%) of the overall program.
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are strucken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health
Service (IHS), Veterans Health Administration system (VA), or academic health center/medical
center/ambulatory care center (both public and private) that is accredited by an agency
recognized by the United States Department of Education or accredited by an accreditation
organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission
Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

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

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL SURGERY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. George Kushner. Committee Members: Dr. Vasiliki Karlis, Dr. John Manahan (limited attendance, July 11, 2023), Dr. Pushkar Mehra, Dr. Jan Mitchell, Dr. Faisal Quereshy (limited attendance, July 11, 2023; unable to attend July 18, 2023). Guests (Open Session Only, Virtual): Dr. Paul Schwartz, president, American Association of Oral and Maxillofacial Surgeons (AAOMS), Dr. David Morrison, vice president, AAOMS, Ms. Mary Allaire-Schnitzer, associate executive director, AAOMS, and Ms. Laurie Oddo, manager, Advanced Education and Resident Affairs, AAOMS. Commission Staff: Ms. Yesenia Ruiz, manager, Advanced Dental Education, Dr. Sherin Tooks, senior director, and Ms. Peggy Soeldner, manager, Advanced Dental Education, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) was held on July 11, 2023 and July 18, 2023, via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL AND MAXILLOFACIAL SURGERY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (p. 1000): The Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) considered the annual report on the frequency of citings of Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery implemented February 12, 2021, and noted there were sixteen (16) citings, in the areas of Standard 2 Program Director and Teaching Staff (four citings), and Standard 4 Curriculum and Program Duration (12 citings). The most frequently cited standard with four (4) citings occurs in Standard 4-11 related to Major Surgery. Due to the limited number of citings, no analysis can be performed at this time.

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

Informational Report on Frequency of Citings of Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery (p. 1001): The Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) considered the annual report on the frequency of citings of Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery. Since implementation of the February 12, 2021, Standards, there have been four (4) site visits. No citings were reported for these site visits.

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

Consideration of Proposed Revisions to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organizations and Authority to Operate (p. 1002): At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.
The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

**Institutional Sponsor (Health Care Organizations):** The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.
The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the
Ad Hoc Committee believed that the prior requirement should be stricken from all advanced
dental education Standards and replaced with a new requirement, which states (underline
indicates addition): **Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.** The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1002) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1002), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) considered the proposed revision to the Accreditation Standards. The OMS RC discussed the objective of the Ad Hoc committee’s work related to organizations that may sponsor advanced dental education programs. Following consideration, the OMS RC did not believe this change to the Standards would impact the oral and maxillofacial surgery programs; however, circulation for a period of public comment for one (1) year is warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.
Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (p. 1003): On October 7, 2022, the Commission on Dental Accreditation (CODA) received a request from Ms. Mary E. Allaire-Schnitzer, associate executive director, on behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS) to consider proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery. At its Winter 2023 meeting, through review of the proposed revisions, the OMS RC discussed that some of the revisions conflicted with Commission policy (e.g., international off-site rotations, authorized enrollment, and reporting educational activity sites) or may conflict with other requirements in the OMS Standards, and thus require further detailed review. The OMS RC noted that the AAOMS education committee has been informed of these conflicting revisions and would further review the proposed revisions through its Committee on Resident Education and Training (CRET). Therefore, the OMS RC believed the discussion of the proposed revisions should be tabled until AAOMS could review the potential revisions in relation to the potential conflicts within the document and with the Commission’s policies. At its Winter 2023 meeting, the Commission concurred with the OMS RC’s recommendation that further consideration of the proposed revisions for the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery be tabled pending further review of the proposed revisions and submission of additional information by the American Association of Oral and Maxillofacial Surgeons to address potential conflicts within the document and with the Commission’s policies.

On June 26, 2023, the Commission on Dental Accreditation received an updated request from Ms. Mary E. Allaire-Schnitzer, associate executive director, on behalf of the AAOMS to consider proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Appendix 1, Policy Report p. 1003).

At this meeting, the Review Committee discussed the revisions and noted many revisions model the wellness standards of the Accreditation Council of Graduate Medical Education (ACGME). There was an in-depth discussion on proposed OMS Standard 4-21.4 “The program must have policies and procedures which allow residents leaves of absence from work in order to address issues not limited to fatigue, illness, family emergencies and parental leave.” The Committee discussed the Commission’s expectation, as noted in CODA Oral and Maxillofacial Surgery Standards, noting all residents who graduate from CODA-accredited oral and maxillofacial surgery programs must attend the full scope and length of the CODA-accredited program. Therefore, the Committee affirmed that a resident who requires leave would require an extension of training in the program. Following discussion, the OMS RC believed the proposed revisions (Appendix 2) should be circulated for one (1) year for public comment.

Recommendation: It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery, found in Appendix 2, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA)
NEW BUSINESS

Consideration of the Policy on Enrollment Increases in Advanced Dental Education Programs in Oral and Maxillofacial Surgery: The Oral and Maxillofacial Surgery Review Committee (OMS RC) discussed the Commission’s Policy on Enrollment Increases in Advanced Dental Education Programs, particularly as it relates to the need to extend a resident’s educational program in oral and maxillofacial surgery. The Committee noted that, on occasion, a resident may require a short-term extension of their program due to prior illness, time away, incomplete program requirements, remediation, or other factors. Currently, the program must report a temporary, one-time only, increase in authorized enrollment to the Commission, which will be considered by the Review Committee and Commission at the next scheduled meeting. It was noted that a resident’s extended curriculum may be over by the time the Commission considers the temporary, one-time only enrollment increase. The Committee believed that a temporary, one-time only increase not to exceed six (6) months could be reviewed and approved by the OMS RC Chair, using the same required guidelines for reporting an enrollment increase and providing evidence of sufficient procedures to support the temporary increase. The administrative review by the RC Chair would permit programs to obtain CODA’s approval in an expedited fashion. If the program did not demonstrate sufficient resources, or if the temporary, one-time only enrollment increase would exceed six (6) months, the program would be required to submit a report for consideration by the Review Committee and Commission at its next scheduled meeting.

Following discussion, the OMS RC believed a revision to CODA’s Policy on Enrollment Increases in Advanced Dental Education Programs was warranted at this time. The Committee also noted that additional advanced dental education disciplines under the Commission’s purview may wish to consider this modification. Nonetheless, the OMS RC believed the modification in policy was appropriate for oral and maxillofacial surgery education and recommended immediate implementation by the Commission of the proposed revision noted below.

(Addition is Underlined)

POLICY ON ENROLLMENT INCREASES IN ADVANCED DENTAL EDUCATION PROGRAMS

An advanced dental education program considering or planning an enrollment increase, or any other substantive change, should notify the Commission early in the program’s planning. Such notification will provide an opportunity for the program to seek consultation from Commission staff regarding the potential effect of the proposed change on the accreditation status and the procedures to be followed.
The following advanced dental education disciplines have authorized total complement enrollment: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery (per year enrollment is authorized), orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics. Programs with authorized enrollment must use the discipline-specific Guidelines to request and obtain approval for an increase in enrollment prior to implementing the increase.

Oral and maxillofacial surgery programs may, from time to time, require a temporary, one-time only increase in enrollment to permit a resident to complete a program, which was extended beyond the program’s regular completion date. A program must use the discipline-specific Guidelines to request a temporary, one-time only increase in enrollment prior to implementing the increase. Upon submission of the program change report, a temporary, one-time only increase in program enrollment of up to a maximum of six (6) months may be reviewed and approved by the Oral and Maxillofacial Surgery Review Committee Chair, if the program provides evidence of sufficient resources and procedures to support the temporary increase. If the temporary, one-time only increase in enrollment may not be adequately supported, as determined by preliminary review by the discipline-specific Review Committee Chair, prior approval by CODA will be required and the report will be considered at the next regularly scheduled Commission meeting.

The following advanced dental education disciplines do not have authorized enrollment: advanced education in general dentistry, general practice residency, dental anesthesiology, oral medicine, and orofacial pain. However, approval of an increase in enrollment in these advanced dental education programs must be reported to the Commission if the program’s total enrollment increases beyond the enrollment at the last site visit or prior approval of enrollment increase. Programs must use the discipline-specific Guidelines to request an increase in enrollment prior to implementing the increase. Upon submission of the program change report, a substantial increase in program enrollment as determined by preliminary review by the discipline-specific Review Committee Chair, will require prior approval by CODA.

A request for an increase in enrollment with all supporting documentation must be submitted in writing to the Commission by May 1 or November 1. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents. Failure to comply with this policy will jeopardize the program’s accreditation status, up to and including withdrawal of accreditation.

Requests for retroactive permanent increases in enrollment will not be considered. The Commission may consider retroactive temporary enrollment increases due to special circumstances on a case-by-case basis, including, but not limited to:

- Student/Resident extending program length due to illness, parental leave, incomplete projects/clinical assignments, or concurrent enrollment in another program;
• Unexpected loss of an enrollee and need to maintain balance of manpower needs;
• Urgent manpower needs demanded by U.S. armed forces; and
• Natural disasters.

If a program has enrolled beyond the approved number of students/residents without prior approval by the Commission, the Commission may or may not retroactively approve the enrollment increase without a special focused site visit at the program’s expense.

If the focused visit determines that the program does not have the resources to support the additional student(s)/resident(s), the program will be placed on “intent to withdraw” status and no additional student(s)/resident(s) beyond the previously approved number may be admitted to the program until the deficiencies have been rectified and approved by the Commission. Student(s)/Resident(s) who have already been formally accepted or enrolled in the program will be allowed to continue.

Revised: 8/23; 2/22; 8/20; 1/20; 8/18; 8/16; 2/16; 8/15; 8/10; Reaffirmed: 7/07; CODA: 08/03:22

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Policy on Enrollment Increases in Advanced Dental Education Programs (noted above), with immediate implementation.

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

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

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORAL AND MAXILLOFACIAL SURGERY EDUCATION**

Due to an ongoing need for additional site visitors, the Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

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

Respectfully submitted,

Dr. George Kushner
Chair, Review Committee on Oral and Maxillofacial Surgery Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

**Health Care Organization:** A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTOLOGY, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).
Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
Commission on Dental Accreditation

Proposed Revision to Standards

Additions are Underlined
Strikethroughs indicate Deletions

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

Commission on Dental Accreditation
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Mission Statement of the
Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and dental professions by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Commission on Dental Accreditation
Adopted: August 5, 2016; Revised August 6, 2021
ACCREDITATION STATUS DEFINITIONS

PROGRAMS THAT ARE FULLY OPERATIONAL:

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

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

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

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

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

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

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for

Oral and Maxillofacial Surgery Standards
meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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

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

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

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all disciplines of advanced dental education, institutions and programs. Each discipline develops discipline-specific standards for educational programs in its discipline. The general and discipline-
specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.

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

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

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

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Oral and Maxillofacial Surgery Accreditation Standards

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

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

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

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

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

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

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

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

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

**In-depth**: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.
Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

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

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

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

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

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

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

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

Oral and Maxillofacial Surgery Terms:

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

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

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

Board Certified: as defined by the American Board of Oral and Maxillofacial Surgery.
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

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

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

Example of Evidence to demonstrate compliance may include:

- OMSITE

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

Example of Evidence to demonstrate compliance may include:

- OMSITE

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

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

• Written agreement(s)
• Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

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

United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria.
The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters must rest within the sponsoring institution. The institution/program must have a formal system of quality assurance for programs that provide patient care.

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

Examples of evidence to demonstrate compliance may include:

- Clinic assignment schedule
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

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

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

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

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

**Intent:** An “institution (or organizational unit of an institution)” is defined as a dental, medical or public health school, patient care facility, or other entity (e.g., OMS practice facility) that engages in advanced dental education. The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

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

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

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Accreditation of Off-Campus Sites found in the Evaluation and Operational Policies and Procedures manual (EOPP).
1-11 The program and sponsoring institution’s collaborative responsibilities must include an ongoing effort for recruitment and retention of a diverse and inclusive workforce of faculty, residents and staff.

Examples of evidence to demonstrate compliance may include:
- Nondiscriminatory policies and practices at all organizational levels.
- Mission and policy statements which promote diversity and inclusion.
- Evidence of training in diversity, inclusion, equity, and belonging.
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

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

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

The responsibilities of the program director must include:

2-1.1 Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.
2-1.2 Ensuring the provision of adequate physical facilities for the educational process.

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

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

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

**Examples of evidence to demonstrate compliance may include:**
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

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

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

**Examples of evidence to demonstrate compliance may include:**
- Copies of faculty meeting minutes
- Sign-in sheets
- Monthly records of outpatient visits by category
- Resident surgical logs/other electronic record databases
- Evaluations of teaching staff
2-1.7  The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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

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

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

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

Examples of evidence to demonstrate compliance may include:
- Written evaluations from faculty and the chair of the program director and teaching staff.
- Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.
- External evaluations of culture, climate, and learning environment.
• Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation.
• Policies and requirements that promote an optimal educational experience, working culture and environment.

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:
• Faculty coverage for clinic, operating room and call schedules
• Patient records

2-2.2 In addition to the full time program director, the teaching staff must have at least one full time equivalent oral and maxillofacial surgeon as defined by the institution per each authorized senior resident position. One of the teaching staff who is not the program director must be at least half-time faculty as defined by the institution.
2-2.3 Eligible oral and maxillofacial surgery members of the teaching staff, with greater than a .5 FTE commitment appointed after January 1, 2000, who have not previously served as teaching staff, must be diplomates of the American Board of Oral and Maxillofacial Surgery or in the process of becoming board certified. Foreign trained faculty must be comparably qualified.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the oral and maxillofacial surgery faculty. Examples of Evidence to demonstrate compliance may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;

b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media; and

c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.

2-4 The program must show evidence of an ongoing faculty development process.

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

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care

Oral and Maxillofacial Surgery Standards
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Student/Resident assessment
Cultural Competency
Ability to work with students/residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities
Consistent faculty use of a national curriculum (e.g., SCORE).
Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.
STANDARD 3 – FACILITIES AND RESOURCES

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

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

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

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

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

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

All residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

**Intent:** Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.
The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.

3-1 Clinical facilities must be properly equipped for performance of all ambulatory oral and maxillofacial surgery procedures, including administration of general anesthesia and sedation for ambulatory patients.

3-2 There must be a space properly equipped for monitoring patients' recovery from ambulatory surgery, general anesthesia and sedation.

3-3 An adequate and accessible dental laboratory facility must be available to the residents to utilize for patient care.

3-4 Adequate onsite computer resources with internet access must be available to the residents.

3-5 Adequate on call facilities must be provided to residents when fulfilling in-house call responsibilities.

3-6 Adequate and accessible diagnostic imaging facilities must be available to residents to utilize for patient care.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of Evidence to demonstrate compliance may include:

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

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

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

If an institution and/or program enrolls part-time residents, the institution must have guidelines regarding enrollment of part-time residents. Part-time residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited
program who enrolls residents on a part-time basis must ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time residents; and (2) there are an equivalent number of weeks spent in the program.

4-1 An advanced dental education program in oral and maxillofacial surgery must encompass a minimum duration of four (4) years of full-time study.

4-2 Each resident must devote a minimum of 120 weeks to clinical oral and maxillofacial surgery.

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

Examples of evidence to demonstrate compliance may include:

- Complete schedule of resident activity

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

**Intent:** Senior level responsibility means residents serving as first assistant to attending surgeon on major cases. Resident serves as first assistant for the majority of surgical procedures performed during this rotation. They are to be present for most pre- and post-operative patient visits.

4-2.2 Rotations to affiliated institutions outside the United States and Canada must not be used to fulfill the core 120 weeks clinical oral and maxillofacial surgery training experience. Surgical procedures performed during foreign rotations must not count toward fulfillment of the 175 major surgical procedures.

4-2.3 Rotations to a private practice must not be used to fulfill the core 120 weeks of clinical oral and maxillofacial surgery training experience must not exceed 4 weeks.

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- Lecture schedules
- Curriculum; behavioral objectives
- Attendance sign-in sheets
- Policy of anesthesia department related to on-call participation by residents if residents are not permitted to be on-call
- Rotation schedules
- **Consistent use of a national curriculum (e.g., SCORE).**
- **Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.**
4-3.1 Anesthesia and Medical Service:

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

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

Examples of evidence to demonstrate compliance may include:

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

4-3.2 Surgical Service:

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

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

- Resident rotation schedules

4-3.3 Other Rotations:

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

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

PHYSICAL DIAGNOSIS

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

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

- Course outlines
- Course syllabi
- Course schedules

**CLINICAL ORAL AND MAXILLOFACIAL SURGERY**

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

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

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

Examples of evidence to demonstrate compliance may include:

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

**MINIMUM CLINICAL REQUIREMENTS**

**OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE**

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

**Intent:** Residents are to participate in outpatient care activities.

Examples of evidence to demonstrate compliance may include:
- Resident rotation schedules
- Outpatient clinic schedules
- Outpatient surgery case log
- Dentoalveolar-related didactic course materials

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

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

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

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

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

4-8.2 The training program must include didactic and clinical experience in the comprehensive management of temporomandibular disorders and facial pain.
Examples of evidence to demonstrate compliance may include:

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

GENERAL ANESTHESIA AND DEEP SEDATION

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

Examples of evidence to demonstrate compliance may include:

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

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

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

Examples of evidence to demonstrate compliance may include:

- Resident’s anesthetic log.
• Clinical tracking system.
• Anesthesia records.
• Oral and Maxillofacial Surgery Benchmarks

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

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

Examples of evidence to demonstrate compliance may include:

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

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

Examples of evidence to demonstrate compliance may include:

• Didactic Schedules
• Resident Anesthetic Logs
• Detailed curriculum plans
• Patient charts
• Simulation experience
• Consistent use of a national curriculum (e.g., SCORE).
• Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.
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Oral and Maxillofacial Surgery RC
CODA Summer 2023

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

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

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

Examples of evidence to demonstrate compliance may include:

* ACLS certification records and cards

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

Examples of evidence to demonstrate compliance may include:

* PALS certification records and cards

ADMISSIONS

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

MAJOR SURGERY

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

**Intent:** Pathology of the temporomandibular joint includes, but is not limited to, internal derangement arthritis, post-traumatic dysfunction, and neoplasms. Management of temporomandibular joint pathology may include medical or outpatient procedures. Other Pathology management includes, but is not limited to, major maxillary sinus procedures, salivary gland/duct surgery, management of head and neck infections, (incision and drainage procedures), and surgical management of benign and malignant neoplasms and cysts.
4-11.3 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.

**Intent:** Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial bones as well as the treatment of obstructive sleep apnea. Surgical procedures in this category include, but are not limited to, ramus and body procedures, subapical segmental osteotomies, Le Fort I, II and III procedures and craniofacial operations. Comprehensive care should include consultation and treatment by an orthodontic specialist when indicated; and a sleep medicine team should be included when indicated. Residents participate in the pre- and post-operative care and intra-operative participation in the treatment of the orthognathic patient and the sleep apnea patient.

Examples of evidence to demonstrate compliance may include:

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

**Intent:** It is expected that in this category there will be both reconstructive and cosmetic procedures performed by residents.
Cosmetic surgery should include but is not limited to three of the following types of procedures: rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty, and scar revision.

Examples of evidence to demonstrate compliance may include:

- Patient records revealing resident experience in reconstructive and cosmetic surgery

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedule on patient record keeping

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

Ethics and Professionalism

4-16 Graduates Residents must receive instruction in the application of the principle of ethical reasoning, and ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.
**Intent:** *Graduates Residents* should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

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

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

Examples of evidence to demonstrate compliance may include:

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

**Patient Safety**

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

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

Examples of evidence to demonstrate compliance may include:

- Documentation of an active, ongoing clinical safety training program. This may include participation in institution-wide programs, or documentation of training in Crew Resource Management, Root Cause Analysis, or other safety-focused protocols
- Formative and summative evaluation of residents’ knowledge of and engagement and compliance with safety initiatives (e.g., use of Benchmarks)
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.
4-18.1 The program must provide resident supervision to promote safe and optimal patient care.

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

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

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

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

Examples of evidence to demonstrate compliance may include:
- Logs of mock emergency drills demonstrating participation by faculty, residents and clinical staff
- Ongoing training using high fidelity simulation adapted to simulate the community-based, ambulatory surgery environment
- Adherence to established emergency preparation recommendations, e.g. the AAOMS Office Anesthesia Evaluation Manual
4-20  The program must routinely employ patient safety tools and techniques in its clinical facilities.

Examples of evidence to demonstrate compliance may include:

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

Wellness

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

Oral and Maxillofacial Surgery Standards
4-21.3 **Resident work hours must be monitored and reviewed.**

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

4-21.4 **The program must have policies and procedures which allow residents leaves of absence from work in order to address issues not limited to fatigue, illness, family emergencies, and parental leave.**
STANDARD 5 - ADVANCED DENTAL EDUCATION RESIDENTS
ELIGIBILITY AND SELECTION

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

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

Specific written criteria, policies and procedures must be followed when admitting residents.

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

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

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

Examples of evidence to demonstrate compliance may include:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge
If the program has determined that graduates of U. S. or Canadian accredited medical schools are eligible for admission, the candidate must obtain a dental degree from a predoctoral dental education program accredited by the Commission on Dental Accreditation prior to starting the final 52 weeks of the required 120 weeks of core OMS training.

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

**EVALUATION**

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

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

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

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

- Cognitive skills;
- Clinical skills;
- Interpersonal skills;
- Patient management skills; and
- Ethical standards.
Examples of evidence to demonstrate compliance may include:

- Rotational evaluations
- Semi-annual summative/formative evaluations
- Oral and Maxillofacial Surgery Benchmarks

5-3 The program director must provide counseling, remediation, censuring, or after due process, dismissal of residents who fail to demonstrate an appropriate level of competence, reliability, or ethical standards.

5-4 The program director must provide a final written evaluation of each resident upon completion of the program. The evaluation must include a review of the resident’s performance during the training program, and must state that the resident has demonstrated competency to practice independently. The final evaluation must be a summative assessment demonstrating a progression of formative assessments throughout the residency program. This evaluation must be included as part of the resident’s permanent record and must be maintained by the institution. A copy of the final written evaluation must be provided to each resident upon completion of the residency.

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

**DUE PROCESS**

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

**RIGHTS AND RESPONSIBILITIES**

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

**Intent**: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a resident (for academic or disciplinary reasons). In addition to information on the program, residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 – RESEARCH

Advanced dental education residents must engage in scholarly activity.

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

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

Examples of evidence to demonstrate compliance may include:

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

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

Examples of evidence to demonstrate compliance may include:

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

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

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in the critical evaluation of scientific literature through journal club or other educational seminars
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.
REPORT OF THE REVIEW COMMITTEE ON ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Brent Larson. Committee Members: Mr. David Cushing, Dr. Sarandeep Huja, Dr. Howard Lieb, Dr. Steven Lindauer, and Dr. Emile Rossouw. Commissioner Trainee: Dr. Glenn Sameshima. Guests (Open Session Only, Virtual): Ms. Michelle Ritterskamp, continuing education senior specialist, American Association of Orthodontists (AAO), and Dr. Sheila Brear chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Commission Staff: Ms. Yesenia Ruiz, manager, Advanced Dental Education, and Dr. Sherin Tooks, senior director, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) was held on July 14, 2023, via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p. 1100): The Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered the annual report on the frequency of citings of Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics implemented January 1, 2014. The ORTHO RC noted that the most frequently cited standards with two (2) citings each were noted in Standard 3 and are related to: 1) continuous recognition/certification in basic life support including cardiopulmonary resuscitation, and 2) adequate secretarial, clerical, dental auxiliary and technology personnel. The remaining citings in the report include one (1) citation. Due to the small number of citings (26 total), no further analysis can be made at this time. The revised Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics was adopted February 12, 2021 and implemented July 1, 2022. Therefore, this report concludes the Frequency of Citings for the January 2014 Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p.1101): The Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered the annual report on the frequency of citings of Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics implemented on July 1, 2022. Since that date, five (5) site visits have been conducted by visiting committees of the Commission utilizing the July 2022 Standards. The ORTHO RC noted the following four (4) Standards were each cited once: Standard 2, Program Director; Standard 2-2, program director position; Standard 2-3, program director sufficient time devoted to the
program; and Standard 3-6 Clinical Facilities. Due to the small number of citings, four (4) total, no further analysis can be made at this time.

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

**Informational Report on Frequency of Citings of Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (p. 1102):**
The Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered the annual report on the frequency of citings of Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics implemented August 7, 2015. Seven (7) site visits have been conducted by visiting committees of the Commission utilizing the August 2015 Standards. The ORTHO RC noted that there were no (0) citings during the period covered by this report.

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

**Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1103):** At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

**Institutional Sponsor (Health Care Organizations):** The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit
United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial
pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure **(Appendix 1, Policy Report p. 1103)** be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.
At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1103, related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered the proposed revision to the Accreditation Standards. The ORTHO RC carefully reviewed the report of the Ad Hoc Committee and the proposed Definition of Terms for “Health Care Organization.” Additionally, the ORTHO RC considered the proposed revisions to Standard 1, related to institutional sponsor, and noted that these changes are intended to ensure the educational validity of the institution sponsoring the advanced dental education program. The Review Committee also believed that the definition of health care organization helps better clarify which organizations would be eligible to sponsor advanced dental education programs. The ORTHO RC also noted the shifting of language and further clarity of expectations that the sponsor of an advanced dental education program has the authority to confer a certificate or degree. Following consideration, the ORTHO RC believed the proposed revisions should be circulated for a period of one (1) year for comment by CODA’s communities of interest, with further consideration by the Review Committee and Commission in Summer 2024.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

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

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

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION**

Due to an ongoing need for additional site visitors, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**
Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Brent Larson
Chair, Review Committee on Orthodontics and Dentofacial Orthopedics Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFacial ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).
Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
CONSIDERATION OF MATTERS RELATED TO PEDIATRIC DENTISTRY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (p. 1200): The Review Committee on Pediatric Dentistry Education (PED RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry implemented July 1, 2013. The report indicated that 110 site visits have been conducted from July 1, 2013 through June 30, 2021 and that the most frequently cited pediatric dentistry-specific area of non-compliance, with 20 citings, is found in Standard 4 related to advocacy. Standard 4-26, related to didactic instruction was cited a total of 9 times. Each area of compliance in Standard 4-26 was cited 3 times and includes didactic instruction in: a) the fundamental domains of child advocacy; b) federally and state funded programs; and c) principles of education. Standard 4-27, related to clinical experiences in advocacy, was cited a total of 11 times. The specific citings relate to clinical experiences in: a) communicating, teaching and collaborating with groups and individuals with 3 citings; b) advocating and advising public health policy legislation and regulations with 4 citings; and c) participating at the local, state and national level in organized dentistry to represent the oral health needs of children with 4 citings. The PED RC noted this will serve as the final report on the frequency of citings for the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry implemented on January 1, 2013. Revised Accreditation Standards were adopted August 7, 2020 with implementation July 1, 2021.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (p. 1201): The Review Committee on Pediatric Dentistry (PED RC) considered the report on the frequency of citings of the
Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry implemented July 1, 2021. Since the implementation date, 22 site visits have been conducted by visiting committees of the Commission from July 1, 2021 through October 31, 2022. The report indicates a total of 7 citings of non-compliance have been made, and the most frequently cited pediatric dentistry-specific area of non-compliance, with 2 citings, is Standard 4-6b2a, completing a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used, of which each student/resident acting as sole primary operator in a minimum of 25 sedation cases. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

**Consideration of Proposed Revisions to Anesthesia Standards of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (p. 1202):** At its August 2021 meeting, the Commission on Dental Accreditation directed the establishment of a multidisciplinary Ad Hoc Committee composed of current and former Pediatric Dentistry Review Committee members as well as representation from the Dental Anesthesiology Review Committee and the Oral and Maxillofacial Surgery Review Committee to study the use of sedation in patient management, including the potential need for revision of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, as applicable, with a report to the Commission in Winter 2022.

The Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards held two (2) meetings in November 2021 and determined that a definition of “Sole Primary Operator” should be added to the Definition of Terms within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry. Additionally, the Ad Hoc Committee determined that an intent statement should be added to Pediatric Dentistry Standard 4-7 to clarify that “Each patient encounter shall have only one (1) sole primary operator.” At its Winter 2022 meeting, the PED RC recommended adoption of these revisions with immediate implementation, and the Commission concurred.

The Ad Hoc Committee also believed that additional meetings were required to discuss outstanding issues related to its charge, with the inclusion of an additional member to provide further perspectives on the American Academy of Pediatric Dentistry anesthesia guidelines. As such, at its Winter 2022 meeting, the PED RC also recommended, and the Commission concurred, that the Commission invite the American Academy of Pediatric Dentistry’s Chair of the Council on Clinical Affairs, Committee on Sedation and Anesthesia to join the Ad Hoc Committee as an additional member to provide a perspective on the potential revision to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry related to anesthesia education for pediatric dentistry. The Commission further directed the Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards to continue its review of pediatric dentistry Accreditation Standards which may warrant revision, with a report to the Commission in Summer 2022.
The Ad Hoc Committee held two (2) additional meetings in May and June 2022. As the discussion continued, the Ad Hoc Committee reviewed components of Pediatric Dentistry Standard 4-7a and b, suggesting the revisions. The proposed revisions differentiate “minimal” and “moderate” sedation. The Committee also determined that the age of pediatric dentistry patients should be clarified to “patients 13 or under.” Further, of the sedation cases not performed as the sole primary operator, beyond those 15 encounters that must involve direct patient care, the remaining may include simulation experiences. The Ad Hoc Committee thoroughly considered the use of simulation in health care education. The Committee noted educational “simulation” methods ranging from written case studies that only address knowledge through simulation methods using high-fidelity mannequins that simulate a real patient experience and assess knowledge and hands-on skill. It was noted that, if used appropriately, simulation that models that real patient experience may provide a valid educational tool. The Ad Hoc Committee believed that case-based written and/or discussion simulation activities are not appropriate methods through which knowledge and skill can be fully assessed.

The Ad Hoc Committee further noted that in September 2011, the Association of American Medical Colleges (AAMC) published the “Medical Simulation in Medical Education: Results of an AAMC Survey” in which the AAMC, for the purpose of the survey, defined “simulation.” Following discussion, the Ad Hoc Committee believed that the AAMC’s definition should be added to the Definition of Terms in reference to simulation activities that are permitted within the Accreditation Standards for pediatric dentistry programs.

The Ad Hoc Committee also concluded and recommended that, with future enhancements in technology and changes in educational models, the Commission further study simulation and its implications to dental and dental-related education programs as it relates to all disciplines within the Commission’s purview, through formation of an Ad Hoc Committee representing all disciplines, with a future report to the Commission.

At its Summer 2022 meeting, the PED RC carefully considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry submitted by the Ad Hoc Committee. Following discussion, the PED RC supported the proposed revisions to the standards submitted by the Ad Hoc Committee and recommended that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 1, Policy Report p. 1202) be circulated to the communities of interest for review and comment, with Hearings held in conjunction with the October 2022 American Dental Association and March 2023 American Dental Education Association meetings, with comments reviewed at the Commission’s Summer 2023 meetings. The PED RC further believed that the Commission should study simulation and its implications to dental and dental-related education programs as it relates to all disciplines within the Commission’s purview, through formation of an Ad Hoc Committee representing all disciplines, with a future report to the Commission.
As directed by the Commission, the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 1, Policy Report p. 1202) were circulated for comment through June 1, 2023. No (0) comments were received at the virtual hearing in conjunction with the ADA meeting and no (0) comments were received at the virtual hearing in conjunction with the ADEA meeting. The Commission office received 20 written comments prior to the June 1, 2023 deadline.

**Summer 2023 Review Committee Meeting:** At this meeting, the Pediatric Dentistry Review Committee considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 1, Policy Report p. 1202) and the comments received prior to the June 1, 2023 deadline (Appendix 2, Policy Report p. 1202).

Through review of the written comments received, the PED RC noted several from the state of California related to the state’s requirement for minimal and moderate sedation permits. The comments indicated that because of the administrative and financial costs of obtaining the sedation permits, the proposed revisions requiring minimal and moderate sedation experience could place an undue burden on clinical faculty who supervise residents, especially at affiliated clinical sites.

Other comments addressed the proposed revisions related to required patient encounters in which sedative agents are used and their relation to the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students, particularly as they relate to providing sedation to patients eight (8) years of age or younger. The comments indicated that the requirements in the Standards are less stringent than the ADA Guidelines and that the Accreditation Standards should at least meet or exceed the ADA Guidelines to ensure pediatric dentistry program graduates have more advanced training requirements than that of dental students or general dentists.

Following lengthy discussion, the PED RC believed the proposed revisions require further consideration and should not be approved at this time. Therefore, the PED RC recommended that a workgroup of the members of the Review Committee, including the current and incoming Review Committee chair, further consider the proposed revisions with a report to the Winter 2024 meetings of the PED RC and Commission.

Additionally, because the continued study of the Standards includes ensuring the requirements align with the ADA Guidelines, the PED RC believed it would be beneficial to consult, as needed, with one (1) of the pediatric dentists who was involved in the development of the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students. The PED RC recommended that Commission direct this consultation, as needed.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct continued review of the proposed revisions to the pediatric dentistry Accreditation Standards related to the use of sedation in patient management, through appoint of a workgroup composed of members of the Review Committee, including the current and
incoming chair, with a report to the Winter 2024 meeting of the Pediatric Dentistry Review Committee and Commission.

It is further recommended that the Commission on Dental Accreditation direct that the pediatric dentistry workgroup to study the use of sedation in patient management within the Pediatric Dentistry Standards include, as needed, consultation with a pediatric dentist who was involved in the development of the current ADA Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students.

**Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1203):** At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

**Institutional Sponsor (Health Care Organizations):** The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in
the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing
often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1203) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1203), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the PED RC considered the proposed revisions, as directed by the Commission. The PED RC also briefly discussed the background that led to the formation of the Ad Hoc Committee
to study the changing landscape of health care delivery centers that may sponsor advanced dental education programs. The PED RC noted the proposed revisions include a proposed Definition of Terms for Health Care Organization, as well as proposed revision to Standards related to institutional sponsors to include health care organizations and a new requirement related to authority to operate, confer a certificate and, as applicable, confer a degree.

The PED RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and the requirements related to the authority to operate. Further, the PED RC believed that the inclusion of the proposed definition and revisions in the Pediatric Dentistry Accreditation Standards could have a positive impact on the discipline by expanding the types of institutions that are eligible to sponsor pediatric dentistry programs. Therefore, the PED RC recommended the circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1 to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

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

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

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PEDIATRIC DENTISTRY EDUCATION**

Due to an ongoing need for additional site visitors, the Review Committee on Pediatric Dentistry Education (PED RC) considered site visitor nominations at this meeting. The Committee’s recommendations on the nominations 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. Joel Berg
Chair, Review Committee on Pediatric Dentistry Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

**Health Care Organization:** A Federally Qualified Health Center (FQHC), Indian Health
Service (IHS), Veterans Health Administration system (VA), or academic health center/medical
center/ambulatory care center (both public and private) that is accredited by an agency
recognized by the United States Department of Education or accredited by an accreditation
organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXilloFACIAL PATHOLOGY, ORAL AND MAXilloFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXilloFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval
to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

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

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON PERIODONTICS EDUCATION TO
THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Paul Luepke. Committee Members: Dr. Wayne Kye, Dr. A.C. Liles, III, Dr. Angela Palaiologou-Gallis, Dr. Vishal Shah, and Dr. Dimitris Tatakis. Guests (Open Session Only, Virtual): Dr. Nicholas Geurs, education consultant, American Academy of Periodontology (AAP), Ms. Stephanie Heffner, staff director, AAP, and Dr. Sheila Brear, chief learning officer, American Dental Education Association (limited attendance), attended the policy portion of the meeting. Commission Staff: Ms. Yesenia Ruiz, manager, Advanced Dental Education, Ms. Peggy Soeldner, manager, Advanced Dental Education, and Dr. Sherin Tooks, senior director, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Periodontics Education (PERIO RC) was held on July 13, 2023, via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO PERIODONTICS EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Periodontics (p. 1300): The Review Committee on Periodontics Education (PERIO RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Periodontics implemented January 1, 2014. The PERIO RC noted there were 28 citings total. The most frequently cited standard, with seven (7) citings, occurred under Standard 4-11b, related to clinical training to the level of competency in adult minimal enteral and moderate parenteral sedation as prescribed by the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. Four (4) citings occurred under Standard 4-10.2d regarding the provisionalization of dental implants. Two (2) citings were noted under Standard 4-11a, related to in-depth knowledge in all areas of minimal, moderate and deep sedation as prescribed by the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. There were also two (2) citings under Standard 4-13.1, which states that the use of private office facilities not affiliated with a university as a means of providing clinical experiences is not approved.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1301): At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022, and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure
to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

**Institutional Sponsor (Health Care Organizations):** The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.
Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to
confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1301) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1301), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the Review Committee on Periodontics Education (PERIO RC) considered the proposed revisions to the Accreditation Standards, noting the Definition of Terms for “Health Care Organization” and the revisions related to institutional sponsorship of programs. The PERIO RC discussed the history of the Ad Hoc Committee and rationale for the development of the proposed revisions. Following consideration, the PERIO RC believed the proposed revisions should be circulated to the communities of interest for one (1) year, with comments reviewed at the Summer 2024 meetings of the PERIO RC and Commission.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

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

Matters related to more than one review committee are included in a separate report.
CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PERIODONTICS EDUCATION

Due to an ongoing need for additional site visitors, the Review Committee on Periodontics Education (PERIO RC) considered site visitor appointments for 2023-2024. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Paul Luepke
Chair, Review Committee on Periodontics Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Periodontics
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

**Health Care Organization**: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTOLOGY, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).
Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON PROSTHODONTICS EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Evanthia Anadioti. Committee Members: Dr. Scott DeVito, Dr. Sang Lee, Dr. Dean Morton, Dr. David Felton, and Dr. Joseph Hagenbruch. Dr. Kent Knoernschild substituted as needed for discipline-specific program reviews. Guests (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education; Ms. Yesenia Ruiz, manager, Advanced Dental Education; Ms. Bridget Blackwood, senior project assistant, and Ms. Michele Kendall, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Prosthodontics Education (PROS RC) was held on July 12, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO PROSTHODONTICS EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Prosthodontics (p. 1400): The Review Committee on Prosthodontics Education (PROS RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Prosthodontics implemented July 1, 2016. The PROS RC noted that there were 43 prosthodontics site visits, including maxillofacial prosthetics, conducted from July 1, 2016 through October 31, 2022. Two (2) areas of non-compliance were cited during the reporting period. One (1) citing under Standard 2-1 related to the program director having primary responsibility for organization and educational and administrative components of the program. Under Standard 5, there was one (1) citing related to a system of ongoing evaluation of student/resident achievement. The Pros RC noted this report serves as the final report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Prosthodontics implemented on January 1, 2016. Revised Accreditation Standards were adopted August 5, 2022 with immediate implementation.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Prosthodontics (p. 1401): The Review Committee on Prosthodontics Education (PROS RC) considered the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Prosthodontics approved and implemented August 5, 2022. The PROS RC noted that between August 5, 2022 and October 31, 2022, one (1) prosthodontics site visit was conducted. To ensure confidentiality, Frequency of Citings reports will not be made available where a limited number (three or less) of programs have been site visited. Once there are four (4) or more site visits of prosthodontics programs, the non-compliance citings will be analyzed and summarized accordingly.

Recommendation: This report is informational in nature and no action is required.
Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1402):

At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards.

The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently
offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as
applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1402) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1402), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the PROS RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as proposed revision to Standards related to institutional sponsors to include health care organizations and a new requirement related to authority to operate, confer a certificate and, as applicable, confer a degree.

The PROS RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the PROS RC believed that the inclusion of the proposed definition and revisions in the Prosthodontics Accreditation Standards should have no impact on prosthodontics education programs. The PROS RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the
October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

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

No site visitor nominations were considered at this meeting.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Evanthia Anadioti
Chair, Review Committee on Prosthodontics Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Prosthodontics
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

**Health Care Organization**: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS, ORAL AND MAXILLOFACIAL SURGERY, PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Healthcare (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).
Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON DENTAL ANESTHESIOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Joseph Giovannitti. Committee Members: Dr. Gerard Kugel, Dr. Mana Saraghi, Dr. Shashi Unnithan, and Dr. Philip Yen. Guest (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, Ms. Yesenia Ruiz, manager, Advanced Dental Education, and Ms. Bridget Blackwood, senior project assistant, Commission on Dental Accreditation (CODA). Dr. Sherin Tooks, senior director, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, CODA, attended a portion of the meeting. The meeting of the Review Committee on Dental Anesthesiology Education (DENTANES RC) was held on July 12, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL ANESTHESIOLOGY EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 1500): The Review Committee on Dental Anesthesiology Education (DENTANES RC) considered the annual report on the frequency of citings of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology adopted and implemented January 25, 2007. Significant revisions were made to the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology in 2012 and 2015. The DENTANES RC noted that 29 site visits were conducted from January 25, 2007 through October 31, 2022. An analysis of the site visit reports indicated a total of ten (10) citings of non-compliance were noted in the reports. Analysis of the data indicated that the most frequently cited Standard is Standard 1-5, written agreements, with four (4) citations. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1501): At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.
Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/ recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/ recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.
Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to
confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1501) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1501), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

Summer 2023 Review Committee Meeting: At this meeting, the DENTANES RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as the addition of requirements related to authority to operate, confer a certificate and, as applicable, confer a degree.

The DENTANES RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the DENTANES RC believed that the inclusion of the proposed definition and revisions in the Dental Anesthesiology Accreditation Standards should have no impact on dental anesthesiology education programs. The DENTANES RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.

Recommendation: It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.
CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

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

Due to an ongoing need for additional site visitors, the Review Committee on Dental Anesthesiology Education (DENTANES RC) considered site visitor nominations at this meeting. The Committee’s recommendations on the nominations are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

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

Proposed Revisions to Definition of Terms and Standard 1-1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health
Service (IHS), Veterans Health Administration system (VA), or academic health center/medical
center/ambulatory care center (both public and private) that is accredited by an agency
recognized by the United States Department of Education or accredited by an accreditation
organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1-1 FOR GENERAL PRACTICE
RESIDENCY AND DENTAL ANESTHESIOLOGY:

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

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

Examples of evidence to demonstrate compliance may include:
• Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
• Evidence of successful achievement of Service-specific organizational inspection criteria
• Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:
• State license or federal authority documenting the institution’s approval to operate and confer a credential
• Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON ORAL MEDICINE EDUCATION TO
THE COMMISSION ON DENTAL ACCREDITATION

Committee Interim Chair: Dr. Lina Mejia (substituting for Dr. Scott DeRossi). Committee Members: Ms. Jennifer Barber, Dr. Michael Brennan, substituting for discipline-specific agenda item; Dr. Michael DeBellis, and Dr. Thomas Sollecito. Dr. Scott DeRossi, Review Committee Chair, was unable to attend the meeting. Guest (Open Session Only, Virtual): Dr. Sheila Brear, chief learning officer, American Dental Education Association, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education; Ms. Yesenia Ruiz, manager, Advanced Dental Education, and Ms. Bridget Blackwood, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Oral Medicine Education (OM RC) was held on July 11, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL MEDICINE EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral Medicine (p. 1600): The Review Committee on Oral Medicine Education (OM RC) considered the annual report on the frequency of citings of the current Accreditation Standards for Advanced Dental Education Programs in Oral Medicine and noted one (1) oral medicine site visit was conducted from August 2, 2019 through October 31, 2022. To ensure confidentiality, Frequency of Citings reports will not be made available where a limited number (three or less) of programs have been site visited. Once there are four (4) or more site visits of oral medicine programs, the non-compliance citings will be analyzed and summarized accordingly.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1601): At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.

The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

Institutional Sponsor (Health Care Organizations): The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a
programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023
Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.

Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate.
Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1601) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1601), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

Summer 2023 Review Committee Meeting: At this meeting, the OM RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as the addition of requirements related to authority to operate, confer a certificate and, as applicable, confer a degree.

The OM RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the OM RC believed that the inclusion of the proposed definition and revisions in the Oral Medicine Accreditation Standards should have little to no impact on oral medicine education programs. The OM RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 1, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.
CONSIDERATION OF MATTERS RELATING TO
MORE THAN ONE REVIEW COMMITTEE

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

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

No site visitor nominations were considered at this meeting.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Lina Mejia
Interim Chair, Review Committee on Oral Medicine Education
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1-1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral Medicine
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1-1 FOR ADVANCED EDUCATION IN GENERAL DENTISTRY, ORAL MEDICINE, AND OROFACIAL PAIN:

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

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

- Accreditation certificate or current official listing of accredited institutions **from a United States Department of Education recognized accreditation organization**
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

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

- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
REPORT OF THE REVIEW COMMITTEE ON OROFACIAL PAIN EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Joseph Cohen. Committee Members: Dr. Steven Bender, Dr. Reny de Leeuw, Dr. Bessie Katsilometes, and Dr. Robert Windsor. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, and Ms. Yesenia Ruiz, manager, Advanced Dental Education, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Orofacial Pain Education (OFP RC) was held on July 10, 2023 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO OROFACIAL PAIN EDUCATION

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain (p. 1700): The Review Committee on Orofacial Pain Education (OFP RC) considered the annual report on the frequency of citings of the current Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain. The OFP RC noted that nine (9) orofacial pain site visits were conducted during the period of July 1, 2017 through October 31, 2022. At the time of this report, there were no (0) areas of non-compliance cited. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain Related to Patients With Special Needs (p. 1701): At the Winter 2022 meeting, the Orofacial Pain Review Committee (OFP RC) considered the request for proposed revision of the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain submitted by the American Dental Association’s Council on Dental Education and Licensure (CDEL). Following considerable discussion, the OFP RC recognized the need to strengthen the Accreditation Standards in the area of patients with special needs and believed the addition of a new Accreditation Standard, or modification of an existing Accreditation Standard was warranted. The OFP RC noted the Commission would be conducting the Validity and Reliability Study for Advanced Dental Education Programs in Orofacial Pain in Spring 2022, and recommended further study of the request from the CDEL related to patients with special needs be postponed and considered at the time of review of the results of the Validity and Reliability Study, with a report to the Commission in Summer 2022. The Commission concurred with the OFP RC recommendation.

At the Summer 2022 meeting, the OFP RC further studied the request from the CDEL related to patients with special needs. Following lengthy discussion, the OFP RC concluded the addition of a new Standard related to patients with special needs was warranted and recommended the new Standard 2-10 be added to the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain. The OFP RC understood that subsequent Standards would require
renumbering. Additionally, the OFP RC recommended the proposed new Standard 2-10 be circulated to the communities of interest for review and comment for a period of one (1) year, with hearings conducted in conjunction with the October 2022 American Dental Association (ADA) Annual Meeting and the March 2023 American Dental Education Association (ADEA) Annual Session. Comments could be reviewed at the Commission’s Summer 2023 meeting.

As directed by the Commission at its Summer 2022 meeting, the proposed new Standard 2-10 within the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain (Appendix 1, Policy Report p. 1701) was circulated to the communities of interest for review and comment through June 1, 2023. No (0) comments were received at the virtual hearing in conjunction with the 2022 ADA meeting, and no (0) comments were received at the virtual hearing in conjunction with the 2023 ADEA meeting. The Commission office received one (1) written comment prior to the June 1, 2023 deadline (Appendix 2, Policy Report p. 1701).

**Summer 2023 Review Committee Meeting:** At this meeting, the Orofacial Pain Review Committee considered the proposed new Standard 2-10 within the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain and the one (1) written comment received prior to the June 1, 2023 deadline, which was supportive of the inclusion of the new Standard 2-10 within the Orofacial Pain Standards.

Through discussion of the proposed addition, the OFP RC further considered the proposed intent statement that programs are “expected to provide educational instruction, either didactically or clinically.” The RC discussed whether the language should be modified to reflect that programs are expected to provide clinical instruction, rather than didactic or clinical instruction. Through further discussion, the RC noted that it is possible that a graduate could complete a program without clinical experience in treating patients with special needs; therefore, the language should remain flexible. Additionally, it was noted that, ultimately, the program has the flexibility to determine the type of training required to ensure its graduates can manage patients with special needs upon completion of the program.

Upon conclusion of the discussion, the OFP RC determined the new Standard 2-10 should be adopted as circulated and recommended an implementation date of July 1, 2024.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the new Standard 2-10 within the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain found in Appendix 1 and related documents with implementation July 1, 2024.

**Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs Related to Sponsoring Organization and Authority to Operate (p. 1702).** At its Winter 2022 meeting, the Commission on Dental Accreditation (CODA) directed the formation of an Ad Hoc Committee to consider the changing landscape of health care delivery centers that may sponsor advanced dental education programs.
The Ad Hoc Committee, which met on December 5, 2022 and January 25, 2023, was charged with two (2) primary considerations: 1) the topic of institutional sponsor, whether a sponsor is an academic institution, hospital, or health care organization, and 2) the standard found in some advanced dental education disciplines that requires the sponsor have proper chartering/licensure to operate and offer instruction leading to a degree, diploma or certificate with recognized education validity.

**Institutional Sponsor (Health Care Organizations):** The Ad Hoc Committee discussed the types of institutions that may sponsor advanced dental education programs. The Committee was reminded that CODA holds United States Department of Education (USDE) recognition as a programmatic accrediting agency; therefore, all educational standards within CODA’s purview include a requirement for institutional sponsor accreditation/recognition to ensure institutional oversight by an external agency. Regarding CODA’s USDE recognition, it was noted there would be no concern in modifying the Standards with regard to institutional accreditation/recognition.

It was also noted that in five (5) of the 14 advanced dental education programs within the Commission’s purview, the Standards permit the program’s sponsor to be an educational institution, hospital, or health care organization (with/without affiliation with an accredited hospital, as specified in the Standards). In the remaining nine (9) advanced dental education disciplines, the sponsor must be an educational institution or hospital. All standards permit United States military programs to sponsor advanced dental education programs, as specified in the Standards.

The Ad Hoc Committee discussed the issue of institutional sponsor given current Health Resources and Services Administration (HRSA) grant opportunities for health care organizations that may sponsor advanced dental education programs. The Ad Hoc Committee discussed the term “health care organization” at length, including the type of entity that may be classified within this category and whether a definition of health care organization should be included in the CODA Standards. The Committee believed that a definition should be included in the Commission’s Definition of Terms, to ensure clarity and transparency in the type of organization that is permitted to sponsor an advanced dental education program, for those standards that currently include the term “health care organization” and those where the term may be adopted and implemented at a future date.

While discussing health care organizations that may sponsor advanced dental education programs, there continued to be discussion and concern that these sponsors have appropriate educational validity and expertise to carry out an academic program at the postdoctoral level. The Ad Hoc Committee considered whether all health care organizations should also have an affiliation with an academic institution to ensure educational quality. In discussion, it was noted that affiliations may exist (absent a need for co-sponsorship); however, many health care...
organizations currently offering CODA-accredited advanced dental education programs are not directly affiliated with academic institutions.

The Ad Hoc Committee determined that a definition of “Health Care Organization” and potential inclusion of “health care organization” as an acceptable sponsoring institution warrant further input from the Commission’s Review Committees to provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Following consideration of the Ad Hoc Committee’s recommendation, the Commission directed the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Review Committees should provide comment on the potential definition and inclusion of this term within their discipline-specific standards.

Charter/License to Operate and Offer Instruction: The Ad Hoc Committee also considered the current language in nine (9) advanced dental education programs’ Accreditation Standards, which states: “Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.”

The Committee noted that the advanced dental education Standards for advanced education in general dentistry, dental anesthesiology, general practice residency, oral medicine, and orofacial pain do not currently include this requirement or an equivalent Standard. These five (5) disciplines recently reviewed their Accreditation Standards documents and tabled the discussion regarding inclusion of this requirement pending final recommendations of the Ad Hoc Committee and the Commission.

Through discussion, the Ad Hoc Committee noted that words such as “chartered,” “licensed,” and “validity” have very distinct legal meanings. The term “authorization” is often used in higher education to indicate that an institution can confer a degree. Chartering and licensing often have to do with legal entities and do not necessarily indicate authority to award a degree, diploma or certificate with recognized education validity. The Ad Hoc Committee also noted the confusion related to this requirement from both the institution’s/program’s perspective and that of the CODA site visitor.

The Ad Hoc Committee believed the intent of this Standard is to ensure educational validity, which in dental education is granted through the accreditation process undertaken by the Commission on Dental Accreditation. Additionally, the conferring of a degree is mandated through institutional accreditation, while conferring of a post-doctoral certificate or diploma is a state or federal function.
Following lengthy discussion, the Ad Hoc Committee concluded that the intent of the requirement is to ensure that the sponsoring organization has the appropriate authority to operate and, as applicable, the necessary approvals to award either a certificate or a degree. As such, the Ad Hoc Committee believed that the prior requirement should be stricken from all advanced dental education Standards and replaced with a new requirement, which states (underline indicates addition): Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree. The Committee noted that an advanced dental education program conferring a certificate must have state or federal approval to operate and, if needed based on its specific jurisdiction (i.e., state or federal regulations), it may also need approval to award a certificate. Likewise, an advanced dental education program awarding a degree will be required to show institutional accreditation providing it the authority to do so.

Following discussions at two (2) meetings, the Ad Hoc Committee recommended circulation of the proposed Definition of Terms for Health Care Organization and proposed revision to Standards related to institutional sponsors to include health care organizations and the proposed revision related to chartering and licensure (Appendix 1, Policy Report p. 1702) be circulated to all Review Committees in Advanced Dental Education for consideration at the Summer 2023 Commission meetings, with a report to the Commission in Summer 2023. The Committee also noted that a Review Committee’s recommendation to revise the Standards would require a period of public comment and further consideration at a future Commission meeting, following the Commission’s consideration in Summer 2023.

At its Winter 2023 meeting, the Commission concurred with the Ad Hoc Committee’s recommendations and directed all advanced dental education Review Committees to consider the proposed revisions to advanced dental education Standards found in (Appendix 1, Policy Report p. 1702), related to sponsoring organization and authority to operate, for possible adoption and implementation, with a report to the Commission in Summer 2023.

**Summer 2023 Review Committee Meeting:** At this meeting, the OFP RC discussed the proposed revisions as directed by the Commission and noted they include a proposed Definition of Terms for Health Care Organization, as well as the addition of requirements related to authority to operate, confer a certificate and, as applicable, confer a degree.

The OFP RC agreed that the proposed revisions provide further clarification of the types of institutions that may sponsor advanced dental education programs and requirements related to the authority to operate. Further, the OFP RC believed that the inclusion of the proposed definition and revisions in the Orofacial Pain Accreditation Standards should have no impact on orofacial pain education programs. The OFP RC also believed circulation of the proposed revisions to the communities of interest to provide the opportunity for review and comment is warranted.
Recommendation: It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions found in Appendix 2, to the communities of interest for review and comment for one (1) year, with Hearings conducted in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting and the March 2024 American Dental Education Association (ADEA) Annual Session with comments reviewed by the Review Committee and Commission at its Summer 2024 meetings.

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

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

Due to an ongoing need for additional site visitors, the Review Committee on Orofacial Pain Education (OFP RC) considered site visitor nominations at this meeting. The Committee’s recommendations on the nominations are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

Dr. Joseph Cohen
Chair, Review Committee on Orofacial Pain Education
Commission on Dental Accreditation

At its Summer 2022 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2023, for review at the Summer 2023 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from August 5, 2022 to June 1, 2023.

This document will be considered by the Commission in Summer 2023.

Additions are Underlined; Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain
STANDARD 2 – EDUCATIONAL PROGRAM

2-1 The orofacial pain program **must** be designed to provide advanced knowledge and skills beyond the D.D.S. or D.M.D. training.

**Curriculum Content**

2-2 The program **must** either describe the goals and objectives for each area of resident training or list the competencies that describe the intended outcomes of resident education.

**Intent:** The program is expected to develop specific educational goals that describe what the resident will be able to do upon completion of the program. These educational goals should describe the resident’s abilities rather than educational experiences the residents may participate in. These specific educational goals may be formatted as either goals and objectives or competencies for each area of resident training. These educational goals are to be circulated to program faculty and staff and made available to applicants of the program.

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

- Written goals and objectives for resident training or competencies

2-3 Written goals and objectives **must** be developed for all instruction included in this curriculum.

**Example of Evidence to demonstrate compliance may include:**

- Written goals and objectives
- Content outlines

2-4 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program’s written goals and objectives or competencies for resident training.

**Intent:** The program is expected to organize the didactic and clinical educational experiences into a formal curriculum plan. For each specific goal or objective or competency statement described in response to Standard 2-2, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal curriculum plan.

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

- Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies
- Didactic and clinical schedules
Biomedical Sciences

2-5 Formal instruction **must** be provided in each of the following:

a. Gross and functional anatomy and physiology including the musculoskeletal and articular system of the orofacial, head, and cervical structures;

b. Growth, development, and aging of the masticatory system;

c. Head and neck pathology and pathophysiology with an emphasis on pain;

d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures;

e. Sleep physiology and dysfunction;

f. Oromotor disorders including dystonias, dyskinesias, and bruxism;

g. Epidemiology of orofacial pain disorders;

h. Pharmacology and pharmacotherapeutics; and

i. Principals of biostatistics, research design and methodology, scientific writing, and critique of literature.

2-6 The program **must** provide a strong foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain including:

a. The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems;

b. Mechanisms associated with pain referral to and from the orofacial region;

c. Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain;

d. Pain classification systems;

e. Psychoneuroimmunology and its relation to chronic pain syndromes;

f. Primary and secondary headache mechanisms;

g. Pain of odontogenic origin and pain that mimics odontogenic pain; and

h. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction.
Behavioral Sciences

2-7 Formal instruction must be provided in behavioral science as it relates to orofacial pain disorders and pain behavior including:

- a. cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors;
- b. the recognition of pain behavior and secondary gain behavior;
- c. psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain, sleep disorders, and sleep medicine; and
- d. conducting and applying the results of psychometric tests.

Clinical Sciences

2-8 A majority of the total program time must be devoted to providing orofacial pain patient services, including direct patient care and clinical rotations.

2-9 The program must provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders to ensure that upon completion of the program the resident is able to:

- a. Conduct a comprehensive pain history interview;
- b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient’s orofacial pain and/or sleep disorder complaints;
- c. Perform clinical examinations and tests and interpret the significance of the data;

**Intent:** Clinical evaluation may include: musculoskeletal examination of the head, jaw, neck and shoulders; range of motion; general evaluation of the cervical spine; TM joint function; jaw imaging; oral, head and neck screening, including facial-skeletal and dental-occlusal structural variations; cranial nerve screening; posture evaluation; physical assessment including vital signs; and diagnostic blocks.

- d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral; and

**Intent:** Additional testing may include additional imaging; referral for psychological or psychiatric evaluation; laboratory studies; diagnostic autonomic nervous system blocks, and systemic anesthetic challenges.
The program must provide training to ensure that upon completion of the program, the resident is able to manage patients with special needs.

**Intent:** The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident’s ability to manage patients with special needs.

**Examples of evidence to demonstrate compliance may include:**
- Written goals and objectives or competencies for resident training related to patients with special needs
- Didactic schedules

The program must provide instruction and clinical training in multidisciplinary pain management for the orofacial pain patient to ensure that upon completion of the program the resident is able to:

a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits;

b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care;

c. Obtain informed consent;

d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient’s treatment responsibilities;

e. Have primary responsibility for the management of a broad spectrum of orofacial pain patients in a multidisciplinary orofacial pain clinic setting, or interdisciplinary associated services. Responsibilities should include:

1. intraoral appliance therapy;

2. physical medicine modalities;

3. sleep-related breathing disorder intraoral appliances;

4. non-surgical management of orofacial trauma;

5. behavioral therapies beneficial to orofacial pain; and

6. pharmacotherapeutic treatment of orofacial pain including systemic and topical medications and diagnostic/therapeutic injections.

**Intent:** This should include judicious selection of medications directed at the presumed pain mechanisms involved, as well as adjustment, monitoring, and reevaluation.
Common medications may include: muscle relaxants; sedative agents for chronic pain and sleep management; opioid use in management of chronic pain; the adjuvant analgesic use of tricyclics and other antidepressants used for chronic pain; anticonvulsants, membrane stabilizers, and sodium channel blockers for neuropathic pain; local and systemic anesthetics in management of neuropathic pain; anxiolytics; analgesics and anti-inflammatories; prophylactic and abortive medications for primary headache disorders; and therapeutic use of botulinum toxin injections.

Common issues may include: management of medication overuse headache; medication side effects that alter sleep architecture; prescription medication dependency withdrawal; referral and co-management of pain in patients addicted to prescription, non prescription and recreational drugs; familiarity with the role of preemptive anesthesia in neuropathic pain.

Residents must participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period).

Intent: Experiences may include observation or participation in the following: oral and maxillofacial surgery to include procedures for intracapsular TMJ disorders; outpatient anesthesia pain service; in-patient pain rotation; rheumatology, neurology, oncology, otolaryngology, rehabilitation medicine; headache, radiology, oral medicine, and sleep disorder clinics.

Each assigned rotation or experience must have:

- written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
- resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
- evaluations performed by the designated supervisor.

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

Examples of evidence to demonstrate compliance may include:
- Description and schedule of rotations
- Written objectives of rotations
- Resident evaluations
Residents must gain experience in teaching orofacial pain.

2-15 2-14 Residents must actively participate in the collection of history and clinical data, diagnostic assessment, treatment planning, treatment, and presentation of treatment outcome.

2-16 2-15 The program must provide instruction in the principles of practice management.

Examples of evidence to demonstrate compliance may include:
Course outlines

2-17 2-16 Formal patient care conferences must be held at least ten (10) times per year.

Examples of evidence to demonstrate compliance may include:
Conference schedules

2-18 2-17 Residents must be given assignments that require critical review of relevant scientific literature.

Examples of evidence to demonstrate compliance may include:

Intent: Residents should be provided opportunities to obtain teaching experiences in orofacial pain (i.e. small group and lecture formats, presenting to dental and medical peer groups, predoctoral student teaching experiences, and/or continuing education programs.

Intent: Suggested topics include: quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care; medicolegal issues, workers compensation, second opinion reporting; criteria for assessing impairment and disability; legal guidelines governing licensure and dental practice, scope of practice with regards to orofacial pain disorders, and instruction in the regulatory requirements of chronic opioid maintenance.

Examples of evidence to demonstrate compliance may include:

Orofacial Pain Standards
Relevant scientific literature should include current pain science and applied pain literature in dental and medical science journals with special emphasis on pain mechanisms, orofacial pain, head and neck pain, and headache.

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

Program Length

2-19 2-18 The duration of the program must be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

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

2-20 2-19 Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in no more than twice the duration of the program length.

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

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

Evaluation

2-21 2-20 The program’s resident evaluation system must assure that, through the director and faculty, each program:

a) periodically, but at least two times annually, evaluates and documents the resident’s progress toward achieving the program’s written goals and objectives of resident training or competencies using appropriate written criteria and procedures;

b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions must be taken; and
c) maintains a personal record of evaluation for each resident that is accessible to
the resident and available for review during site visits.

**Intent:** While the program may employ evaluation methods that measure a resident’s
skills or behavior at a given time, it is expected that the program will, in addition,
evaluate the degree to which the resident is making progress toward achieving the
specific goals and objectives or competencies for resident training described in response
to Standard 2-2.

**Examples of evidence to demonstrate compliance may include:**
- Written evaluation criteria and process
- Resident evaluations with identifying information removed
- Personal record of evaluation for each resident
- Evidence that corrective actions have been taken
Commission on Dental Accreditation

Proposed Revisions to Definition of Terms and Standard 1-1

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain
PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED
DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION
AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are strikethrough

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION
STANDARDS:

Definition of Terms:

**Health Care Organization**: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
PROPOSED REVISIONS FOR STANDARD 1-1 FOR ADVANCED EDUCATION IN
GENERAL DENTISTRY, ORAL MEDICINE, AND OROFACIAL PAIN:

Each sponsoring or co-sponsoring United States-based educational institution, hospital or health care organization must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate must have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree must have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:
- State license or federal authority documenting the institution’s approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree
INFORMATIONAL REPORT ON REVIEW COMMITTEE AND COMMISSION MEETING DATES

**Background:** Below is the meeting schedule for all Review Committees and the Commission through Summer 2025. Review Committees meet at least two (2) weeks prior to the Commission meeting.

### REVIEW COMMITTEE AND COMMISSION MEETING DATES

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<tr>
<th>Review Committee</th>
<th>Summer 2023</th>
<th>Winter 2024**</th>
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<td>Feb. 1 10:00 a.m.</td>
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<td>Jan. 30 10:00 a.m.</td>
<td>Aug. 7 10:00 a.m.</td>
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<td>Feb. 2 10:00 a.m.</td>
<td>Aug. 9 10:00 a.m.</td>
<td>Jan. 31 10:00 a.m.</td>
<td>Aug. 8 10:00 a.m.</td>
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** 2024 and 2025 meeting dates are tentative.

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

Prepared by: Dr. Sherin Tooks
REPORT OF THE STANDING COMMITTEE ON FINANCE

Background: In January 2001, the Commission on Dental Accreditation (CODA) established a Standing Committee on Finance to assist the Chair in planning the Commission’s annual budget. In 2010, CODA reaffirmed the Finance Committee as a standing committee of the Commission. In Summer 2014, the Commission modified the charge of the Finance Committee to include oversight of the Commission’s Research and Development Fund. In Winter 2019, the Commission again modified the charge of the Finance Committee to include review and recommendations regarding the Intercompany Memorandum of Understanding and Shared Services. In Winter 2020, the Commission further modified the charge of the Finance Committee to replace “Research and Development Fund” with “Administrative Fund” as an oversight responsibility of the Finance Committee.

The Finance Committee’s charge is to: Monitor, review and make recommendations to the Commission concerning the annual budget, provide administrative oversight of the administrative fund, and review and make recommendations regarding the Intercompany Memorandum of Understanding and Services Agreement.

June 27, 2023 Finance Committee Meeting: The Standing Committee on Finance met on June 27, 2023 via a virtual meeting. Dr. Maxine Feinberg, chair, Finance Committee and vice chair, CODA, Dr. Victor Badner, Dr. Maxine Feinberg (chair), Dr. Frank Licari, Ms. Lisa Mayer, Dr. Garry Myers, Dr. Miriam Robbins were in attendance. Ms. Lonni Thompson, and Dr. Deborah Weisfuse were unable to attend. Dr. Sherin Tooks, senior director, CODA, Ms. Kathleen Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner, and Ms. Kelly Stapleton, managers, CODA, Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, Mr. Naveed Mughal, manager, Financial Services, Education and Professional Affairs, ADA, and Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, ADA were also in attendance.

The Standing Committee reviewed its charge as its first order of business.

Update on 2022-2023 Budget Activity and Update on 2024 Budget: The Standing Committee on Finance reviewed the Commission’s 2023 budget activity for CODA’s U.S.-based program, CODA’s international program, and CODA’s Preliminary Accreditation Consultation Visit (PACV) program, including year-end 2022 actuals. The Committee also discussed the 2024 budget process along with a comparison of the CODA 2023 and 2024 budget for all three (3) programs within CODA. The Committee recalled that the Commission adopted a 2% increase in the 2023 annual fee and a 0% increase in the 2024 annual fee.

The Committee also discussed the continued increase in applications, Ad Hoc committees, and workload within the Commission, as well as ongoing initiatives to enhance volunteer training. As a result of the continued increase in Commission activities and projects, the Standing Committee believed that one (1) additional staff should be approved as part of the 2024 budget. Furthermore, the Standing Committee believed that additional employees may be needed within CODA; therefore,
the Standing Committee will revisit the topic of human resource allocations to the Commission following completion of the financial and comparative analysis study.

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation direct the addition of one (1) full-time staff in the Commission’s 2024 annual operating budget.

Review of CODA Administrative Fund: The Standing Committee on Finance reviewed the CODA Administrative Fund Balance Sheet and Disbursement Accounting Form. The Committee noted that the Commission, in Summer 2022, directed that the 2023 Administrative Fund fee ($25) be waived for all CODA-accredited programs.

The Finance Committee learned that the Ad Hoc Committee to Consider Advanced Dental Education Delivery Models and Combined Programs completed its work, with a resulting total expense of $7,710, which was $2,290 less than the budgeted $10,000 for this project. Upon completion of this project, the CODA Administrative Fund balance was reduced to $317,933.

Additionally, in Summer 2022, the Commission approved up to $20,000 to engage with a financial expert to study CODA’s revenue and expense planning model and assist the Commission with long-term projection modeling to obtain a revenue-neutral budget, and to conduct a comparative analysis among other accreditors related to financial models and administrative funds.

Since there is currently a $300,000 cap placed on the CODA Administrative Fund by the American Dental Association (ADA), the Finance Committee believed that there should be no ($0) administrative fund fee to educational programs in 2024. This conclusion was made following review of the Administrative Funds collected and the potential uses which, if more than $300,000, would be transferred to the American Dental Association at year-end. The Finance Committee concluded the Commission should rescind its Winter 2023 directive that CODA-accredited programs receive an Administrative Fund fee of $25 in 2024. Rather, the Finance Committee recommends the Commission direct there be no (0) Administrative Fund fee applied to programs in 2024. With this change, the Finance Committee believed that the Commission’s Administrative Fund would remain at or below the $300,000 cap.

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation rescind the $25 Administrative Fund fee scheduled for 2024, and direct that in 2024 there be no ($0) Administrative Fund fee applied to CODA-accredited dental and dental-related education programs.

Review of Intercompany Memorandum of Understanding and Services Agreement: The Standing Committee on Finance discussed the Intercompany Memorandum of Understanding and Services Agreement, which included a three-year term to expire on January 1, 2025. The Finance Committee noted that the shared services fee in 2022 remained consistent with 2021, a total of $694,471. The Committee also noted that, following the COVID pandemic, the Commission’s offices were
relocated within the American Dental Association building. The Finance committee concluded that the office relocation may warrant an adjustment in office space rent paid by CODA to the ADA.

**Finance Committee Recommendations:** This report is informational in nature and no action is required.

**Timeline (Long-Term Plan) to Assume Total Expenses and Authority to Determine and Manage Annual Operating Budget:** The Finance Committee reviewed meeting materials related to the Commission’s goal to obtain authority to determine and manage its annual operating budget, without further discussion.

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

**Financial and Comparative Analysis Study:** The Finance Committee again reviewed the Commission’s Summer 2022 directive that, through the Finance Committee, the Commission engage with an expert financial analyst to study CODA’s revenue and expense planning model and assist the Commission with long-term projection modeling to obtain a revenue-neutral budget, and to conduct a comparative analysis among other accreditors related to financial models and administrative funds.

A subcommittee of the Finance Committee met on May 2, 2023 to discuss the financial and comparative analysis study. Members of the subcommittee included: Dr. Maxine Feinberg (chair), Dr. Victor Badner, Dr. Frank Licari, Dr. Miriam Robbins, and Dr. Deborah Weisfuse. Dr. Garry Myers was unable to attend. Dr. Sanjay Mallya, chair, *ex officio*, Dr. Sherin Tooks, senior director, CODA, and Ms. Jamie Asher Hernandez, Ms. Kathleen Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner, and Ms. Kelly Stapleton, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA were also in attendance. The subcommittee reviewed the background materials and developed a draft Request for Proposal (RFP) that could be circulated to potential financial analysts. The subcommittee also directed staff to obtain recommendations of financial analysts that may be contacted to submit the RFP for review by the Finance Committee.

Following the subcommittee’s meeting, the RFP deliverables were finalized and circulated to the Standing Committee on Finance. At its meeting, the Finance Committee approved the Request for Proposal (*Appendix 1*). The RFP will be circulated, and the Finance Committee will continue to oversee the financial and comparative analysis study, with a report to the Commission in Winter 2024.

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

**Update on ADA-CODA Relationship Workgroup:** The Finance Committee noted that the ADA-CODA Relationship Workgroup planned to meet on July 6, 2023.
**Finance Committee Recommendation:** This report is informational in nature and no action is required.

**Commission Actions:**

Prepared by: Dr. Sherin Tooks
REQUEST FOR PROPOSAL RELATED TO FINANCIAL AND COMPARATIVE ANALYSIS STUDY

Section I: Description of Project and Deliverables

Scope of Project:

The Commission on Dental Accreditation is soliciting proposals to study its revenue and expense planning model and assist the Commission with long-term projection modeling to obtain a revenue-neutral budget and, further, to conduct a comparative analysis among other accreditors related to financial models and administrative funds.

Project Deliverables:

The proposal should include a highly detailed project description and timeline for deliverables. The Commission on Dental Accreditation’s expected deliverables are:

- An analysis of the financial model and administrative fund structure of the Commission on Dental Accreditation compared to three (3) to four (4) similar accrediting agencies that are recognized by the United States Department of Education and positioned within a professional association.
  - The analysis must include a comparison of:
    - Methods to collect revenue and manage expenses.
    - Volunteer compensation strategies and funding mechanisms.
    - Administrative or reserve funds, including structure and contributions.
    - Technology resources, and long-term maintenance strategies.
    - Shared services with the professional association and other business expenses.
    - Staffing structures based on the number of programs accredited and size of the accrediting agency.
- An analysis of the Commission on Dental Accreditation’s overall budget process (revenue and expenses), and recommendations related to long-term projection modeling strategies to attain a revenue-neutral budget.
- An analysis of the Commission on Dental Accreditation’s administrative fund structure, and recommendations based on analysis conducted including sufficiency of the fund and methods to retain funds.
- Development of two (2) to three (3) sample budget models to assist the Commission on Dental Accreditation with long-term projection modeling to attain a revenue-neutral budget while projecting for future process improvements.
Phases of the Project and Deliverables at Each Phase:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Deliverables</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>One (1), 1-hour meeting with the Finance Committee to discuss the project and deliverables.</td>
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<td>A written plan to address the deliverables. [Upon review of the plan by the Finance Committee, a final plan will be developed.]</td>
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<tr>
<td>Phase II</td>
<td>Collection of data to address each deliverable.</td>
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<td>One (1), 1-hour meeting with the Finance Committee to discuss progress and alterations to the plan (as needed), to occur at the mid-point of data collection.</td>
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<tr>
<td>Phase III</td>
<td>Submission of a comprehensive written report addressing all deliverables, including data collected and analyzed and recommendations to the Finance Committee and Commission on Dental Accreditation.</td>
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</tr>
<tr>
<td></td>
<td>One (1), 1-hour meeting with the Finance Committee to discuss the findings, conclusions, and recommendations.</td>
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</table>

**Section II: Budget**

The financial and comparative analysis study budget must not exceed $20,000.
Section III: Qualifications

The qualifications of the financial analyst should include the following:

- A background in finance, particularly related to non-profit agencies.
- Experience with financial modeling and projection for annual budgeting development.
- Ability to develop long-term financial strategies to attain a revenue-neutral budget.
- Understanding of administrative/reserve funds within a non-profit agency.
- Experience with accrediting agencies that are recognized by the United States Department of Education and/or located within a professional association, preferred.
Quality Assurance and Strategic Planning
Commission Only
Summer 2023

REPORT OF THE STANDING COMMITTEE ON
QUALITY ASSURANCE AND STRATEGIC PLANNING

**Background**: The Standing Committee on Quality Assurance and Strategic Planning (QASP) charge is to:

- Develop and implement an ongoing strategic planning process;
- Develop and implement a formal program of outcomes assessment tied to strategic planning;
- Use results of the assessment processes to evaluate the effectiveness of the Commission and make recommendations for appropriate changes, including the appropriateness of its structure;
- Monitor USDE, and other quality assurance organizations e.g. Council on Higher Education Accreditation (CHEA), American National Standards Institute/International Organization for Standardization (ANSI/ISO), and International Network for Quality Assurance Agencies in Higher Education (INQAAHE) for trends and changes in parameters of quality assurance; and
- Monitor and make recommendations to the Commission regarding changes that may affect its operations, including expansion of scope and international issues.

**June 20, 2023 Meeting of the QASP**: The QASP conducted a virtual meeting on June 20, 2023, which included the following committee members: Dr. Sanjay Mallya (Committee and CODA Chair), Ms. Margaret Bowman-Pensel, Dr. Joseph Giovannitti, Dr. Frank Licari, Dr. Gary Myers, Dr. Monica Nenad, and Dr. Timmothy Schwartz. Dr. Carolyn Brown was unable to attend. Dr. Sherin Tooks, senior director, CODA, and Ms. Jamie Asher Hernandez, Ms. Kathleen Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner, and Ms. Kelly Stapleton, managers, CODA, were in attendance. Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, attended a portion of the meeting.

The QASP initiated its meeting with a review of the charge to the standing committee. Discussion was focused on ongoing quality assurance and strategic planning activities, and additional items of interest to CODA related to strategic planning and operational effectiveness. Below is a summary of QASP discussions and recommendations.

**Consideration of Ongoing Quality Assurance and Strategic Planning Activities**: The Standing Committee on Quality Assurance and Strategic Planning (QASP) reviewed the Commission’s activities and accomplishments related to Ad Hoc Committees, Standing Committees, meetings attended, and presentations given by CODA staff from January through June 2023 (Appendix 1).

**Quality Assurance and Strategic Planning Committee Recommendation**: This report is informational in nature and no action is required.

**Additional Quality Assurance and Strategic Planning Items for Discussion**: Activities Related to the Commission on Dental Accreditation of Canada (CDAC): The QASP members reviewed proposed revisions for the dental assisting and dental hygiene educational standards of the Commission on Dental Accreditation of Canada (Commission-only Appendix
2 and 3). The Committee noted that the changes are not substantive; therefore, a response from the Commission is not warranted at this time.

**Quality Assurance and Strategic Planning Committee Recommendation:** This report is informational in nature and no action is required.

*Trends in Dental Education, Practice, Research, and Higher Education – Letter from the National Coalition of Dentists for Health Equity:* The Standing Committee on Quality Assurance and Strategic Planning discussed the February 16, 2023 letter and previously reviewed November 4, 2022 letter and materials from the National Coalition of Dentists for Health Equity (NCDHE) found in Appendix 4. The QASP noted the Commission’s Winter 2023 action following consideration of the November 2022 NCDHE correspondence, directing the CODA Ad Hoc Committee on Predoctoral Standards Revisions to consider the information while reviewing potential revisions to the Accreditation Standards for Dental Education Programs.

In its February 16, 2023 letter, the NCDHE notes other short term recommendations that would not require revision of the Accreditation Standards. The QASP members reviewed this topic again and believed that the NCDHE letter appears to focus on the enforcement of standards, calibration of site visitors, and diversity of CODA’s site visitor volunteers.

Related to enforcement of the Accreditation Standards, the QASP members noted that in dental education the site visit team reviews a program’s compliance based upon the program’s defined levels of diversity, which are typically based on local and state diversity data. The QASP believed it would be unrealistic in some areas of the country to hold a program to national diversity statistics. Additionally, it was noted that given the current climate in some states related to diversity, equity, inclusion and belonging (DEIB), it may be difficult for academic institutions, particularly those that receive state funding, to engage in certain diversity efforts. The Commission continues to monitor national trends and potential changes in federal and state regulations related to DEIB, and the future impact on the educational programs within CODA’s purview as well as the accreditation activities of the Commission. Additionally, the Ad Hoc Committee on Predoctoral Standards Revisions will continue its review of potential revisions to the Accreditation Standards for Dental Education Programs, with a report to the Commission following the completion of its work.

Related to site visitor training and the composition of site visit teams, the QASP noted CODA’s historic and ongoing efforts to recruit site visitors with diverse backgrounds. The Commission also continues to provide site visitor training, both initial and ongoing, to its cadre of site visitors. It was noted that the Commission is not solely responsible to address this issue; rather, the collective field of dentistry and dental education should support faculty and student recruitment, and volunteerism of individuals with diverse backgrounds within the Commission.

Following discussion, the Standing Committee believed that the Commission should direct a letter to the NCDHE regarding its second review of the NCDHE’s request and Commission discussion, noting the continued review of this topic by the Ad Hoc Committee on Predoctoral Standards Revisions.
Quality Assurance and Strategic Planning Committee Recommendation: It is recommended that the Commission on Dental Accreditation direct a formal letter to the National Coalition of Dentists for Health Equity to inform the Coalition of the Commission’s second review of its correspondence and actions that are underway by the Commission related to diversity, equity, inclusion and belonging.

Trends in Dental Education, Practice, Research, and Higher Education – Update on United States Department of Education, General Accreditation Matters, and CODA Recognition: The Standing Committee on Quality Assurance and Strategic Planning engaged in a discussion related to several potential regulatory changes that could affect accrediting agencies, including the Commission on Dental Accreditation.

The QASP discussed proposed regulations related to clinical experiences. Under the United States Department of Education (USDE) proposed new § 668.16(r) educational programs would be required to provide students with geographically accessible clinical or externship opportunities related to program or licensure requirements within 45 days of completion of other coursework. This proposed regulation appears to have been focused on institutions that do not make opportunities available to students or offer clinical or externship opportunities that are distant and inaccessible from the program’s main location.

The QASP also discussed the May 18, 2023 notice of clarification from the USDE related to requirements for institutional accrediting agencies related to distance education. The Standing Committee noted that the USDE has waived the requirements until October 7, 2023, which is 180 days subsequent to the termination of the national emergency related to the COVID 19 pandemic. QASP noted that CODA revised its Policy on Distance Education to align with the USDE revised definition, and has been applying this policy to program reviews for some time.

The QASP noted proposed regulations on gainful employment, which would require increased transparency related to the ability of program graduates to afford educational programs and pay their student loan debt. Programs that fall below the required metrics could lose access to federal financial aid and other funding.

Finally, the QASP received an update on the Third Party Services Guidelines of the USDE. It was noted that in spring 2023, the USDE further clarified its expectations for establishment of third party service agreements that provide certain services to educational institutions. There had previously been concern among programmatic accreditors related to the impact of this regulation on clinical externship rotations. The initial call for comment resulted in revised guidelines and further clarification that suggests clinical/externship rotations, which are typically covered under other existing regulations, would not fall under the requirements of the Third Party Services Guidelines.

Following discussion of each item, the QASP concluded it would continue to monitor activities of the USDE and other regulatory bodies; however, no action is required by the Commission at this time.
Quality Assurance and Strategic Planning Committee Recommendation: This report is informational in nature and no action is required.

Commission Actions:

Prepared by: Dr. Sherin Tooks
CODA ACTIVITIES RELATED TO STRATEGIC PLAN
(Spring 2023)

Ad Hoc Committees:
- Alternative Site Visit Methods
- Ratios in Accreditation Standards
- Volunteerism
- Professional Development and Mega Issues
- Oral Medicine Reciprocity with CDAC
- Dental Hygiene Accreditation Standards and Enrollment Guidelines
- Predoctoral Accreditation Standards

Standing Committees:
- Quality Assurance and Strategic Planning
- Finance
- Documentation and Policy Reviews
- Communication and Technology
- International Predoctoral Accreditation
- Nominations

Workgroup:
- ADA-CODA Relationship Workgroup

Meetings Attended and Presentations Given:
- March 9, 2023 - National Association of Dental Laboratories Educator Section Conference
- March 10-14, 2023 – American Dental Education Association Annual Meeting
- March 27, 2023 – Predoctoral Site Visitor Update and Site Visit Orientation Sessions
- March 28, 2023 – Allied Site Visitor Update and Site Visit Orientation Sessions
- March 29, 2023 – Advanced Site Visitor Update and Site Visit Orientation Sessions
- March 30, 2023 – Q&A Session
- March 30, 2023 – CODA Hearing on Standards
- April 6, 2023 – Program Director 101 Webinar
- April 28, 2023 – Presentation to Special Care Dentistry Association Director’s Session
- May 22, 2023 – Presentation to HRSA Teaching Health Centers
- June 6, 2023 – Presentation at ADEA Allied Program Director’s Meeting
- June 15-16, 2023 – Site Visitor Training 2-Day Workshop
- June 22, 2023 – Presentation at ADEA Workforce Webinar

Invitations to Future Meetings:
- ADEA Fall Meeting
• National Council on Disability Meeting
• HRSA Teaching Health Centers Meeting

**Site Visits (Return from COVID):**
- Allied N=37; Spring 2023-completed 27 visits; Fall 2023-scheduled 10 visits
- Advanced N=33; Spring 2023-completed 18 visits; Fall 2023-scheduled 15 visits
- Predoctoral Dental N=4; Spring 2023-completed 2 visits; Fall 2023-scheduled 2 visits
February 16, 2023

Sherin Tooks
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
tookss@ada.org

Dear Dr. Tooks,

A representative of the National Coalition of Dentists for Health Equity (NCDHE) attended the Feb 10 CODA meeting. We are very pleased that CODA voted to accept the recommendations of the Predoctoral Review Committee to forward our letter to the ad hoc Predoctoral Revision Committee.

This is significant progress. As a reminder, we want to point out that our letter also contained a number of short term recommendations that would not need Accreditation Standards revision. We hope that the ad hoc Committee or some other component of CODA will give due consideration to these other recommendations as well.

The NCDHE stands ready to assist in any way we can as CODA moves forward to discuss these important and timely issues of diversity. Thank you for your consideration.

Sincerely,

Lawrence F. Hill DDS MPH
President, National Coalition of Dentists for Health Equity
6825 Vineyard Haven Loop
Dublin, OH 43016
513-544-8844
November 4, 2022

Sherin Tooks
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
	tookss@ada.org

Dear Dr. Tooks,

I am writing to CODA as President of the National Coalition of Dentists for Health Equity (https://www.dentistsforhealthequity.org ). Our mission is to unite dentists in support of evidence-based, high quality and cost-effective oral health services including disease prevention and treatment and care delivery models. One of our priorities is to advance racial and ethnic diversity in the oral health workforce which starts in the recruitment and retention of historically underrepresented racial and ethnic (HURE) dental students and faculty.

We are writing to express our concern that the current CODA predoctoral education standards do not appear to be assuring that academic dental institutions recruit a racially diverse student body or faculty; we are specifically referring to Black, Latinx, and American Indian/Alaska Native students and faculty. We know that CODA adopted the new diversity standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that “between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis. Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class rose by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, https://www.adea.org/HURE/ ).” The conclusion we draw is that dental schools are not recruiting enough HURE students to meet the intent of the Standards. However, during that same time period, no dental schools that have completed self-studies and site visits have received a recommendation for not meeting the standards.

We are offering several suggestions to CODA. Two are short term with an understanding that CODA appropriately takes considerable time in changing standards, which entails seeking input from many individuals, communities, and entities before making changes

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.
in the Standards. The third is long term and recommends a number of direct changes to the language in some of the standards.

First, the short-term suggestions. These comments would imply that Standards 1-3 and 1-4 are in fact strong enough but only if they are enforced. In other words, policies for improvement exist, but there does not seem to be a CODA requirement for outcomes. We believe that schools must show evidence of improved diversity among HURE students and faculty. The problem is enforcement of those two standards as CODA has also included a strong statement on diversity under the general information on educational environment. We recommend that site visit committees be better trained and educated on how to assess whether a school has actually put into place a viable plan that achieves positive results. Further, site visit committees must be diverse and should be inclusive of representatives of HURE dental educators. Under the structural diversity section, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is good but showing an improvement based on the school’s plans and policies should also be demonstrated. Schools should recognize that having a plan is not sufficient. These standards have been in place for at least a decade and the schools will have had seven years since their last self-study, so there should not be any excuse for actual improvement in the numerical distribution of HURE students, faculty, and staff.

Since site visit teams are different for each school there is no consistency in the assessment process unless there are explicit expectations of what schools should achieve from each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards to achieve the educational environment clearly stated in their requirements.

The second short term suggestion also would not require any changes in the Standards. It is the experience of the educators in NCDHE that Site Visit teams are not very racially diverse. If that is the general case, are site visit teams comprised to be able to make informed judgements regarding racial and ethnic diversity? Are site visitors selected from schools that excel in their racial and ethnic diversity to ensure that capacity/expertise to judge racial and ethnic diversity is present on-site visit teams? Are site visitors from dental schools with limited racial and ethnic diversity given responsibility to judge racial and ethnic diversity? We suggest that CODA make greater efforts to assure that site visit teams have racial and ethnic diversity among membership of the site visit team that determines how academic dental institutions meet the CODA diversity standards.

The longer-term suggestions build on the recommendations of the recent Journal of Dental Education paper by Smith, PD, Evans CA, Fleming, E, Mays, KA, Rouse, LE and Sinkford, J, ‘Establishing an antiracism framework for dental education through critical assessment of accreditation standards.’ We also recommend reviewing at least two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, ‘Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;’ and Formicola, AJ and Evans, C, ‘Gies re-visited.’ We have attached these three papers to this letter.

**Standard 1-3**

**Comment** - Not much is known about how dental schools address racism in their humanistic environment policies and practices. Although policies exist and are evaluated for accreditation, HURE students and faculty may still experience microaggressions, discrimination, and barriers to socialization and mentorship. Those experiences can negatively influence student and faculty views on the academic environment as well as the profession. Such experiences may be underreported due to fear of retaliation and/or disbelief that such concerns will be adequately addressed. In addition, due to
low numbers of HURE students and faculty, even anonymous humanistic surveys may not allow them to voice their concerns.

**Proposed Strategies for Standard 1-3**

- Dental schools should acknowledge that racially motivated grievances may be underreported and actively seek feedback from HURE students and faculty on how to improve dental schools’ prevention and reaction to such grievances.
- Dental schools must provide evidence of their methods and frequency of engaging HURE students and faculty to address racism in the humanistic environment, while also providing evaluation of the effectiveness of those methods.
- Dental schools should provide evidence of the number and types of racially motivated grievances that get reported with evidence of their effectiveness in mitigating student and faculty concerns.
- Dental schools must provide evidence of students’ and faculty their knowledge of the personal and institutional consequences of racist violations of the humanistic environment.

**Standard 1-4**

**Comment**- Despite the historical lack of representation of HURE students and faculty, it appears that dental schools continually meet this standard. It is unknown if the accreditation process has held any dental schools accountable for not meeting the standard due to few HURE students and faculty. A limitation of this standard is that it allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not emphasize HURE students and faculty, which also undermines the collective priority among dental schools to increase the number of HURE dentists within the profession. Additionally, CODA provides no specificity for the level of engagement that dental schools should have with HURE populations for recruitment.

**Proposed Strategies for Standard 1-4**

- Dental schools should develop and support partnerships with predental programs at Historically Black Colleges and Universities (HBCUs) and Minority Serving Institutions (MSIs). Identifying and addressing limitations of those partnerships should also be a major emphasis.
- Dental schools must show how they are progressing toward increasing HURE students and faculty longitudinally. If schools consistently fail to show improvement, they must provide evidence that new efforts are being implemented or existing efforts are being modified on a continual basis.
- Dental schools must demonstrate a school-based pipeline program to develop future dentists from the schools HURE community to the K-12 and baccalaureate level.
- Dental Schools should provide evidence of financial commitment to support HURE students and faculty through such activities as direct support and development grants.
- Dental Schools must evaluate their home state’s racial and ethnic demographic data compared to the dental school’s racial and ethnic demographics for students, faculty, and staff.
- Dental Schools must evaluate the success of their policies and procedures related to improving diversity.

**Standard 4-4**

**Comment**- One issue with this standard is how dental school applicants’ potential to successfully complete a dental education program is determined. Admissions decisions are made by committees of people, and although there are trainings and processes to address certain implicit biases toward HURE applicants, the process is still subjective. There are unique social and structural issues that exist for HURE applicants that must also be considered when assessing HURE applicants’ potential for success. Those issues may influence HURE students’ undergraduate academic performance. Additionally, HURE applicants may develop an interest in a dental career later in their academic journey, have few academic mentors to guide them in meeting pre-requisite requirements for dental school applications,
and have less access to Dental Admissions Test preparation programs. Because there are few HURE students and faculty in the learning and social environments of some dental schools, members of admissions committees could question whether HURE students will have the levels of peer and faculty support to mitigate microaggressions, and implicit and explicit biases that may negatively impact their academic performance. Another issue is that policies intended to reduce racial discrimination may exist, but dental schools do not have to provide evidence as to whether those policies are being assessed and are working.

**Proposed Strategies for Standard 4-4**

- Dental schools should identify, acknowledge, and address the full social and structural contexts that HURE applicants bring with them, and implement systems to include those contexts in decision making about applicants’ potential to succeed and enhance learning and professional environments; rather than just their potential to fit in and/or matriculate their particular programs.
- Dental schools must have systems in place for faculty and administrators to know how to address the social and academic concerns of HURE students rather than view those types of issues as deficits. As it stands, the institutional power of dental education programs may require that students and faculty adjust to the needs and comforts of their systems rather than modifying their systems to achieve equity in opportunities for success. For example, some dental schools may provide special accommodations for students with test taking anxiety, but similar considerations may not be available for students experiencing anxiety due to microaggressions from other students and/or faculty.
- In lieu of the lack of HURE faculty, dental schools must show evidence that they are actively measuring the levels of implicit racial bias that exist among admissions committee members and if those levels are consistently balanced. Admissions criteria should further consider beyond which applicants might successfully matriculate their programs, but which applicants will have an interest, desire, and commitment to learn about issues or more socially aligned curriculum shifts, such as structural competency, community-based practice, and addressing racism in dental practice and policy.

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

We would be happy to discuss these recommendations in person or via a Zoom call. We recognize that we have covered a lot of ground in these recommendations, but this issue is important enough to warrant attention by CODA. We would be happy to be of assistance in implementation of any of these suggestions. I can be reached at larryhill66@icloud.com and dmaywhoor@gmail.com or via telephone at 513-544-8844.

Sincerely,
Larry Hill, DDS, MPH
President, National Coalition of Dentists for Health Equity

cc:
**American Dental Education Association** - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer, American Dental Education Officer
**National Dental Association** - Dr. Nathan Fletcher, Chairman of the Board; Keith Perry, Executive Director; Dr. Cheryl Lee, President
Diverse Dental Society – Dr. Sheila L. Armstrong, Board Member; LaVette Henderson, President
American Dental Therapist Association - Rachel Pfeffer, Interim Executive Director
Hispanic Dental Association - Dr. Manuel Cordero, Director, and CEO; Mercedes Mota Martinez, 2022 President
Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director
American Dental Association - Jane Grover, Executive Director; Dr. George R. Shepley, President
Americana Dental Hygiene Association – Ann Battrell, Executive Director; Ann Lynch, Policy Director
Community Catalyst – Tera Bianchi, Program Director, Dental Access Project
National Indian Health Board – Brett Webber, Environmental Health Programs Director
American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Analise Cothron, Executive Director
Gies re-visited

Allan J. Formicola DDS, MS1  |  Caswell Evans DDS, MPH2

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KEYWORDS
admissions, diversity, inclusion, race, recruitment, societal expectations

A number of reports and studies including the Surgeon General’s Report of 2000, “Oral Health in America”, linked the poor oral health of Black Americans to a lack of Black American practitioners. This stark fact officially recognized what communities of color had been experiencing historically and called for changes to address the evolving social and health care environment in the United States.

One of the major issues that continue to challenge this country is what is the best way to include Black Americans fully and equally into the life of the nation after a long legacy of segregation and subjugation? Although actions during the last quarter of the 20th century, prodded by legislation and Supreme Court rulings, opened the door for Black students to enroll in all institutions of higher education, including the professional schools, they were unable to create significantly greater equality in dental education. Indeed, the path to increasing more Black dental professionals is to build more positively on past successes and to reform the system of education that has the potential to make that happen. The history of Black Americans in the United States, their present position, and the current role of practicing dentists today serve to give context and an understanding of how to secure equitable access to dental care for Black Americans.

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1  UNDERSTANDING HISTORY

The 1926 Gies Report, Dental Education in the United States and Canada,1 set the stage for dental education in the 20th Century as the 1910 Flexner Report2 accomplished earlier for medical education. Gies traveled to all dental schools throughout the U.S. and Canada between 1919 and 1926 and evaluated each school based on its finances, facilities, research, and curriculum. His report evaluated the need for practitioners to base treatment on a scientific basis and identified the most pressing oral diseases impacting the oral health of the population. It established the blueprint for dental schools to become an integral part of the higher university system in the nation rather than for-profit or free-standing. The accrediting agency for dental schools initially prepared standards to evaluate schools based on the Gies Report. Most schools followed the recommendations in the Gies Report or closed. The Gies Report included the need to expand the enrollment of Black students in schools as there was only 1 Black dentist to about 8500 people in the “Negro population”.

Gies1 recognized that Howard University and Meharry Medical College were the only two dental schools that were devoted to the training of “colored” dentists at a high level. He called them the “pioneer Negro schools of dentistry”2 and urged that they receive liberal [financial] support. But he noted as well that there were twenty-five dental schools that also admitted white and some “colored” students. Between 1919 and 1925, the years in which he collected data from the dental schools, 152 “Negroes” graduated from twelve of those 25 schools. Reflecting the times, Gies stated “General growth of sentiment for segregation has increased the tendency in many dental schools, to restrict
the attendance to white students, or to admit only the small number of colored students that may be useful for the treatment of a few Negro patients in the infirmary.” So, instead of urging all dental schools to admit students of color, he supported the need for additional dental schools for “Negros.”

Gies ascribed the role of Black dentists as needed to treat the Black population. He also recognized that the White population at that time was generally indifferent to the welfare of the “colored” citizens, and the White population “fails to see the ends of enlightened self-interest, for every Negro having a communicable disease [which he states] is a menace to the health of all with whom he may be associated and particularly to the well-being of those he may serve personally and intimately.” Essentially, Gies believed that the Black population at that time was generally indifferent to the welfare of the “colored” citizens, and the White population failed to see the ends of enlightened self-interest, for every Negro having a communicable disease was a menace to the health of all with whom he may be associated and particularly to the well-being of those he may serve personally and intimately.

Gies’ notions reflect the same general thought found in the Flexner Report of 1910: “The negro must be educated not only for his sake but for ours. He is, as far as the human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.” Because of his ideology, Flexner called for medical education to ensure that “these men can be imbued with the missionary spirit…to serve their people humbly and devotedly, they may play an important part in the sanitation and civilization of the whole nation.” A recent article in the New York Times Science Section entitled, “Black American Deaths, and a Paper From 1910” described the “lesser-known side of the Flexner Report”, specifically the poor health of Black Americans, the segregated care they received, and the exclusion of Black medical students from training programs.

This history demonstrates the attitude of both Flexner and Gies, their social views, and the educational policies that prevailed in the US up until the 1950s. It was not until the Supreme Court struck down the pervasive attitude of “separate but equal” in the 1954 decision in Brown versus Board of Education of Topeka that the integration of schools became public policy. Beginning in the late 1960s and with civil rights legislation, higher education, including professional schools, understood the need for diversity in the academy. With Affirmative Action admission policies, approved by the Supreme Court, medical, law, and dental schools prompted by a changing social environment committed to increasing the recruitment and enrollment of URM students and to include historically underrepresented students. The Robert Wood Johnson Foundation-funded “Pipeline, Profession and Practice: Community Based Dental Education”, also known as the Dental Pipeline Program. It was a major national effort to increase the enrollment of historically underrepresented students. The ten-year project (2000–2010) was funded by the Robert Wood Johnson Foundation in collaboration with the California Endowment and the WK Kellogg Foundation. It funded dental schools in the nation to increase the recruitment and enrollment of URM students and to include community-based education as part of the curriculum. Fifteen of the participating dental schools were followed as part of an evaluation of the program. Over a period of 5 years, the fifteen schools employed the following strategies to increase the recruitment and enrollment of
underrepresented minority students: summer enrichment programs, postbaccalaureate programs, held meetings with preprofessional advisors from colleges with a major enrollment of URM students, created new recruitment materials directed to colleges with high enrollment of URM students, environment scans, attended admissions workshops directed to a whole-file review of candidates. Some formed collaboratives to work together on efforts.

Enrollment of URM students increased overall by 54.4% in the schools included in the evaluation. There was variability within the schools with four schools achieving 20% of their freshman classes made up of URM students and in two schools there was no change. Schools changed institutional policies related to admissions, and the internal school environment for student diversity, and added mentoring programs and scholarship funds to increase the diversity of the student body. This program demonstrated that schools that desired diversity could achieve it if they expended the effort. However, it required schools to reform existing policies and practices in critical areas such as recruitment, admissions, and institutional climate for diversity and inclusion. The Commission on Dental Accreditation (CODA) has the responsibility to determine whether schools have accomplished reforms to satisfy two standards on diversity. The first standard, standard 1-4, states that schools must have policies and practices in place to achieve diversity among their students, faculty, and staff and comprehensive strategies to improve the institutional climate for diversity. The second standard, standard 4-4, states that schools must have admission policies and procedures designed to include recruitment and admission of a diverse student population. There is also a statement in CODA standards that expects the educational environment in schools to ensure an in-depth exchange of ideas and beliefs across gender, racial, ethnic cultural, and socioeconomic lines. Whether schools achieve these standards or not is up to site visit teams who visit each school every 7 years. The standards on diversity were only added to the accreditation standards during the first decade of the 21st Century.

To move forward it is important to recognize that more needs to be accomplished. For example, in 2010–11 surveys of dental education, there were 10 dental schools that did not enroll any Black students, five that enrolled no Hispanic students, and two that enrolled not a single Black or Hispanic student. A recent analysis showed that interventions to support diversity in dental schools showed little benefit to Black students over the past 20 years. An analysis of annual ADA survey data from 2010 to 2020 showed that the percentage of enrollees who were Black in 2000 was 4.7% and in 2019 it was 5.7%, far below the 13.4% Black Americans in the population.

Between 2010 and 2020, seventy-seven dental schools have been reviewed by CODA. CODA data shows that no dental school has been cited for not satisfying CODA diversity standards. Are the standards too broad in their intent and interpretation? Can diversity be demonstrated in so many ways that preclude the consideration of underrepresented minority students and faculty as meaningful and essential elements? Are the standards true markers in the attempt to achieve greater racial equity among students, faculty, and ultimately the profession?

It will take greater sustained efforts by all dental schools to recruit and enroll Black students. Students of color recognize that more faculty of color are needed as mentors to improve the relationship between them and the predominantly white faculty. The role of Black faculty members is critical to the sustained efforts needed. Between the 2015 and 2019 academic years, there was no change in the percentage of the full-time and part-time African American dental faculty, which was only 4% of the faculty. Since full-time faculty carry much of the teaching, administration, and research responsibility, it is important to have an appreciation for those Black faculty members employed by the nation’s dental schools and to assess how best to increase their numbers on the faculties nationwide. They are needed to assist in recruiting and mentoring Black students.

Currently, the American Dental Education Association is conducting a climate survey of all dental schools in the United States and Canada. We are hopeful that this new survey will provide useful information which will lead to a new emphasis on the importance of moving all dental schools in the right direction by including diversity and inclusion in their student body and their faculty. It is important for all schools to become aware of the successful strategies that have been shown to work. There is no need to reinvent the wheel.

3 | THE ROLE OF ALL PRACTICING DENTISTS IS TO TREAT THE ENTIRE POPULATION

Unfortunately, there is still unequal access to oral health care in the United States. The reasons are complex, varied, and intertwined, ranging from social, financial, and racial issues. Black and other populations of color also face obstacles of equity to obtain the same quality of care as white patients.

In the first instance, vestiges of the Gies and Flexner models of health care education for Black students are no longer valid today. Their ideas which ascribed the responsibility of Black dentists and physicians respectively to treat the Black population as the rationale for improving
the representation of Black practitioners in practice are no longer tenable. Both the Surgeon General’s Report of 2000 and the 2021 NIH report, Oral Health in America: Advances and Challenges, released in collaboration with the US Surgeon General, cited the fact that Black youth had a significantly higher prevalence of untreated caries than White youth. Why? Because there continues to be a shortage of dentists in 5800 dental shortage areas in the US affecting approximately 58 million people. Three percent of the dentists are Black (2011–2015) while 13.3% of the population is Black. In comparison, 74.8% of dentists are white while 61.3% of the population is white.22,23

In the second instance, the need to treat all segments of the multiracial US population cannot be solved by segmenting practitioners’ responsibility by race or ethnicity. All practitioners are responsible to treat patients from all aspects of the population.24 But, there are barriers to fully embracing such an oral health system. For example, practitioners must recognize and accept the obligation to treat all the low-income Medicaid patients, including all historically underserved population groups. Currently, only less than half of the practicing dentists even accept Medicaid patients. At the same time, practitioners also need to understand that cultural bias for treatment options must be confronted in order for treatment outcomes to be equitable for all patients regardless of their individual characteristics.24,25

Therefore, to become an inclusive society, outreach is needed from our educational institutions to marginalized populations and ethnic groups. More specifically, a renewed commitment to bring parity to eliminate oral health inequities among Black Americans can only be rectified through a willingness to put into place policies and practices that include Black Americans fully in the academy and as patients in all dental practices.

In revisiting Gies Chapter V, “Deficiency of Dental Service for the Negro Group”, the following question arises from the fact that he stated that the “general growth of sentiment for segregation has increased the tendency, in many dental schools, to restrict the attendance to white students ….”26 Was he satisfied with the fact that in 1924–25 only 27 “Negros” were graduated from 12 dental schools of the 40 dental schools (exclusive of Howard and Meharry) that accepted both Black and White students?27 What, if he had recommended that all of the then 40 dental schools admit Black dental students. By accepting the “prevailing sentiment for segregation” which “prevents admission of more than a few colored students to the existing medical and dental schools attended by white students”, Gies,28 unwittingly, gave legitimacy to the idea that Black dentists should be educated by Black dental schools to only provide care for the Black population. His support of Howard and Meharry as the “pioneer Negro schools of dentistry” was correct. But, his inability to realize that the health of all of the public in the United States required a cohesive approach regardless of race and ethnicity in order that all people should and would receive the same level of prevention and care. The 1926 Gies Report set out the blueprint for dental education in the United States until the 1960s when the health science schools broadened the vision for their institutions and their professions. An opportunity was lost when the reports by the Carnegie Foundation for the Advancement of Dentistry and Medicine in the early part of the 20th Century failed to question the social convention of their day. It is time now to recognize the social movement of the 21st Century and, particularly that all dental schools in the United States must open their doors to all qualified Black applicants.

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7. Ibid. pg. 180.
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ORIGINAL ARTICLE

Establishing an antiracism framework for dental education through critical assessment of accreditation standards

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Abstract

Purpose: The purpose of this manuscript is to establish an antiracism framework for dental education. Since the accreditation process is an influential driver of institutional culture and policy in dental education, the focus of the framework is the Commission on Dental Accreditation (CODA) standards for predoctoral education.

Methods: The authors of this manuscript reviewed each CODA predoctoral standard for opportunities to incorporate antiracism strategies. Eight standards were identified under themes of diversity (Standards 1-3, 1-4, 4-4), curriculum development (Standards 2-17, 2-26), and faculty recruitment and promotion (Standards 3-1, 3-4, 3-5). Guided primarily by National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, a logic model approach was used to critically assess those standards for opportunities to establish antiracism strategies, with anticipated outcomes and impacts.

Results: Strategies highlighted a need to improve recruitment, admissions, and accountability among dental schools to address the low numbers of historically underrepresented racial and ethnic (HURE) students and faculty. They emphasized the inclusion of racism in curricula geared toward training dental students to provide care to HURE populations. Finally, there are opportunities to improve accountability that dental schools are providing equitable opportunities for career advancement among HURE faculty, with consideration of conflicting demands for scholarship with HURE student mentoring, role modeling, teaching, and/or service.

Conclusions: The framework identifies gaps in CODA standards where racism may be allowed to fester, provides specific antiracism strategies to strengthen antiracism through the accreditation process, and offers dental education programs, a process for evaluating and establishing their own antiracism strategies.

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1 | INTRODUCTION

Antiracism in dental education demands that institutions and policies counter the effects of racism while dismantling the systemic forces that perpetuate it. It is a process of promoting and advocating for policies and leaders that speak against racism, educate others about its harmful effects on the dental profession, and build institutional cultures that are intolerant of racist ideology and/or complacency toward racial inequity. Accreditation is one of, if not the most, influential driver of policy, procedures, and institutional cultures within dental education. The Commission on Dental Accreditation (CODA) is intended to serve the interest of the public and the profession by developing and monitoring standards to assess and verify the quality of dental education programs in the United States.1 Dental education programs rely on the accreditation process for quality improvement, which assures affinity in their ability to train dentists who can address the oral health needs of the general population. The importance and influence of accreditation status on educational programs obliges accrediting agencies to establish the precedent for antiracism policy and accountability.

The educational environment section of CODA predoctoral standards states that, “each dental school must... have policies and practices to achieve an appropriate level of diversity among its students, faculty and staff (p. 12).”1 However, current CODA predoctoral standards provide limited specificity and clarity on the level of commitment or precise levels that dental schools must demonstrate to address dimensions of racial diversity among students, faculty, and staff. There are no specific CODA-driven metrics to standardize how schools address race and ethnicity in curricula, that is, implicit bias, discrimination, and cultural competency. Additionally, expectations among dental schools for the recruitment, retention, and promotion of historically underrepresented racial and ethnic (HURE) faculty are also unclear. HURE is defined as American Indian/Alaska Native, Black/African American, Hispanic/Latinx, and Native Hawaiian or Other Pacific Islander population groups.

The framework presented in this paper is built with an assumption that dental education needs to: (1) provide rationale for the dental accreditation process to establish metrics that address dimensions of diversity and drive change in diversity initiatives, curricula, and faculty development; (2) emphasize the role of accreditation standards in promoting or inhibiting the effectiveness of strategies and practices aimed at reducing the effects of racism within the dental education; and (3) provide the basis for a system approach to addressing institutional racism within dental education programs. The intention of this framework is to offer guidance for using the accreditation process to drive institutional policy changes that specifically address racism, and improve accountability that dental schools are working collectively to develop and achieve antiracist aims.

1.1 | The need for antiracism in dental education

1.1.1 | Historical lack of diversity among students and faculty

The 1926 Gies Report2 iterated that poor oral health among Black people threatened the health of the general population, and that Black dentists were not being produced at rates that could keep up with the growth of Black populations in various parts of the country. At that time, most dental schools did not admit Black students into their programs, and most of the ones that did admitted a limited number of them solely to care for the Black patients who presented to their infirmaries. The majority of dentists were trained at two historically Black dental schools: Howard University College of Dentistry and Meharry Medical College School of Dentistry. Since then, the total number of yearly HURE dental school graduates has increased, with more diversity in aggregate at US dental schools. However, those changes are not substantial enough to significantly improve racial and ethnic diversity within the dentist workforce.

The pretense that Black dentists were valuable in the limited context of only servicing the needs of Black infirmary patients in 1926 aligned with the systemic practice of racial segregation of that time. The question to be asked now is: has the conceptual basis for that pretense changed over the past 100 years? It has been predicted that by the year 2045, people of color are expected to comprise the majority of the US population, yet racial inequity and underrepresentation in the oral health workforce will likely persist.
1.1.2 Lack of HURE dentists and poor quality of access to dental care among HURE populations

HURE populations experience more untreated tooth decay, tooth loss, and severe periodontal disease than non-Hispanic White populations.5–10 Having HURE dentists improves the poor availability, affordability, and quality of dental care that occurs as a result of fewer dental providers in communities where higher concentrations of HURE populations reside, poor patient–doctor communication, discrimination, and HURE populations’ historical mistrust of healthcare providers.11–16 Yet, the number of HURE dentists are low relative to the total number of dentists in the US population. In 2021, the Health Policy Institute of the American Dental Association reported that relative to the racial mix of the US population, White and Asian dentists were overrepresented (88.2%), while Black (3.8%) and Hispanic (5.9%) dentists were underrepresented.17 From 2010 to 2020, of the 63,583 dental school graduates, 54.07% identified as White/Caucasian, 23.6% Asian (non-Hispanic/Latino), 4.7% non-Hispanic Black, 7.23% Hispanic, and 0.45% American Indian/Alaska Native, with a reduction in the percentage of non-Hispanic Black and American Indian/Alaska Native graduates from 5.4% to 4.7%, and 0.7% to 0.4%, respectively.18

HURE dentists provide care to significant numbers of racially concordant patients, and greater percentages provide care to Medicaid patients, compared to White dentists.5,19 Mertz et al.20,21 reported that on average, Black and Hispanic dentists’ patient mix was 44% Black and 42% Hispanic, respectively. There is a maldistribution of dentists providing routine care to underserved populations.22 It has been reported that in 2017, only 25% of White dentists treated at least one Medicaid patient, compared to 46% of Black dentists and 33% of Hispanic dentists.18 Only 12% of White dentists treated 100 or more Medicaid patients compared to 30% of Black dentists and 22% of Hispanic and Asian dentists, respectively. These data highlight the significant value of HURE dentists in improving access to care for lower income and HURE populations, and addressing oral health inequities.

2 DEVELOPING THE FRAMEWORK

The antiracism framework presented in this manuscript was conceptualized using the logic model approach employed by the US Department of Health and Human Services, Office of Minority Health in the development of their strategic framework for improving racial/ethnic minority health and eliminating health disparities.23 Each CODA standard for predoctoral dental education programs was reviewed by the authors of this manuscript. Standards that were closely associated with diversity, curriculum development, and faculty recruitment and promotion were critically discussed to identify opportunities to incorporate antiracist strategies (Table 1). Proposed strategies were then developed to offer guidance for how the accreditation process can incorporate antiracist language and processes for evaluating dental schools’ progress toward positive outcomes (Figure 1).

Guidance for developing the antiracism strategies proposed in this framework were informed by the Liaison Committee on Medical Education standards, the American Dental Education Association (ADEA) Faculty Diversity Toolkit, the US Department of Health and Human Services National Standards for Culturally and Linguistically Appropriate Services (CLAS), and the ADEA Minority Faculty Development and Inclusion Program.24–28 For primary guidance, we relied upon national CLAS standards, which were adopted by the US Department of Health and Human Services with the intention of establishing a blueprint for health organizations to advance health equity, improve quality, and help eliminate healthcare disparities.26 There are 15 CLAS standards; seven of which have been mapped to CODA standards assessed for this framework (Table 2). The purpose of using CLAS standards was to align the proposed strategies for CODA standards with national priorities for addressing health equity.

3 CRITICAL REVIEW OF ACCREDITATION STANDARDS

Eight CODA standards were identified for review. Concerns for each standard and proposed strategies to address them are outlined in Table 3 and discussed below.

3.1 Racial diversity among students and faculty

3.1.1 Standard 1-3

Not much is known about how dental schools address racism in their humanistic environment policies and practices. Although policies exist and are evaluated for accreditation, HURE students and faculty may still experience microaggressions, discrimination, and barriers to socialization and mentorship. Those experiences can negatively influence student and faculty views on the academic environment as well as the profession. Such experiences may be underreported due to fear of
TABLE 1  Summary of Commission on Dental Accreditation (CODA) standards and intent statements related to diversity, dental education curriculum, and faculty recruitment and promotion

<table>
<thead>
<tr>
<th>CODA standards</th>
<th>Intent statements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Racial diversity among students and faculty</strong></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.</td>
</tr>
<tr>
<td>1-4</td>
<td>The dental school must have policies and practices to: (a) achieve appropriate levels of diversity among its students, faculty, and staff; (b) engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; and (c) systematically evaluate comprehensive strategies to improve the institutional climate for diversity.</td>
</tr>
<tr>
<td>4-4</td>
<td>Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.</td>
</tr>
<tr>
<td><strong>Race, racism, and curricula</strong></td>
<td></td>
</tr>
<tr>
<td>2-17</td>
<td>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.</td>
</tr>
<tr>
<td>2-26</td>
<td>Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.</td>
</tr>
</tbody>
</table>

The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff. The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum, and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to gender, racial, ethnic, cultural, and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff. The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.

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 healthcare; basic principles of health literacy and effective communication for all patient populations recognition of healthcare disparities and the development of solutions; the importance of meeting the healthcare needs of dentaly underserved populations; and the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multidimensionally diverse society. Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral healthcare workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service. (Continues)
TABLE 1 (Continued)

<table>
<thead>
<tr>
<th>CODA standards</th>
<th>Intent statements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Faculty recruitment and promotion</strong></td>
<td></td>
</tr>
<tr>
<td>3-1 The number, 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. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.</td>
<td>Faculty should have 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 competence in all areas of the dentistry covered in the program.</td>
</tr>
<tr>
<td>3-4 A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship, and service.</td>
<td></td>
</tr>
<tr>
<td>3-5 The dental school must have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.</td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 1 Conceptual illustration of the logic model approach used to develop the antiracism framework for predoctoral dental education accreditation standards. CODA, Commission on Dental Accreditation

retribution and/or disbelief that such concerns will be adequately addressed. In addition, due to low numbers of HURE students and faculty, even anonymous humanistic surveys may not allow them to voice their concerns.

3.1.2 Proposed strategies for Standard 1-3

- Dental schools should acknowledge that racially motivated grievances may be underreported and actively seek feedback from HURE students and faculty on how to improve dental schools’ prevention and reaction to such grievances.
- Dental schools must provide evidence of their methods and frequency of engaging HURE students and faculty to address racism in the humanistic environment, while also providing evaluation of the effectiveness of those methods.
- Dental schools should provide evidence of the number and types of racially motivated grievances that get reported with evidence of their effectiveness in mitigating student and faculty concerns.
- Dental schools must provide evidence of students’ and faculty their knowledge of the personal and institutional consequences of racist violations of the humanistic environment.

3.1.3 Standard 1-4

Despite the historical lack of representation of HURE students and faculty, it appears that dental schools continually meet this standard. It is unknown if the accreditation process has held any dental schools accountable for not meeting the standard due to few HURE students and faculty. A limitation of this standard is that it allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not emphasize HURE students and faculty, which also undermines the collective priority among dental schools to increase the number of HURE dentists within the profession. Additionally, CODA provides no specificity for the level of engagement that dental schools should have with HURE populations for recruitment.

3.1.4 Proposed strategies for Standard 1-4

- Dental schools should develop and support partnerships with predoctoral programs at Historically Black Colleges and Universities (HBCUs) and Minority Serving Institutions (MSIs). Identifying and addressing limitations of those partnerships should also be a major emphasis.
### TABLE 2 National Culturally and Linguistically Appropriate Services (CLAS) standards addressed in this framework

<table>
<thead>
<tr>
<th>Standard</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.</td>
<td>1-3, 1-4, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.</td>
<td>1-3, 1-4, 2-17, 2-26</td>
</tr>
<tr>
<td>Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.</td>
<td>1-3, 2-17, 2-26</td>
</tr>
<tr>
<td>Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.</td>
<td>2-17</td>
</tr>
<tr>
<td>Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.</td>
<td>1-3, 1-4, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
<tr>
<td>Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.</td>
<td>2-26</td>
</tr>
<tr>
<td>Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.</td>
<td>1-3</td>
</tr>
<tr>
<td>Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.</td>
<td>1-3, 1-4, 2-17, 2-26, 3-1, 3-4, 3-5, 4-4</td>
</tr>
</tbody>
</table>

- Dental schools must show how they are progressing toward increasing HURE students and faculty longitudinally. If schools consistently fail to show improvement, they must provide evidence that new efforts are being implemented or existing efforts are being modified on a continual basis.

**3.1.5 Standard 4-4**

One issue with this standard is how dental school applicants’ potential to successfully complete a dental education program is determined. Admissions decisions are made by committees of people, and although there are trainings and processes to address certain implicit biases toward HURE applicants, the process is still subjective. There are unique social and structural issues that exist for HURE applicants that must also be considered when assessing HURE applicants’ potential for success. Those issues may influence HURE students’ undergraduate academic performance. Additionally, HURE applicants may develop an interest in a dental career later in their academic journey, have few academic mentors to guide them in meeting pre-requisite requirements for dental school applications, and have less access to Dental Admissions Test preparation programs. Because there are few HURE students and faculty in the learning and social environments of some dental schools, members of admissions committees could question whether HURE students will have the levels of peer and faculty support to mitigate microaggressions, and implicit and explicit biases that may negatively impact their academic performance. Another issue is that policies intended to reduce racial discrimination may exist, but dental schools do not have to provide evidence as to whether those policies are being assessed and are working.
<table>
<thead>
<tr>
<th>Problems</th>
<th>CODA standards</th>
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<td><strong>Racial diversity among students and faculty</strong></td>
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<td>Limited specificity and clarity on the intention of dental schools to</td>
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<td>Dental schools must provide evidence of their processes for systematically addressing race-related concerns for the humanistic environment while also addressing student and faculty concerns for retaliation</td>
<td>Written and enforced processes for addressing race-related concerns for the humanistic environment</td>
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<td>address racial diversity among students and faculty</td>
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<td>Students and faculty must be required to provide evidence of their knowledge of and acceptance of the personal and institutional consequences of humanistic misconduct</td>
<td>Accountability among students and faculty of their understanding that race-related humanistic misconduct will not be tolerated</td>
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<td>Dental schools must be required to provide evidence of the number and types of race-related grievances and how they were able to effectively mitigate those grievances</td>
<td>Accountability within dental schools that race-related grievances are being adequately addressed</td>
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<td>Dental schools must show benchmarks for racial representation and how they are progressing toward meeting those benchmarks longitudinally over time</td>
<td>Processes for increasing racial representation through pipeline programs</td>
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<td>Evaluation metrics that identify strengths and weaknesses of recruitment processes</td>
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<td>4-4</td>
<td>Predoctoral programs must have written standards, criteria, and evaluation metrics that account for applicants’ social contexts</td>
<td>Evidence of pipeline program modifications over time</td>
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<td>Dental schools must have protocols and programs in place that specifically and effectively address the social and academic concerns of underrepresented minority students, that is, discrimination and microaggressions</td>
<td>Processes for reviewing students holistically and based on addressing the dental profession’s needs</td>
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<td>Dental schools must show evidence that they are annually measuring and balancing the levels of implicit racial bias that exist among admissions committee members</td>
<td>Underrepresented minority dental students will have adequate academic, social, and resilience supports in place to combat the effects of discrimination and microaggressions, that is, faculty and peer mentors, tutors, and wellness counseling</td>
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<td>Dental schools will have knowledge of the levels of implicit racial bias on admissions committees and will be required to show evidence that those levels are consistently balanced throughout the admissions process</td>
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<td><strong>Race, racism, and curricula</strong></td>
<td>2-17</td>
<td>Dental students’ must be knowledgeable of racialized oral health inequities and how racism intersects with structural and social determinants of health to influence differential access to care among various populations</td>
<td>Dental schools will have evidence-based content embedded in the curriculum that addresses how racism intersects with structural and social determinants of health to influence differential access to care among various populations by race</td>
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<td>Dental students will be assessed on their knowledge of how racism intersects with structural and social determinants to contribute to racialized oral health inequities</td>
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<tr>
<td>2-26 As part of their clinical training, dental students must provide</td>
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<td>provide dental care in community-based settings</td>
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<td>Community-based clinical experiences must provide opportunities for dental students to learn about structural and social determinants of health and cultural competency, while emphasizing the ethical obligation that dentists have to ensure adequate access to care to the entire population</td>
<td>All dental students will participate in community-based rotations Community-based rotations will educate students on structural and social determinants of health, cultural competency, and dentists ethical obligation to ensure access to dental care to the entire population</td>
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<td>Faculty recruitment and promotion</td>
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<td>Lack of clarity on expectations for recruitment and promotion of</td>
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<td>Dental schools must be required to include underrepresented minority faculty in their definition of “sufficient” and show evidence of recruitment and hiring underrepresented minority faculty</td>
<td>Evidence that dental schools are working toward increasing their number of underrepresented minority faculty Increased number and improved quality of faculty development training programs for underrepresented minority faculty</td>
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<td>3-4 At the onset of hiring and annual faculty reviews, dental schools</td>
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<td>Dental schools must show evidence of quality improvement processes and longitudinal results of their hiring, recruiting, and retention of full-time underrepresented minority faculty and administrators</td>
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<td>articulate expectations for faculty workload and performance that align</td>
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<td>Dental schools’ promotion and tenure guidelines must articulate how race-related demands for service, student mentorship, and peer mentorship are weighted for underrepresented minority faculty</td>
<td>All full-time underrepresented minority faculty will be given opportunities for promotion and tenure Increased numbers of underrepresented minority faculty on promotion and tenure tracks</td>
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<td>with criteria for promotion and tenure</td>
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<td>3-5 Dental schools must demonstrate that full-time underrepresented</td>
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<td>minority faculty are provided with annual updates to the promotion and</td>
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<td>tenure process and their eligibility</td>
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<td>Abbreviation: CODA, Commission on Dental Accreditation.</td>
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3.1.6 Proposed strategies for Standard 4-4

- Dental schools should identify, acknowledge, and address the full social and structural contexts that HURE applicants bring with them, and implement systems to include those contexts in decision making about applicants’ potential to succeed and enhance learning and professional environments; rather than just their potential to fit in and/or matriculate their particular programs.
- Dental schools must have systems in place for faculty and administrators to know how to address the social and academic concerns of HURE students rather than view those types of issues as deficits. As it stands, the institutional power of dental education programs may require that students and faculty adjust to the needs and comforts of their systems rather than modifying their systems to achieve equity in opportunities for success. For example, some dental schools may provide special accommodations for students with test taking anxiety, but similar considerations may not be available for students experiencing anxiety due to microaggressions from other students and/or faculty.
- In lieu of the lack of HURE faculty, dental schools must show evidence that they are actively measuring the levels of implicit racial bias that exist among admissions committee members and if those levels are consistently balanced. Admissions criteria should further consider beyond which applicants might successfully matriculate their programs, but which applicants will have an interest, desire, and commitment to learn about issues for more socially aligned curriculum shifts, such as structural competency, community-based practice, and addressing racism in dental practice and policy.
3.2 | Race, racism, and dental school curricula

3.2.1 | Standard 2-17

Most dental students are exposed to HURE populations during their clinical education. Yet, students may not have a full understanding of how structural racism, bias, and discrimination negatively impact oral health. This standard does not require that dental schools educate students on topics such as racism, bias, and discrimination.

3.2.2 | Proposed strategies for Standard 2-17

- Dental schools must provide evidence of what is being taught about race and racism in their curricula, as well as the pedagogy and purpose for incorporating such content.
- Dental schools must provide evidence of who, how, and where such content is being taught, with reporting of faculty qualifications to deliver such content.

3.2.3 | Standard 2-26

Students have opportunities to witness how structural racism contributes to racialized oral health inequities through community-based experiences. However, the standard only requires that dental schools present “opportunities” for students to have community-based experiences. Dental schools need to only encourage students to take advantage of such opportunities, and the level of student engagement varies, which may eviscerate the intentionality of the standard. Additionally, the curricular focus of community-based experiences varies among dental schools. For example, curricular content to support community-based experiences may only focus on individuals with special healthcare needs or rural populations. Finally, the intent of this standard is that dental students develop an appreciation for community service rather than competency working in community-based environments. As written, this statement minimizes the role of dentists in improving access to care among HURE populations through conventional provision of care and policy development.

3.2.4 | Proposed strategies for Standard 2-26

- Dental schools should expose students to community-based settings where HURE populations receive dental care, so that they can experience how racism affects oral health and how real-world antiracism approaches function to improve oral health in clinical settings. Community-based programs should also develop students’ confidence in their ability to incorporate antiracist approaches to dental care.

- Dental schools must provide evidence of how their community-based programs are measuring and improving students’ self-efficacy in providing dental care to HURE populations in community-based settings.

3.3 | Faculty opportunity and development

3.3.1 | Standard 3-1

How dental schools determine faculty qualifications that are “sufficient” for their programs is the concern for this standard. There are few full-time HURE faculty to assure racial representation in research, curricula development, institutional policy development, and student mentorship/role modeling. This standard gives dental schools leniency to not hire or engage with scholars who have expertise in issues of race and racism if they deem those aspects of dental practice and policy of lesser importance. This standard also does not address the unique needs that HURE students may have for mentorship, academic support, and role modeling. For example, a dental school with few HURE students may not need any full-time HURE faculty to meet its definition of “sufficient.” Also, a dental school with no HURE faculty may not deem it necessary that they have HURE administrators. What must be considered is that students and faculty may choose to not attend or work in environments where they feel the racial disparity in power among faculty and administration will place them at a disadvantage.

3.3.2 | Proposed strategies for Standard 3-1

- The antiracism approach to this standard should recognize how misinterpretation of “sufficient” may perpetuate cycles of inequity. Dental schools must include HURE faculty in their definition of “sufficient” and show evidence of how they are meeting this standard in their hiring and recruiting practices.

- Dental schools must show evidence of quality improvement processes and longitudinal results of their hiring, recruiting, and retention of HURE faculty.

3.3.3 | Standards 3-4 and 3-5

Because they are few in number, HURE faculty may be hired and/or called upon for roles that other faculty
members may not. For example, they may be asked to teach at various and multiple levels of the curriculum where racial representation is lacking. Their positions may demand more service to provide adequate racial representation on committees. In addition, the needs for student mentorship and role modeling at dental schools with few HURE students and faculty may place extraneous demands on their time. Thus, the amount of time devoted to teaching, scholarship, and service may vary from their non-HURE colleagues, which demands either a more subjective approach or a unique set of objectives for faculty evaluations. Some HURE faculty may choose not to pursue academic careers due to potential limits imposed by such factors on their ability to progress in an academic career. This not only hinders faculty recruitment and retention, but may subsequently limit the recruitment and retention of HURE students due to their preferences to learn in environments with better racial representation.

3.3.4 | Proposed strategies for Standards 3-4 and 3-5

- Dental schools must routinely and directly communicate their intentions for faculty performance with HURE faculty, with reasonable expectations for promotion and tenure. Such intentions and expectations must also exist within written policies that outline criteria for faculty promotion and tenure.

4 | CONCLUSION

The framework presented in this manuscript offers suggestions for enhancement of CODA standards to enable dental schools to use accreditation as a guide for evaluating and addressing areas where institutional racism may be having an effect. It also provides an aspirational vision for how the accreditation process can universally drive change toward antiracism in dental education. To achieve that vision, the framework proposes explicit attention to several issues, which is also consistent with national CLAS standards, to identify and adjudicate potential factors of institutional racism. Among them are:

1. Beyond evidence of plans and procedures, dental schools should be held accountable for outcomes.
2. Diversity is defined too broadly and without specificity.
3. Collaborative partnerships with HBCUs and MSIs hold promise for attracting HURE students into dental schools.
4. Composition and implicit biases of admissions committees should be regularly assessed and balanced by dental schools, and evaluated during accreditation reviews.
5. There is insufficient intentionality in the CODA standards regarding race, oral health inequities, social justice, and access to care in dental school curricula.
6. There is insufficient emphasis on ensuring that dental students have community-based experiences with HURE so that they can see and experience racialized oral health inequities in unfiltered environments.
7. There is too little emphasis on the need to ensure that racial diversity of faculty include HURE, and that faculty from HURE have equitable opportunities to achieve promotion and tenure.
8. While the paper focuses more on CODA accreditation standards than the site visit process, it is worth noting the value of accreditation site visit teams being structured in a manner that ensures inclusion of people fully versed in antiracist considerations.

As educators, a question that should challenge and haunt us is: Why has so little changed since the findings made clear in the 1926 Gies report regarding the numerical capacity of dentists of color to meet the needs of populations dependent upon them for oral health services? After nearly 100 years, many of the report’s findings could be used to describe dental education today. Like most societal issues, there are numerous facets contributing to this outcome. However, a closer look at the systems and essential structures we rely upon to provide guidance is mandatory. W. Edward Deming’s statement that “every system is perfectly designed to get the results it gets,” has been applied to numerous aspects of the health system, and its application to the context of institutional racism within dental education seems appropriate. CODA, by providing standards and setting expectations, directly determines the quality of the dental education system. Thus, it is incumbent upon CODA to assess the system of dental education relative to its potential contribution to institutional racism.

To date, the dental literature is sparse in its attention to antiracism issues, relative to medicine.36,37 However, the papers to follow in this compendium present a strong launching point for necessary antiracism considerations in dental education, and ultimately for the dental profession.

EDITOR’S DISCLOSURE
This article is published in the Journal of Dental Education as part of a special issue. Manuscripts for this issue were solicited by invitation and peer reviewed. Any opinions expressed are those of the authors and do not represent the Journal of Dental Education or the American Dental Education Association.
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Perspectives on Justice, Equity, Diversity, and Inclusion (JEDI): A call for oral health care policy

Brian J. Swann DDS, MPH | Tawana D. Feimster DDS, MS | Deirdre D. Young DDS, MHSA | Steffany Chamut DDS, MPH, FICD

Abstract
Educational Institutions in the U.S. have responded to government policies that called for more inclusive educational systems. The goal is to reduce the oppression created by “racism” and enhance the environmental trajectory toward equity and justice. Although significant social and economic advances have been made, these have not been sustainable, and disparities remain. As educational systems have not kept pace with the demographics and economic trends, there is a call to action to affirm the need to establish policies that support diversity within pipeline pathways, faculty recruitment, and retention. Leveraging knowledge and networking across institutions with communities can transform academic cultures, reduce unconscious/implicit bias, and microaggression. As racism exists in every segment of our culture, building sustainable capacity and a system proportional to the populations’ relative needs can help chart a direction forward for policies that support justice, equity, diversity, and inclusion among dental institutions.

KEYWORDS
academic institutions, dental schools, justice, equity, diversity, and inclusion, oral health, policies, underrepresented minorities

INTRODUCTION
Dental workforce diversity is a nationwide priority. Currently, the United States (U.S.) population is facing a diversity shift, where one in four Americans identify as Black, African American, Hispanic, Asian, or other. Unfortunately, the U.S. dental education and workforce are not mirroring the nation’s demographics, which leaves significant gaps demanding to be filled in order to effectively address the critical needs of the diverse populations and their health disparities.

1.1 History of racism in healthcare and dental education
Black Americans and all other underrepresented minorities (URM) have historically sought a way out of oppression in the form of unfair treatment and searching for employment and education opportunities, as well as equitable healthcare. The “supremacy model” incorporates racism, which justifies oppression in many forms, disparities in opportunities, denial of quality healthcare, and even slave labor in many parts of the world. This is a critical
global problem. Exploitation and discrimination methods manipulate people so that the power of ownership and control remains with those who perpetuate superiority. Higher education was originally designed to educate White people to hold leadership positions. In order to achieve equity, inclusion, and justice, it is required that the control of institutions be divided proportionally. The fear or hesitation to share the power, consciously or subconsciously, would mean a monumental change in the entire global system. This is too large to tackle without major chaos. Therefore, it would be feasible to agree to redevelop a proportional healthcare system that matches the percentages of the population in the U.S. (i.e., if Black Americans make up 12% of the U.S. population, then we should produce 12% of the graduating doctors/dentists, supported by at least 12% of the faculty and administration).

It is important to understand the history relative to great strides in American educational systems and the reactions to major social and economic movements. To begin, Harvard was America’s first college. In 1639, its founder, John Harvard, donated resources that initiated an integrated educational system for both European immigrants and the indigenous Native Americans from the Wampanoag tribe. Before any Wampanoag graduated, the King of England restricted this program to include only Europeans. Secondly, the Civil War (1861–1865) was largely fought to stop the expansion of slavery and eventually created laws to end the practice of slavery for Blacks, Africans, and Native Americans in 1865. The Harvard School of Dental Medicine (HSDM), opened in 1867 as the first university-based dental in the country. The first two dental classes included a Black male, whose parents were former slaves. The first graduate went on the practice in the Washington D.C. area, and the second became one of Harvard’s first Black professors and practiced in the Boston area. Due to several policy changes, different administration, increased academic costs, and changes in the admission process, it would be 104 years before the next person of color would graduate from HSDM.

The Civil Rights Movement of 1960–70s was a racial and economic revolution that eventually led to U.S. policy changes and increased civil rights for all Americans. After countless deaths, arrests, destruction of property, and eventual peaceful protests, policies were created whereby institutions received federal funding to encourage integration of their student populations.

As a result of the Civil Rights movement, fundamental changes around structural racism and policies began setting the path to improve access to opportunities and reduce racial inequities. For HSDM, that included admitting three Black students, of which one would be the first Black female to enter and graduate from the program. Throughout the country, institutions began opening their doors for Black, Hispanic, Asian, Native American, and female students. But, they were eventually hindered by the Bakke Case (1978), which lobbyed against affirmative action. The notion of reverse discrimination swept across the nation when the U.S. Supreme Court ruled against the policy of a “quota” system which held a certain number of seats to be filled by underrepresented students to help ensure a diversity mix. Consequently, the number of students of color stagnated contradicting equity and causing this opportunity to spiral off course.

Currently, the Black Lives Matter Movement is the result of heightened violence toward Black Americans. The heart of the problem continues to be the oppressive system of racism that seems driven by fear of change. In 2020, over 200 health care organizations declared “racism” as a public health crisis. The lack of sustainable organizational structures and processes continues to limit opportunities to create mechanisms for creativity and innovation. These are necessary to support the advancement of culturally sensitive care delivery, and a range of talent to develop bold inclusive ideas and national strategies that would lead to equitable healthcare and health outcomes.

A more immediate cure for this dilemma is not only to produce providers based on demographics, but to reduce the cost of dental education, patient care costs, and to increase health insurance benefits that emphasize prevention.

1.2 The state of dental education, workforce diversity, and oral health equity

The national focus to address the disparities in oral health faced by URM students dates back to 1926 when William Gies authored the landmark report on “Dental Education in the U.S. and Canada”. This recognition was finally moved forward following the 2000 U.S. Surgeon General’s Report on Oral Health, which stated oral health is essential for overall health and well-being; therefore, a person cannot enjoy a healthy life and have the foundation to achieve healthy aging without oral health; and in 2005, good oral health was acknowledged as a basic human right during the Liverpool Declaration, and supported by the World Health Organization. Just as these recognitions highlighted access to oral health, we must also consider the impact on overall access and equity. A current challenge and concern from the Global Congress on Dental Education include inequities in access to education and oral health care.

Oral health care disparities amongst racial, ethnic, and socioeconomic sectors are prevalent worldwide that limit dental safety nets and access to dental care resources for rural and underserved populations. This is evident
in workforce shortages and health professional shortage areas (HPSAs).\textsuperscript{10} For appropriate access to dental care, the population to provider ratio must be at least 5000:1, and 4000:1 for communities facing high needs. In 2021, there were 6,906 dental HPSAs requiring about 11,416 dental workers to meet the access to dental care needs.\textsuperscript{10}

To meet future dental care needs, the graduating dental workforce must consider existing and predicted changes in the aging and diverse demographic population trends. Recognizing the influence of public and private dental educational institutions, as well as, disparities, inequalities and social conditions is key toward leveraging the planning and future of dental education in terms of diversity, inclusion, equity, and belonging, as well as the goal to advance access to dental care for all.\textsuperscript{9,11}

According to the 2021 Oral Health in America: Advances and Challenges report a diverse workforce will increase the likelihood of having more providers working in rural and underserved areas while providing culturally sensitive services to aid toward longer-term health outcomes.\textsuperscript{12,13} With changes in U.S. demography and needs, institutions must have a sustainable plan to address the insufficient number of URM students being admitted into dental schools.\textsuperscript{13} Despite the Commission on Dental Accreditation (CODA) Standards 1–4, requiring dental schools to make appropriate efforts to maintain a diverse faculty, staff, and students in dental medicine, URM groups remain low in comparison to the U.S. population.\textsuperscript{14}

1.3 Pipeline programs and their limited success

It is recognized that dental pipeline programs are effective in strengthening dental school applications, increasing dental entrance exam scores, growing diverse dental cohorts, and increasing access to care.\textsuperscript{15} In 2019, some of the students admitted were Black or African American. At high school and college levels, pipeline programs for students from URM groups have been established; however, limited programming has been developed for middle school students. Earlier health career exposure can increase middle-grade students’ awareness of oral health professions and ultimately enhance recruitment efforts.\textsuperscript{16} Successful models include the HRSA’s Health Careers Pipeline and Diversity Program, which aimed to increase the national health workforce that is reflective of the U.S. population. For example, HSDM HRSA-funded “Catalyzing Oral Health Workforce for Rural and Vulnerable Populations” training programs aim to train URM in rural areas to address the oral healthcare needs of aging and underserved populations. Pathway programming advances the delivery of effective, culturally sensitive, and patient-centered care with an emphasis on high-need areas.

2 CHALLENGES

Some of the challenges that are faced while addressing oral health care policy stem from the disparities between the proportions of racial and ethnic populations that have been historically underrepresented in the dental profession relative to their number in the U.S. general population. In 2019, there were 9.5% of U.S. dentists from the Historically Underrepresented Racial and Ethnic (HURE) group while almost 31.9% of this same group made up the U.S. population.\textsuperscript{1} (Figure 1).

Black and African American dentists (3.6%) are less than one-third of the share of the U.S. served population, while Hispanic/Latinx (5.6%) are 18.5%, three times larger. The 3.6% of Black and African American in the dental profession is less than one-third of the share of Black or

![Table 1.1. HURE Groups, Count and Percent of U.S. Population and of Professionally Active Dentists, 2011 and 2019](image-url)
African Americans in the served population, and Hispanics trail closely with 5.6% of U.S. dentists identifying as Hispanic/Latinx with their proportion of the U.S. population being 18.5%, three times larger. There has been an increase in the parity gap over the past decade between HURE groups as a percentage of the U.S. population and HURE groups as a proportion of professionally active dentists. The parity gap has increased from 21.2% in 2011 to 22.4% in 2019.1 (Figure 1).

Deans commonly say there are not enough qualified URM dental school applicants and faculty to fill these positions. As a result, the lack of diversity at dental schools has a downstream effect on addressing access to care in URMs’ communities.

It also affects the learning outcomes of every dental student because a diverse faculty have a direct impact on the learning outcomes of all students.1 Addressing and eliminating these disparities, will increase the number of URM dental providers to address problems seen with access to care in underrepresented communities and produce better learning outcomes for the students.

Dental schools’ deans need assistance in finding URM students and faculty. For many finding URM students or faculty has not been a priority, or they only follow the status know where to look. Still, others fail to use the Toolkit provided by the American Dental Education Association (ADEA), and/or do not allocate funds and resources to find qualified URM students and faculty. Another challenge that has been recognized is the impact that influential alumni, donors, and dental societies have on the policies surrounding diversity, equity, and inclusion at dental schools. Because financial donors maintain a certain amount of control, if they do not agree with diversifying the field of dentistry, this creates a major barrier to increasing diversity. Additionally, other dental school gatekeepers such as board of directors and university senior administration can be influenced by state and local politics.

Among the most significant challenges to increasing diversity at dental schools are the actual high tuition and operational costs. The average investment toward dental school tuition for the graduating class of 2020 was $284,855,
a cost that has continued to increase over the years.\textsuperscript{17} (Figure 2). The high costs of dental education directly impact dental school admissions and attendance. URM students without adequate finances or those who have been denied equal access to education find it challenging or even impossible to gain entry to dental programs. Those who do manage acceptance and successful completion, leave with considerable debt.\textsuperscript{8} Students seeking to satisfy their investment will be less likely to work in underserved communities where oral health care is most needed.

With barriers hindering URMs’ applications and acceptance into dental schools, the increase in the number of URM applicants between 2011 and 2019 was minimal. With a HURE annual 4.8% growth rate applying to dental school between 2011 and 2019, by the end of the 2010s, 993 HURE students were starting their dental doctoral degrees. The increased enrollment led to a 4% annual increase in HURE graduates between 2011 and 2019.\textsuperscript{1} (Figure 3). Based on the 2017 U.S. Census population projection, the HURE proportions of the U.S. population will continue to increase and will reach 34.7% in 2030 and 42% in 2060.\textsuperscript{1,18} The majority of the growth will come from the Hispanic/Latinx while Black or African American numbers will grow at a much slower pace.

With demographic shifts impacting access to care, dental schools must examine the educational debt that students face after graduation.\textsuperscript{10} Public university graduates and those who often join loan repayment programs after graduation have a wider selection of options due to lesser financial constraints, which is a significant predictor for public service.\textsuperscript{10}

On the contrary, as a result of high student debt, evidence suggests that graduates would rather practice in wealthy areas, instead of selecting academia, public health, or serving in underserved communities.\textsuperscript{12} ADEA has explored the idea that the Dental Admission Test could be a way of eliminating a certain portion of the applicant pool.

As a resolve, most dental schools are using a holistic process including application, grade point average, DAT test scores, recommendation letters, personal statements, and students/faculty/administrators’ interviews. One of the biggest barriers in this process is getting an interview. Retention is a barrier depending on the student’s experiences. Students with documented learning disabilities should be given special consideration especially when testing. It would be best that there is a written and a signed document indicating that a student’s learning disability will be considered during the entire educational process. Practically speaking, the level of sensitivity and experience from administration can be enhanced through required continuing education.

Dental education and policies have not kept pace with demographic and economic trends.\textsuperscript{11} To meet future dental care needs, the graduating dental workforce must consider existing and predicted changes in the aging and diverse demographic population trends. Recognizing the influence of public and private dental educational institutions, as well as, disparities, inequalities and social conditions is key toward leveraging the planning and future of dental education in terms of diversity, inclusion, equity, and belonging, as well as the goal to advance access to dental care for all.\textsuperscript{9,11}
2.1 | Recommendations

Finally, institutions must overemphasize recruitment and retention efforts. Inclusive programming and policies can enhance community members’ sense of belonging, thus, impacting retention. Institutions must consider campus culture and students’ well-being through the development of JEDI activities. As we think more broadly about retention strategies, academic units should work toward greater transparency and foster a community of inclusion that is free from harassment and discriminatory practices. Some strategies to address retention include establishing advisory councils, dedicated JEDI offices, and employee resource groups with the goal of collectively examining barriers and implementing best practices. Training toward addressing micro-aggressions and unconscious/explicit bias is crucial for the development of strong retention programming.19 Research has shown that faculty and staff participation in town hall meetings, focus group discussions, surveys, and community-building activities help foster stakeholder engagement and identify areas for improvement in JEDI integration. Using best practices in the hiring process can improve the number of faculty, and JEDI’s recognition and contributions.

URM faculty and administrators are crucial to attracting and retaining URM students. The current dental education workforce has to make room for more diversity on this level. Otherwise, we may continue the patterns we have historically seen. Meaning that not much happens until there is a major movement. But in the meantime, things remain the same because the incentive for change is not present. Having one or two faculty within an entire school creates problems of backlash and lack of promotion. It becomes a vicious cycle. Head administrators including deans and boards have to be willing to give power by increasing the pace of diversity and inclusion.

Although clinical care represents a large portion of oral healthcare, it is not the entire oral healthcare picture. As it relates to dental faculty, there is a need for role morels that address oral healthcare beyond the “status quo”. This means focusing more on public health, policy, research, academia, and advocacy.

3 | CALL TO ACTION

All institutions of higher education must examine policy and practices at each level ranging from equitable recruitment and retention efforts for staff, faculty, and students, holistic admission processes, sustained community outreach investment, and co-creating community building activities.

Best practices in higher education that advance recruitment and retention of a diverse candidate pool include job postings that explicitly encourage women, minorities, people with disabilities, veterans, and intersectional individuals to apply. Institutions must recognize the value diversity brings to making, designing, creating, and expanding spaces for social discourse through committing to equitable hiring practices and training for all hiring managers on implicit bias and standardized interviewing procedures.

Through the recruitment of diverse educators that have demonstrated commitment to excellence by providing leadership in teaching, scholarship, research, or service, institutions can build a diverse scholarly environment and deepen their investment in the community it serves. By partnering with other health sciences or other colleges on campus, dental institutions can sustain impact through a diverse curriculum, experiential learning, and community outreach.

Dental institutions must move beyond statements that support CODA standards, and establish programming, policy, and procedures, then disseminate findings that actually lead to a shared understanding and establish best practices. To overcome the problem of a small pool of eligible applicants from underrepresented racial/ethnic populations, dental institutions should have policies that grow the pool of eligible students by preparing them through pipeline programs starting as early as grade school.15

Investment in retention programming should be clearly articulated in strategic planning with actionable metrics that have financial support. Retention efforts should be publicized with college stakeholders to allow for all parties to participate in the achievement of identified strategies and action steps.

In the development of pipelines, there needs to be a broader explanations that consider and respond to the following questions:

1. What is dentistry and what is oral health?
2. What are the types of jobs associated with dentistry and with oral health?
3. How does one prepare for dental school and eventually for these associated jobs?
4. What about the costs of getting this education and what options exist for repayment and long-term opportunities for a good and sustainable income?

With changes in U.S. demography and needs, institutions must have a sustainable plan to address the insufficient number of URM students being admitted into dental schools.13 Nationally, institutions have pledged to address racism and inequities on college campuses. The pledges to address barriers have varied, and the short-term programs with verbal commitments require sustained assurances
to unravel structural imbalances and uneven practices. Over 200 health care organizations pledged to take action toward eliminating racial health inequities by tackling systemic barriers impacting URM.\textsuperscript{5} At this pivotal juncture, it is time to elevate the conversation to action and reaffirm institutional pledges of dismantling systemic barriers in higher education. In dental education, there are several strategies that can be implemented to confront these challenges and advance JEDI with students and faculty.\textsuperscript{20,21} It is essential that dental institutions establish or re-establish policies that strengthen pathway programming and foster a community that supports and advances a diverse and equitable campus.

Substantial evidence notes that diverse faculty are more likely to develop curricula advancing health equity, educating and conducting research toward the elimination of health disparities, and creating cultural sensitivity strategies.\textsuperscript{22} Developing a well-defined roadmap for individualized mentorship and career development aid toward a longstanding, highly individualized minority student-faculty career-mentoring program within an academic medical-centered setting.\textsuperscript{23} Additionally, a leadership development task force and/or a faculty-led diversity liaison program model could promote pathways to leadership positions within the academic environment.\textsuperscript{20}

Case Western Reserve University led a group of six universities to develop a project entitled “Institutions Developing Excellence in Academic Leadership–National (IDEAL-N)”. Over 3 years, the program leveraged knowledge, skills, resources, and networks to develop academic leaders and institutional gender equity transformation for women faculty in science, technology, engineering, and math (STEM).\textsuperscript{23} Institutions must strengthen inclusive policies when engaging and retaining URM students and faculty and supporting their advancement.

**ACKNOWLEDGMENTS**

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**EDITOR’S DISCLOSURE**

This article is published in the *Journal of Dental Education* as part of a special issue. Manuscripts for this issue were solicited by invitation and peer reviewed. Any opinions expressed are those of the authors and do not represent the *Journal of Dental Education* or the American Dental Education Association.

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**REFERENCES**


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REPORT OF THE STANDING COMMITTEE ON DOCUMENTATION AND POLICY REVIEW

**Background:** The Standing Committee on Documentation and Policy Review met via virtual meeting on June 19, 2023. Committee members in attendance included: Dr. Scott DeVito (chair), Dr. Joel Berg, Dr. Scott DeRossi, Dr. Paul Luepke, Dr. Monica Nenad, and Dr. Marshall Titus. Dr. Nancy Rosenthal was unable to attend. Dr. Sherin Tooks, senior director, and Ms. Jamie Asher Hernandez, Ms. Kathleen Navickas, Ms. Peggy Soeldner, Ms. Yesenia Ruiz, and Ms. Kelly Stapleton, managers, CODA, were in attendance. Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, also attended.

The Committee began its meeting with a review of the Committee’s charge. The Committee discussed the following items:

**Regular Review of Commission Policies:** One of the charges of the Standing Committee on Documentation and Policy Review is to regularly review Commission policies and procedures found in the Commission’s Evaluation and Operational Policies and Procedures manual (EOPP) to ensure that they are current and relevant. Following discussion of the policies scheduled for regular review, as well as proposed revisions, the Standing Committee determined that, unless noted, the policies remain current and relevant. In addition, the Standing Committee believed revisions to select policies noted in Appendix 1 are warranted and recommended they be adopted.

**Standing Committee Recommendation:** It is recommended that the Commission on Dental Accreditation adopt and implement immediately the proposed revisions to policies found in Appendix 1, including the revision of policies in the Commission’s EOPP and in all appropriate Commission documents.

**Consideration of Proposed Revisions to Miscellaneous Policies:** On occasion, outside of the regular policy review process, policies that may warrant revision are identified for discussion and possible revision by the Standing Committee. These policies include the following: Criteria for Consideration of an Application for Accreditation, Site Visitors, Materials Available from the Commission, Information on the Commission’s Website, Reporting Program Changes in Accredited Programs, Policy on Preparation and Submission of Documents to the Commission, Due Process Related to Appeal of Accreditation Status Decisions, Review Committees and Review Committee Meetings, Commission and Commission Meetings, and the Commission’s Policy on Temporary Use of Alternative Site Visits.

The Standing Committee considered proposed revisions to the *Criteria for Consideration of an Application for Accreditation*, which were proposed to clarify the situations where drafted and signed contractual agreements are required for inclusion in a developing program’s accreditation application.
The Standing Committee also considered the proposed revision to the Site Visitor policy, section related to site visitor criteria. The proposed revisions are specifically related to the criteria for site visitors for Dental Therapy programs and include modification of the temporarily waived requirement of a dental therapist educator on the site visit team. This proposed change was indicated due to the ongoing limited number of available dental therapist educator site visitors.

The Standing Committee reviewed proposed revisions to Commission’s policies Materials Available from the Commission, Information on the Commission’s Website, Reporting Program Changes in Accredited Programs and the Policy on Preparation and Submission of Documents to the Commission and noted they are editorial in nature and relate to enrollment guidelines for various disciplines.

The Commission’s Policy on Due Process Related to Appeal of Accreditation Status Decisions was also considered by the Standing Committee. Through review, the Standing Committee noted the proposed revision clarifies that program representatives may appear before the Commission to address questions related to Review Committee recommendations, in addition to appealing accreditation status decisions.

Through review of the Commission’s Policies on Review Committees and Review Committee Meetings, Commission and Commission Meetings, the Standing Committee noted the proposed revisions relate to the training of Review Committee Members and Commissioners, specifically the requirement that they observe at least one (1) site visit within their first year of service. The Standing Committee learned that, due to the number of Review Committee members and Commissioners that require this training, and based on their schedules and the availability of site visits to which they may be assigned, scheduling the observations has been challenging. The Standing Committee discussed a preferred alternative which would require new Review Committee members and Commissioners to participate in the Commission’s two-day Site Visitor Training Workshop. Additionally, since the site visitor training is conducted virtually, additional attendees could easily be accommodated without an increased financial burden on the Commission. The Standing Committee learned that the summer 2023 site visitor training was opened to all new and active (reappointed) site visitors resulting in a measurable increase in attendance. Through discussion, the Standing Committee agreed that participating in the site visitor training is a preferred training approach to ensure that new Review Committee members and Commissioners understand the fundamental principles of CODA’s accreditation process and the role of the site visitor. Additionally, the Standing Committee noted that Review Committee members and Commissioners attend a specific training in the winter, related to their role with the Commission.

The Standing Committee also considered a proposed revision to the Commission’s Policy on Temporary Use of Alternative Site Visits. Through discussion, the Standing Committee recalled the policy was developed in response to the COVID-19 pandemic to provide guidance for conducting site visits during the pandemic. The Standing Committee noted the policy also includes protocol for conducting the follow up in-person site visit following the virtual site visit, as required by the United States Department of Education (USDE). The Committee learned the follow-up in-
person site visits are in progress and will be concluded in fall of 2023. Through discussion, the Standing Committee learned that, according to the policy, one (1) of the site visitors who attended the virtual visit must conduct the on-site follow up visit. The Committee also learned that there have been occasions when the original site visitors cannot participate in the follow-up in-person site visit, for a variety of reasons, including that the site visitor is no longer an active site visitor. Therefore, the proposed revision allows for any active site visitor in the discipline to conduct the on-site follow-up site visit.

Following discussion of the policies, the Standing Committee determined that the revisions to policies, as noted in Appendix 2, are warranted and recommended they be adopted.

**Standing Committee Recommendation:** It is recommended that the Commission on Dental Accreditation adopt and implement immediately the proposed revisions to policies found in Appendix 2, including the revision of policies in the Commission’s EOPP and in all appropriate Commission documents.

**Commission Action:**

Prepared by: Ms. Peggy Soeldner
PROPOSED REVISIONS TO POLICIES UNDER REGULAR REVIEW

Underline indicates addition; Strikethrough indicates deletion

III. GENERAL COMMISSION POLICIES AND PROCEDURES

A. POLICY AND PROCEDURE FOR DEVELOPMENT AND REVISION OF ACCREDITATION STANDARDS

The Commission on Dental Accreditation has authority to formulate and adopt educational requirements and guidelines, i.e. standards, for the accreditation of dental educational programs within its purview. These include the predoctoral programs, as well as advanced and allied dental education programs.

In developing and revising accreditation standards, the appropriate communities of interest are substantially involved in all stages of the process. The process culminates in the adoption of accreditation standards which become the property of the Commission. Any individual who assists in developing or revising a standards document must sign a release giving the Commission the right to copyright such documents. During the initial step of the process, representatives from the discipline involved are invited to participate in the development of the preliminary document. These representatives are selected in cooperation with the organizations(s) nationally recognized in the discipline whose membership is reflective of the discipline.

The communities of interest (COI) include, but are not limited to, the following: sponsoring organizations and certifying boards of all dental and dental related disciplines under the purview of the Commission, program directors, dental school deans, administrators of non-dental school institutions offering dental programs, and constituent societies of the American Dental Association.

The Commission uses consistent definitions and terms in its standards documents. The Commission monitors the consistency of the definitions of terms used in the accreditation standards documents and lists a glossary of terms and approved definitions to be used by appropriate audiences when the revision of the accreditation standards for a discipline is initiated.

The following language is used when draft revisions of standards are circulated:

The Commission directed that the proposed revision of the (discipline) Standards be distributed to the appropriate communities of interest for review and comment. The Commission also directed that the proposed revised standards be presented in a hearing to be held....
Based on current word processing programs, the Commission now indicates a proposed deletion with a strikethrough and recommended additions are underlined. In the case of multiple circulations of proposed revisions, each successive revision will be presented to show all currently proposed changes to the original document, which is the current document in use by the Commission. The title page of the document will provide a chronology of Commission action(s) on revisions. The header on each page will indicate the meeting at which the proposed document was considered by the Commission. In addition, documents for circulation will have line numbers throughout.

The following is a summary of the standards development and revision process:

Step 1. Development of a preliminary document by staff and selected representatives of the discipline involved.

Step 2.
   i. Consideration of preliminary document by appropriate Review Committee
   ii. Recommendation by Review Committee for circulation of document to COI by the Commission
   iii. Commission authorizes circulation

Step 3.
   i. Circulation of preliminary document to COI for review and comment
   ii. Hearings are conducted with communities of interest, as appropriate.

Step 4.
   i. Comments from COI compiled by staff
   ii. Comments reviewed by appropriate review committee and appropriate changes made
   iii. Recommendation by Review Committee to implement changes, or to recirculate for further comment if changes are significant
   iv. Commission approves changes and authorizes implementation timeframe or recirculation to COI for comments
   v. Steps 3 and 4 can be repeated, depending upon significance of changes. In the case of multiple circulations of proposed revisions, each successive revision will be presented to show all currently proposed changes to the original document, which is the current document in use by the Commission. The title page of the document will provide a chronology of Commission action(s) on revisions. The header on each page will indicate the meeting at which the proposed document was considered by the Commission. In addition, documents for circulation will have line numbers throughout.

Step 5. Commission notifies all appropriate individuals and programs of implementation timeframe.
1. **Frequency Of Citings:** Each of the Review Committees and the Commission regularly review an updated analysis of the number of “must” statement citings and their distribution among the “must” statements in the accreditation standards for each discipline. These analyses are conducted at the summer meetings. Frequency of Citings Reports are provided to programs and presented at workshops. 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.

Reaffirmed: 8/23; 8/18; 8/12, 8/10

B. **POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS**

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of
standards are made to reflect significant changes in disease and practice patterns, scientific or
technological advances, or in response to changing professional needs for which the Commission
has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year
after the validity and reliability of the standards has been assessed, the Commission will conduct
a study to determine whether the accreditation standards continue to be appropriate to the
discipline. This study will include input from the broad communities of interest. The
communities will be surveyed and invited to participate in some national forum, such as an
invitational conference, to assist the Commission in determining whether the standards are still
relevant and appropriate or whether a comprehensive revision should be initiated.

The following alternatives, resulting in a set of new standards, might result from the assessment
of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with
Commission policies. An implementation date is specified and copyright privileges are sought
when the document is adopted. Assessment of the validity and reliability of these new standards
will be scheduled in accord with the policy specified above. Exceptions to the prescribed
schedule may be approved to ensure a consistent timetable for similar disciplines (e.g. advanced
dental education programs and/or allied dental education programs).

Revised: 8/18; 7/07, 07/00; Reaffirmed: 8/23; 8/12, 8/10, 7/06; Adopted: 12/88

C. PROCEDURES FOR HEARING ON STANDARDS

The Commission makes every effort to have two Commissioners attend each hearing on
standards sponsored by the Commission. The Commission believes that two Commissioners is
an appropriate number to routinely attend hearings on standards, but also believes that those in
attendance are not always appropriately visible. Thus, the Commission directed that all members
of the Commission who are present during Commission sponsored hearings on standards be
introduced at the beginning of the hearing on standards and, if feasible, be seated at a head table
to ensure their visibility to those offering testimony.

The purpose of a hearing on standards is to provide individuals, institutions and organizations
that will be affected by the document with an opportunity to comment. The Commissioner
selected to chair the hearing is generally responsible for:

- Calling the hearing to order, indicating that the hearing is one (1) hour but will be concluded
in 30 minutes if limited comments are received and the agenda is completing during that
time;
• Introducing him/herself, other Commission members and Commission staff present;
• Explaining the purpose of the hearing on standards;
• Providing brief background information on the proposed revision;
• Explaining the ground rules for the hearing;
• Listening to comments and maintaining the order and flow of the hearing; and
• Concluding the hearing.

The goal of a hearing on standards is to hear as many varied points of view on the proposed
documents as possible in an orderly fashion. The following ground rules facilitate achieving this
goal:
• The document should be reviewed on a page-by-page basis so that comments on specific
issues can be provided at the same time.
• General comments on the document can be considered either before or after the page-by-
page review, as determined by the Chair.
• Individuals who wish to provide comments should wait to be recognized by the Chair, and
identify themselves by giving their name, city, state, and educational institution, if
applicable.
• Individuals reference the specific section of the document on which they wish to comment by
indicating the page and line numbers of the section.
• Comments should be as concise as possible.
• Individuals should provide written comments that summarize their verbal remarks to the
Chair by the end of the hearing.

Hearings on standards should be constructive. It is sometimes helpful for the Chair to ask an
individual who is speaking at length against a section of the proposed document whether he/she
has a specific suggestion for revision. This can help to clarify the speaker’s objection more
precisely and to bring the comments to closure.

Occasionally, an individual or a few individuals may monopolize a hearing on standards. In
fairness to other attendees who may wish to speak, the Chair should direct individuals who have
had ample opportunity to express their opinions to conclude their remarks.

Commissioners are present to listen to representatives of the communities of interest and should
avoid becoming involved in debates about the relative merits of specific sections of the
document.

Similarly, hearings on standards attendees should refrain from engaging in heated debates with
each other. If such debates develop, the Chair may wish to remind participants that the
Commission is interested in considering all viewpoints on the issues and that no decision
regarding any issue will be determined during a hearing on standards.

At the close of the hearing on standards, the Chair should advise attendees of other opportunities for comment (i.e. other hearings on standards, if any, and the deadline for written comments) and indicate when the Commission will take the final action on the document.

Revised: 8/21; 2/15; Reaffirmed: 8/23; 8/18; 8/12, 8/10, 7/07, 7/01; CODA: 12/91:15

D. CONFLICT OF INTEREST POLICY

Evaluation policies and procedures used in the accreditation process provide a system of checks and balances regarding the fairness and impartiality in all aspects of the accreditation process. Central to the fairness of the procedural aspects of the Commission’s operations and the impartiality of its decision making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one’s duty to make decisions in the public’s interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be: 1) any relationship with an institution or program, or 2) a partiality or bias, either of which might interfere with objectivity in the accreditation review process. Procedures for selection of representatives of the Commission who participate in the evaluation process reinforce impartiality. These representatives include: Commissioners, Review Committee members, site visitors, and Commission staff.

In addition, procedures for institutional due process, as well as strict guidelines for all written documents and accreditation decisions, further reinforce adherence to fair accreditation practices. Every effort is made to avoid conflict of interest, either from the point of view of an institution/program being reviewed or from the point of view of any person representing the Commission.

On occasion, current and former volunteers involved in the Commission’s accreditation process (site visitors, review committee members, commissioners) are requested to make presentations related to the Commission and its accreditation process at various meetings. In these cases, the volunteer must make it clear that the services are neither supported nor endorsed by the Commission on Dental Accreditation. Further, it must be made clear that the information provided is based only on experiences of the individual and not being provided on behalf of the Commission.

Revised: 8/15; 8/14; Reaffirmed: 8/23; 8/18; 2/18; 8/12, 8/10

1. Visiting Committee Members: Conflicts of interest may be identified by either an institution/program, Commissioner, site visitor or Commission staff. An institution/program has the right to reject the assignment of any Commissioner, site visitor or Commission staff because
of a possible or perceived conflict of interest. The Commission expects all programs, Commissioners and/or site visitors to notify the Commission office immediately if, for any reason, there may be a conflict of interest or the appearance of such a conflict.

All active site visitors who independently consult with educational programs accredited by CODA or applying for accreditation must identify all consulting roles to the Commission and must file with the Commission a letter of conflict acknowledgement signed by themselves and the institution/program with whom they consulted. All conflict of interest policies as noted elsewhere in this document apply. Contact the CODA office for the appropriate conflict of interest declaration form.

Conflicts of interest include, but are not limited to, a site visitor who:

- is a graduate of a program at the institution;
- has served on the program’s visiting committee within the last seven (7) years;
- has served as an independent consultant, employee or appointee of the institution;
- has a family member who is employed or affiliated with the institution;
- has a close professional or personal relationship with the institution/program or key personnel in the institution/program which would, from the standpoint of a reasonable person, create the appearance of a conflict;
- manifests a partiality that prevents objective consideration of a program for accreditation;
- is a former employee of the institution or program;
- previously applied for a position at the institution within the last five (5) years;
- is affiliated with an institution/program in the same state as the program’s primary location;
- is a resident of the state; and/or
- is in the process of considering, interviewing and/or hiring key personnel at the institution.

Note: Because of the nature of their positions, a state board representative will be a resident of the state in which a program is located and may be a graduate of the institution/program being visited. These components of the policy do not apply for state board representatives, although the program retains the right to reject an individual’s assignment for other reasons.

If an institutional administrator, faculty member or site visitor has doubt as to whether or not a conflict of interest could exist, Commission staff should be consulted prior to the site visit. The Chair, Vice-Chair and a public member of the Commission, in consultation with Commission staff and legal counsel, may make a final determination about such conflicts.

Revised: 2/21; 8/18; 2/16; 8/14; 1/14; 2/13; 8/10; Reaffirmed: 8/23; 8/12

2. Commissioners, Review Committee Members And Members Of The Appeal Board: The Commission firmly believes that conflict of interest or the appearance of a conflict of interest must be avoided in all situations in which accreditation recommendations or decisions are being made by Commissioners, Review Committee members, or members of the Appeal Board.
Commissioner, Review Committee member, or member of the Appeal Board should participate in any way in accrediting decisions in which he or she has a financial or personal interest or, because of an institutional or program association, has divided loyalties and/or has a conflict of interest on the outcome of the decision.

During the term of service as a Review Committee member, these individuals should not serve as site visitors for an actual accreditation site visit to an accredited or developing program, unless deemed necessary. Two instances when a review committee member could serve on a site visit include: 1) an inability to find a site visitor from the comprehensive site visitor list, or 2) when the review committee believes a member should attend a visit for consistency in the review process. This applies only to sites visits that would be considered by the same review committee on which the site visitor is serving. Review committee members may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, review committee members may not serve as a site visitor for mock accreditation purposes. These policies help avoid conflict of interest in the decision making process and minimize the need for recusals.

During the term of service as a commissioner or appeal board member, these individuals may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, Commissioners or appeal board may not serve on a site visit team during their terms.

Areas of conflict of interest for Commissioners, Review Committee members and/or members of the Appeal Board include, but are not limited to:

- close professional or personal relationships or affiliation with the institution/program or key personnel in the institution/program which may create the appearance of a conflict;
- serving as an independent consultant or mock site visitor to the institution/program;
- being a graduate of the institution/program;
- being a current employee or appointee of the institution/program;
- previously applied for a position at the institution within the last five (5) years;
- being a current student at the institution/program;
- having a family member who is employed by or affiliated with the institution;
- manifesting a professional or personal interest at odds with the institution or program;
- key personnel of the institution/program having graduated from the program of the Commissioner, Review Committee member, or member of the Appeal Board;
- having served on the program’s visiting committee within the last seven (7) years; and/or
- no longer a current employee of the institution or program but having been employed there within the past ten (10) years.

To safeguard the objectivity of the Review Committees, conflict of interest determinations shall be made by the Chair of the Review Committee. If the Chair, in consultation with a public
member, staff and legal counsel, determines that a Review Committee member has a conflict of
interest in connection with a particular program, the Review Committee member will be
instructed to not access the report either in advance of or at the time of the meeting. Further, the
individual must leave the room when they have any of the above conflicts. In cases in which the
existence of a conflict of interest is less obvious, it is the responsibility of any committee
member who feels that a potential conflict of interest exists to absent himself/herself from the
room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Commission, conflict of interest determinations shall be made
by the Chair of the Commission. If the Chair, in consultation with a public member, staff and
legal counsel, determines that a Commissioner has a conflict of interest in connection with a
particular program, the Commissioner will be instructed to not access the report either in
advance of or at the time of the meeting. Further, the individual must leave the room when they
have any of the above conflicts. In cases in which the existence of a conflict of interest is less
obvious, it is the responsibility of any Commissioner who feels that a potential conflict of
interest exists to absent himself/herself from the room during the discussion of the particular
accreditation report.

To safeguard the objectivity of the Appeal Board, any member who has a conflict of interest in
connection with a program filing an appeal must inform the Director of the Commission. The
Appeal Board member will be instructed to not access the report for that program either in
advance of or at the time of the meeting, and the individual must leave the room when the
program is being discussed. If necessary, the respective representative organization will be
contacted to identify a temporary replacement Appeal Board member.

Conflicts of interest for Commissioners, Review Committee members and members of the
Appeal Board may also include being from the same state, but not the same program. The
Commission is aware that being from the same state may not itself be a conflict; however, when
residence within the same state is in addition to any of the items listed above, a conflict would
exist.

This provision refers to the concept of conflict of interest in the context of accreditation
decisions. The prohibitions and limitations are not intended to exclude participation and
decision-making in other areas, such as policy development and standard setting.

Commissioners are expected to evaluate each accreditation action, policy decision or standard
adoption for the overall good of the public. The American Dental Association (ADA)
Constitution and Bylaws limits the involvement of the members of the ADA, the American
Dental Education Association and the American Association of Dental Boards in areas beyond
the organization that appointed them. Although Commissioners are appointed by designated
communities of interest, their duty of loyalty is first and foremost to the Commission. A conflict
of interest exists when a Commissioner holds appointment as an officer in another organization
within the Commission’s communities of interest. Therefore, a conflict of interest exists when a
Commissioner or a Commissioner-designee provides simultaneous service to the Commission
and an organization within the communities of interest. (Refer to Policy on Simultaneous
Service)

Revised: 2/21; 8/16; 2/16; 2/15; 8/14; 1/14, 8/10; Reaffirmed: 8/23; 8/18; 8/12

3. Commission Staff Members: Although Commission on Dental Accreditation staff does not
participate directly in decisions by volunteers regarding accreditation, they are in a position to
influence the outcomes of the process. On the other hand, staff provides equity and consistency
among site visits and guidance interpreting the Commission’s policies and procedures.

For these reasons, Commission staff adheres to the guidelines for site visitors, within the time
limitations listed and with the exception of the state residency, including:

• graduation from a program at the institution within the last five years;
• service as a site visitor, employee or appointee of the institution within the last five years;
and/or
• close personal or familial relationships with key personnel in the institution/program.

Revised: 8/14; 8/10, 7/09, 7/07, 7/00, 7/96, 1/95, 12/92; Reaffirmed: 8/23; 8/18; 8/12, 1/03;
Adopted: 1982

E. CONFIDENTIALITY POLICY

All materials generated and received in the accreditation process are confidential. In all instances
Protected Health Information (PHI), Personally Identifiable Information (PII) and
student/resident/fellow identifying information must not be improperly disclosed. The
Commission’s confidentiality policies apply to Commissioners, Review Committee members,
members of the Appeal Board, and site visitors. Confidential materials are maintained to ensure
the integrity of the institution/program and of the accreditation process, and may be shared by the
Commission in instances related to USDE re-recognition or responding to state or federal legal
requirements, as appropriate. Because of the confidential nature of the accreditation process, the
Commission identifies three (3) points of contact with whom Commission staff is authorized to
communicate, either in writing or verbally. These individuals are designated by the sponsoring
institution and include the chief executive officer (university president/chancellor/provost or
medical center director), the chief academic officer (dean/academic dean/chair/chief of dental
service, etc.), and the program director. Commission staff is not authorized to discuss program-
specific situations or share confidential material with any other individual(s).

Confidentiality applies without limitation, to the following:

SELF-STUDY DOCUMENT: At the discretion of the institution, the administration may either
release information from this document to the public or keep it confidential. The Commission
will not release the self-study document.
SITE VISIT REPORT: The preliminary draft of a site visit report is an unofficial document and remains confidential between the Commission and the institution’s executive officers and may not, under any circumstances, be released. Members of a visiting committee who review preliminary drafts of the report must consider the report as privileged information and must not discuss it or make its contents known to anyone, under any circumstances. Oral comments made by site visit team members during the course of the site visit are not to be construed as official site visit findings unless documented within the site visit report and may not be publicized. Further, publication of site visit team members’ names and/or contact information is prohibited. Reasons for assigning any non-adverse status other than full approval remain confidential between the institution and the Commission unless the institution wishes to release them. Public release of the final draft of the site visit report that is approved by the Commission is at the sole discretion of the institution. If there is a point of contention about a specific section of the final site visit report and the institution elects to release the pertinent section to the public, the Commission reserves the right to make the entire site visit report public.

INSTITUTION'S RESPONSE TO A SITE VISIT REPORT: Release of this information is at the sole discretion of the institution. An institution’s response must not improperly disclose any Protected Health Information; however, if any such information is included in the response, such information will not be made public.

TRANSMITTAL LETTER OF ACCREDITATION NOTIFICATION: Information such as accreditation status granted and scheduled dates for submission of additional information is public information. However, release of other information or details is at the sole discretion of the institution and will not be disclosed by the Commission.

PROGRESS REPORT: The scheduled date for submission of progress reports is public information. Release of the content of a progress report is at the sole discretion of the institution. If there is a point of contention about a particular portion of the progress report and the institution elects to release the pertinent portion to the public, the Commission reserves the right to make public the entire progress report. Progress reports must not disclose Protected Health Information (PHI) or Personally Identifiable Information (PII).

SURVEYS: Routinely gathered data are used in the accreditation process and also provide a national database of information about the accredited dental and dental-related educational programs. The Commission may release to the public any portion of survey data that is collected annually unless the terms of confidentiality for a specific section are clearly indicated on the survey instrument. Subsections of each survey instrument containing data elements which are confidential are clearly marked. Any data which may be reported from confidential subsections are published in a manner which does not allow identification of an individual institution/program.
EXIT INTERVIEWS: The final conference or exit interview between the site visit committee and the chief executive officer, dental dean, chief of dental service or the program director(s) is also confidential. Additional people may be included at the discretion of the institutional administration. The interview is a confidential summation of the preliminary findings, conclusions, recommendations and suggestions which will appear in the site visit report to the institution. This is a preliminary oral report and the preliminary written report is often only in draft stage at this point; therefore, this session may not be recorded in either audio or video format. Note taking is permitted and encouraged.

ON-SITE INTERVIEWS AND ORAL COMMUNICATIONS: In order to carry out their duties as on-site evaluators, visiting committee members must communicate freely with administrators, faculty, staff and students and any other appropriate individuals affiliated with an education program. As part of their on-site accreditation duties, committee members are expected to share with other team members pertinent and relevant information obtained during interviews. All oral communications occurring on-site, however, are confidential. Interviews may not be recorded in either audio or video format. Note taking is permitted and encouraged. When the site visit ends, team members may communicate orally, or in writing, only with Commission staff or other team members about any on-site interview or conversation. All questions related to any aspect of the site visit including oral communications must be referred to the Commission office.

MEETING MATERIALS/DISCUSSIONS: Background reports and informational materials related to accreditation matters are regularly prepared for review by the Commission and its Review Committees. These materials and all discussions related to accreditation matters routinely remain confidential. All Ad Hoc and Standing Committee meeting materials remain confidential unless the Commission determines the materials warrant public distribution. The Commission determines when, and the manner in which, newly adopted policy and informational reports will receive public distribution.

PROTECTED HEALTH INFORMATION: Patients’ protected health information, which includes any information that could identify an individual as a patient of the facility being site visited, may not be used by the site visitors, Review Committee members, or Commissioners for any purpose other than for evaluation of the program being reviewed on behalf of the Commission. Protected Health Information may not be disclosed to anyone other than Commissioners, Commission staff, Review Committee members or site visitors reviewing the program from which the Protected Health Information was received. Individual Protected Health Information should be redacted from Commission records whenever that information is not essential to the evaluation process. If a site visitor, Review Committee member, or Commissioner believes any Protected Health Information has been inappropriately used or disclosed, he/she should contact the Commission office.

MEETINGS: Policy portions of the Review Committee and Commission-meetings are open to observers, while accreditation actions are confidential and conducted in closed session.
Hoc and Standing Committee meetings, and all meetings related to CODA operations are confidential and conducted in closed session. All deliberations of the Appeal Board are confidential and conducted in closed session.

NOTICE OF REASONS FOR ADVERSE ACTION: Notice of the reasons for which an adverse accreditation action (i.e. deny or withdraw) is taken is routinely provided to the Secretary of the U.S. Department of Education, any appropriate state agencies, and, upon request, to the public. Revised: 8/23; 8/20; 8/18; 2/18; 2/16; 8/14; 1/05, 2/01, 7/00; Reaffirmed: 8/12, 8/10; Adopted: 7/94, 5/93

1. Reminder Of Confidentiality: To be read at meetings or on site visits:

The Commission on Dental Accreditation reminds you that confidentiality is an integral part of the accreditation process. The Commission must have access to much sensitive information in order to conduct its review of programs and in the course of its operations and meetings. The confidentiality of this information must be protected by participants of meetings as well as by participants on accreditation site visits.

To remind you of the seriousness with which the Commission views its commitment to protect confidentiality, the Commission requires that all participants of meetings and site visits sign an Agreement of Confidentiality. In signing the Agreement which was provided mailed to you, you indicated your familiarity with the Commission’s policy on confidentiality and agreed to abide by it. If you have not already signed the Agreement, please arrange to do so.

Unless indicated otherwise, all meeting and site visit materials, all information obtained on-site, all patient Protected Health Information, and all discussions related to the accreditation of programs and Commission operations are confidential. Patients’ Protected Health Information, which includes any information that could identify an individual as a patient of the facility you are visiting or reviewing, may not be used by you for any purpose other than for evaluation of the program on behalf of the Commission. If you believe any Protected Health Information has been inappropriately used or disclosed, you must contact the Commission office. And, please remember that confidentiality has no expiration date -- it lasts forever!

Revised: 8/23; 1/05; Reaffirmed: 8/18; 8/12, 8/10, 7/01; Adopted: 12/85

2. The Agreement Of Confidentiality:

Agreement of Confidentiality

I am aware that, as a participant of an accreditation site visit, committee, or the Commission, I have access to accreditation information which must remain confidential. I have read and understand the Commission on Dental Accreditation’s policy on Confidentiality and Public Disclosure and agree to protect the confidentiality of all accreditation materials, all patient
Protected Health Information, recommendations and suggestions and discussions before, during
and after the meeting or site visit.

__________________________________   ___________________
Signed                             Date

Revised: 1/05; Reaffirmed: 8/23; 8/18; 8/12, 8/10, 7/01; Adopted: 12/8

F. POLICY ON PUBLIC DISCLOSURE

Following each meeting, final accreditation actions taken with respect to all programs, are
disclosed to all appropriate agencies, including the general public. The public includes other
programs or institutions, faculty, students and future students, governing boards, state licensing
boards, USDE, related organizations, federal and state legislators and agencies, members of the
dental community, members of the accreditation community and the general public. In general,
it includes everyone not directly involved in the accreditation review process at a given
institution.

If the Commission, subsequent to and following the Commission’s due process procedures,
withdraws or denies accreditation from a program, the action will be so noted in the
Commission's lists of accredited programs. Any inquiry related to application for accreditation
would be viewed as a request for public information and such information would be provided to
the public. The scheduled dates of the last and next comprehensive site visits are also published
as public information.

The Commission has procedures in place to provide a brief statement summarizing the reasons
for which it takes an adverse accreditation action. If initial accreditation were denied to a
developing program or accreditation were withdrawn from a currently accredited program, the
reasons for that denial would be provided to the Secretary of the U.S. Department of Education,
the appropriate accrediting agencies, any appropriate state licensing or authorizing agencies, and
to the public. In addition, the official comments that the affected institution or program may
wish to make with regard to that decision, or evidence that the affected institution has been
offered the opportunity to provide official comment will also be made available to the Secretary
of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state
licensing or authorizing agencies, and to the public

All documents relating to the structure, policies, procedures, and accreditation standards of the
Commission are available to the public upon written request. Other official documents require
varying degrees of confidentiality.

Revised: 1/05, 2/01, 7/00; Reaffirmed: 8/23; 8/18; 8/12, 8/10; Adopted: 7/94, 5/93
G. POLICY ON SIMULTANEOUS SERVICE

A member of the Commission on Dental Accreditation, including its Standing and Review Committees,* and Appeal Board, may not simultaneously serve as a principal officer of another organization within any of the Commission’s primary communities of interest if that organization has a role in appointing or co-appointing a member of the Commission. The Commission interprets principal officer to mean those in the position of being final decision-makers which usually includes positions such as the president, president-elect, immediate past president, secretary or treasurer of an organization, as well as members of any executive committee that has decision-making authority which does not require confirmation by a board or house. The Commission has defined primary community of interest in this context as any organizations who have a role in appointing Commissioners, and the Regional Clinical Testing Agencies. Additional criteria found in CODA’s Rules for nominations apply during an individual’s entire term on CODA.

When such a conflict is revealed at the time of appointment, the appointing organization will be informed that the conflict exists and requested to take steps to identify a replacement on the specific committee, Appeal Board, or Commission.

When such a conflict arises during the term of a current Commissioner, Review Committee, or Appeal Board member, the Commissioner, or Review Committee, or Appeal Board member will be asked to resolve the conflict by resigning from one of the conflicting appointments. In the event that the member resigns from the Commission or Appeal Board, the appointing organization will appoint another individual to complete the unfinished term, as specified by the Rules of the Commission on Dental Accreditation. In the event that the member resigns from the Review Committee, the Commission will contact the representative organization for nominations to fulfill the unfinished term.

If the term of the vacated Commission, Appeal Board, or Review Committee position has fifty percent (50%) or less of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for appointment to a new, consecutive four-year term. If more than fifty percent (50%) of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

*this applies to appointments made after 2013

Revised: 8/23; 2/19; 8/18; 8/16; 2/13, 7/09, 7/01, 7/95; Reaffirmed: 8/13; 8/10, 7/07

H. NON-DISCRIMINATION POLICY:

The Commission on Dental Accreditation does not discriminate against any person in the conduct of its activities because of race, color, religion, sex, sexual preference, gender identity, age, disability or national origin.

Revised: 8/23; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01, 5/84, 7/95
I. POLICY ON PROFESSIONAL CONDUCT AND PROHIBITION AGAINST HARASSMENT

All staff members and volunteers must treat each other and all others with whom we work on behalf of the ADA1 with integrity, courtesy and professionalism. It is ADA policy that all staff members and volunteers are responsible for assuring that the work place is free from improper harassment. With this policy, the ADA prohibits not only unlawful harassment, but also other unprofessional and discourteous actions. For example, rude, insulting, disrespectful, disruptive, uncivil and unprofessional comments or conduct will also not be tolerated.

Workplace harassment isn’t limited to sexual harassment, and doesn’t preclude same-gender harassment; it can occur between any two people - co-workers, managers, or even non-employees like clients, contractors, or vendors.

The ADA absolutely prohibits sexual harassment and harassment on the basis of one’s status as a member of a legally-protected class, such as race, color, religion, sex (including pregnancy, childbirth and related medical conditions), gender, gender identity, national origin, age (40 or older), disability (mental or physical), sexual orientation, military status, genetic information, and marital status. These types of discriminatory harassment are prohibited by state and federal laws and may subject the ADA and/or the individual harasser to liability for any such unlawful conduct.

Offensive conduct may include, but is not limited to, offensive jokes, slurs, epithets or name calling, physical assaults or threats, intimidation, ridicule or mockery, insults or put-downs, offensive objects or pictures, unwelcome sexual advances, unwanted physical contact (including touching), and all other verbal, or physical conduct directed at an individual because of their status as a member of a protected class that is unwelcome and interferes with work performance. Such conduct constitutes unlawful harassment when:

- Submission to such conduct is made either implicitly or explicitly a condition of the individual’s employment;
- Submission to or rejection of such conduct is used as the basis for decisions affecting an individual’s employment; or
- Such conduct is sufficiently severe or pervasive to alter the conditions of employment and to create a hostile or abusive working environment.

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1 For purposes of these HR protocols ‘the ADA’ collectively refers to the American Dental Association and its two affiliated organizations, the for-profit company ADA Business Enterprises, Inc. (ADABEI) and the not-for-profit educational and research focused ADA Foundation (ADAF).
Each staff member and volunteer must exercise his or her own good judgment to avoid engaging in conduct that may be perceived by others as harassment. As an ADA staff member or volunteer, you are responsible for keeping our work environment free of all such harassment. If you believe that you have been harassed, or if you become aware of an incident of harassment, whether by an employee, a member, or a non-employee or non-member, you should report it as soon as possible to your supervisor, a volunteer leader, and/or to the Human Resources, (312-440-2005).

If the incident is reported to an employee’s supervisor or a volunteer leader, the supervisor or volunteer leader must then report the incident to the head of ADA Human Resources. Do not allow an inappropriate situation to continue by not reporting it, regardless of who is creating that situation.

No staff member or volunteer in this organization is exempt from this policy. This policy applies to the immediate work place as well as to ADA related activity outside the ordinary work place, such as travel on ADA business, meetings outside the ADA building, email and telephone communications, and ADA-sponsored social or recreational events.

In response to every complaint, the ADA will take prompt investigatory actions and corrective and preventative actions where necessary. A staff member who brings such a complaint to the ADA in good faith will not be adversely affected as a result of reporting the harassment or objectionable conduct. All staff members should be aware that the privacy of the charging party and the person accused of the harassment will be protected to the extent consistent with effective enforcement of this policy.

The ADA will retain confidential documentation of all allegations and investigations. Any staff member or volunteer found to have violated this policy may be subject to disciplinary action up to and including discharge from employment with the ADA or removal from a volunteer position. Any memoranda regarding a determination that a violation of the Professional Conduct Policy and Prohibition against Harassment has occurred shall be placed in a staff member’s personnel file.

Effective: January 1, 2015

**Procedures Applicable to Professional Conduct Policy and Prohibition against Harassment**

a. If you believe that there has been a violation of the ADA’s Professional Conduct Policy and Prohibition against Harassment (ADA’s Policy) immediately contact your supervisor, or Human Resources.

b. If an incident is reported to a supervisor or volunteer leader, the supervisor or volunteer leader must then notify Human Resources of the incident.

**Reminder to Supervisors and Volunteer Leaders**

If you witness or are informed of a potential incident of harassment or violation of our professional conduct policy, you MUST report it to Human Resources at (312) 440-2005.
c. In a timely and confidential manner, the ADA will conduct an investigation of any complaint that is made pursuant to the ADA’s Policy. Human Resources will conduct an investigation, which includes interviewing witnesses with potential knowledge of the objectionable conduct.

d. It is the obligation of each staff member and volunteer to cooperate in these investigations by providing truthful, thorough information.

e. The alleged harasser is given an opportunity to relate his/her version of the events and to provide any information that the ADA should consider before it finalizes its investigation. If the alleged harasser refuses to participate, the ADA will base its decision on the other information gathered during the investigation, the inferences drawn from that evidence and the alleged harasser’s unwillingness to cooperate in the interview.

f. Information obtained pursuant to the investigation is confidential and will be reported to those within the ADA on a “need to know” basis. The privacy of the complaining party and the person accused of the harassment will be protected to the extent consistent with effective enforcement of this Policy.

g. Attempting to influence the investigation or to disclose confidential information by discussing it with others can be cause for disciplinary action, up to and including discharge, except to the extent such disclosure may be legally permissible.

h. Human Resources, in consultation with legal counsel, will make a recommendation to the Executive Director as to whether there has been a violation of the ADA’s Policy and whether corrective action, if any, should be taken.

i. Any staff member found to have violated the Professional Conduct Policy and Prohibition against Harassment will be subject to disciplinary action up to and including discharge. Any memoranda regarding violation of the Professional Conduct Policy and Prohibition against Harassment will be placed in the staff member’s personnel file.

The ADA prohibits managers and supervisors from taking adverse job consequences against staff who engage in protected activities such as:1) lodging a discrimination complaint or concern, 2) participating in an investigation of such a discrimination complaint or concern or 3) opposing employment practices that an employee reasonably believes discriminate against the employee or another staff member.

The ADA prohibits any form of retaliation against any staff member for making a bona fide complaint under this policy or for assisting in a complaint investigation. Any individual, however, whose complaint is determined to be false or made in bad faith, or supported by false information, may be subject to disciplinary action.

The ADA specifically reserves its right to change, modify or eliminate any of the provisions of its Procedures Applicable to the Professional Conduct Policy and Prohibition against Harassment Policy at any time with or without notice. Effective: January 1, 2015.

Revised: 8/15; 8/14; 7/09, 1/03, 7/97; Reaffirmed: 8/23; 8/18; /13; 8/10; CODA: 01/95:11
J. PROGRAM FEE POLICY

Programs accredited by the Commission pay an annual fee. The annual fee is doubled in the year of the program’s regular interval accreditation site visit. As there is some variation in fees for different disciplines based on actual accreditation costs, programs should contact the Commission office for specific information. Other than doubling of the annual fee during the site visit year, site visits are conducted without any additional charge to the institution and the Commission assumes all expenses incurred by its site visitors. However, accredited programs with multiple sites which must be site visited during a regular site visit and programs sponsored by the U.S. military in international locations are assessed a fee at the time of the site visit. The fee is established on a case-by-case basis, dependent upon the specific requirements to conduct the visit (e.g. additional site visitors, additional days, and additional travel time and expenses). Fees are also assessed to the program for the conduct of special focused site visits. (See Invoicing Process for Special Focused Site Visits in Policy on Special Site Visits). International dental education programs also pay an annual fee and site visit fees (See International Dental Education Site Visits). Expenses for representatives from the state board of dentistry or from other agencies, such as a regional accrediting agency, are not assumed by the Commission. Fee structures are evaluated annually by the Commission. The Commission office should be contacted for current information on fees.

An annual administrative fee is also applied to each program. Fees may also be associated with staff consulting services (See Staff Consulting Services, and International Policies and Procedures)-administrative fees related to the Commission policy on protected health information and personally identifiable information (See Policy and Procedures Related to Compliance with the Health Insurance Portability and Accountability Act).

All institutions offering programs accredited by the Commission on Dental Accreditation are expected to adhere to the due date for payment of all fees for each accredited program sponsored by the institution. Written requests for an extension must specify a payment date no later than thirty (30) days beyond the initial due date. Failure to pay fees by the designated deadline is viewed as an institutional decision to no longer participate in the Commission’s accreditation program. Following appropriate reminder notice(s), if payment or a request for extension is not received, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting. Programs which have been discontinued or had accreditation withdrawn will not be issued a refund of accreditation fees.

Revised: 1/20; 2/19; 2/15; 8/14; 8/13; 7/08; Reaffirmed: 8/23; 8/18; 8/13; 8/10, 7/07, 7/01, 7/95
K. POLICY ON CODA ADMINISTRATIVE FUND

In 2020, the Commission on Dental Accreditation approved the reclassification of its Research and Development Fund (R&D Fund) to an Administrative Fund.

The Commission on Dental Accreditation Administrative Fund may include but is not limited to the following uses:

- Commission studies and activities related to quality assurance and strategic planning
- Conduct of business through newly formed ad hoc or sub-committees not previously budgeted; engagement of site visitors to gain unique expertise or to provide training
- Ongoing review and enhancement of business resources, human resources, and technology resources in various aspects of the CODA accreditation program
- Expenses related to Shared Services Agreement with the American Dental Association not previously budgeted
- Other business purposes as applicable to the work of the Commission on Dental Accreditation

Criteria Guideline for Distribution of Funds:

1. Funds $5,000 or less: Funds in this category are classified as discretionary funds that may be used by the CODA Director. A maximum of $5,000 per use is permissible, with a requirement for immediate reporting on the use of the funds, via email, to the Finance Committee for informational purposes. The discretionary funds do not require a formal request by a CODA committee, nor do they require prior approval for use by the Finance Committee or Commission.

2. Funds between $5,001 and $20,000: Projects which require this level of funding must be reviewed and approved by the Finance Committee prior to use. Approval by the Commission is not required.

3. Funds greater than $20,000: Projects which require funding in excess of $20,000 must be submitted for review and approval by the Commission upon recommendation of the Finance Committee.

All Funding Disbursements:

- The Finance Committee and Commission will review a full accounting of the Administrative Fund and uses of the fund at each finance committee and Commission meeting.
- Fund allocations requiring approval by the Finance Committee or the Commission require formal requests/proposals from the Commission’s review committees or standing committees; disbursement of funds within the Director’s discretionary allocation do not require formalized requests.

Reaffirmed: 8/23; Adopted: 2/20
L. GUIDELINES FOR MANAGING PROGRAM FILES

All correspondence is maintained and documentation related to one accreditation cycle will be stored electronically. Electronic documents/correspondence do not need signatures (per Commission legal counsel). Transmittal letters can be saved to the accredited program’s document retention Knowledge Center space without a signature.

Accredited programs
- All correspondence and letters of transmission of Commission action;
- All site visit reports - The most recent site visit report (including the institution’s response);
- Two (2) most recent self-studies - Most recent self study (with the hospital’s bylaws, and course outlines appendix);
- Second most recent self study (without hospital bylaws or course outlines appendix);
- All previous site visit reports (including institution’s responses);
- Progress reports related to the two (2) most recent site visit reports (without course outlines);
- Special Reports: (e.g. interim review, major change, transfer of sponsorship) occurring during time period of the two most recent site visit reports.

Discontinued programs
- All correspondence and letters of transmission of Commission action and site visit reports;
- Two (2) most recent site visit reports (with institutional responses);
- Two (2) most recent self-studies; and
- Progress reports related to the two (2) most recent site visit reports

Programs with accreditation withdrawn
- All correspondence and letters of transmission of Commission action;
- Two (2) most recent site visit reports (with institutional responses);
- Two (2) most recent self-studies (without hospital bylaws or course outlines); and
- Progress reports related to the two (2) most recent site visit reports.

Revised: 8/23; 8/02, 8/03, 8/99; Reaffirmed: 8/18; 8/15; 8/10, 7/09; Adopted: 9/92
IV. POLICIES AND PROCEDURES RELATED TO ACCREDITATION OF PROGRAMS

A. ACCREDITATION STATUS DEFINITIONS

1. Programs That Are Fully Operational:
   Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.
   
   Approval (with reporting requirements): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards or policies must be demonstrated within a timeframe not to exceed eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

   Circumstances under which an extension for good cause would be granted include, but are not limited to:
   • sudden changes in institutional commitment;
   • natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
   • changes in institutional accreditation;
   • interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

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

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

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

**Other Accreditation Actions:**

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

Reaffirmed: 8/23; 8/18; Adopted: 2/16

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

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

Revised: 2/16; 8/13; Reaffirmed: 8/23; 8/18

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

Revised 6/17; Reaffirmed: 8/23; 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9

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

Reaffirmed: 8/23; 8/18; 8/13; Adopted: 8/11

B. APPLICATION FOR ACCREDITATION FOR FULLY OPERATIONAL PROGRAMS
WITH ENROLLMENT AND WITHOUT ACCREDITATION

Those programs that have graduated at least one class of students/residents and are enrolling
students/residents in every year of the program are considered fully operational. These programs
will complete the self-study document and will be considered for the accreditation status of
“approval with reporting requirements” or “approval without reporting requirements” following
a comprehensive site visit (Please see procedures for the conduct of a comprehensive site visit).
Students/Residents who are enrolled in the program at the time accreditation is granted, and who
successfully complete the program, will be considered graduates of an accredited program.
Students/Residents who graduated from the program prior to the granting of accreditation will
not be considered graduates of an accredited program.

Because accreditation is voluntary, a program may withdraw its application for accreditation at
any time prior to the Commission taking action regarding an accreditation status. When an
accreditation status has been granted, the program has the right to ask that the status be
discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of
programs, application forms, deadlines for submission and accreditation standards. Program
administrators and faculty are encouraged to consult with Commission staff during this initial
process.

An application fee must be submitted with a program’s application for accreditation. Programs
should contact the Commission office for the current fee schedule.
The following steps apply:

1. An application for accreditation is completed by the program and submitted to the Commission on Dental Accreditation, along with appropriate documentation and application fee. Provided that the application is in order, the first opportunity for the Commission to consider the program is generally 12 to 18 months following the Commission’s formal acknowledgment of receipt of the application, initiation of the review process, and following an initial site visit.

2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet the Accreditation Standards and has sufficiently addressed and documented the Criteria for Consideration of An Application for Accreditation before proceeding to the next step of the application process.

3. If it is determined that the Criteria for Consideration of An Application for Accreditation have been sufficiently addressed and documented, and that the program, as proposed, appears to have the potential to meet the Accreditation Standards, a site visit is scheduled four (4) to seven (7) months following completion of the application review.

4. Substantive changes to the proposed program that occur between the date of submission of the application and scheduled site visit, if one is warranted, must be reported to the Commission immediately, will require further review, and may result in a delay of the site visit.

5. After the site visit has been conducted, the visiting committee submits a draft report to the Commission office.

6. Following the site visit, the preliminary draft of the site visit report is transmitted to the institution for consideration and comment.

7. The visiting committee’s report and the institution’s response to the preliminary report, should one be submitted, are transmitted to the discipline-specific Review Committee for consideration at its meeting prior to the Commission meeting.

8. The Commission then considers the Review Committee’s report and takes action on the accreditation status.

9. The Commission’s action regarding accreditation status and the final site visit report are transmitted to the institution within thirty (30) days of the Commission’s meeting.

**Time Limitation for Review of Applications:** The review of an application will be terminated if an institution fails to respond to the Commission’s requests for information for a period of six (6) months. In this case, the institution will be notified that the application process has been terminated. If the institution wishes to begin the process again, a new application and application fee must be submitted.

Revised: 8/22; 2/22; 2/21; 8/16; 2/16; 8/13; 7/08; Reaffirmed: 8/23; 8/18; 8/13; 8/10; Adopted: 8/02
C. APPLICATION FOR INITIAL ACCREDITATION FOR DEVELOPING PROGRAMS

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 “developing.” The same review steps that apply for Application for Accreditation for Fully Operational Programs with Enrollment and Without Accreditation apply to Application for Initial Accreditation for Developing Programs.

The developing program must not enroll students/residents until initial accreditation status has been obtained. Once a program is granted “initial accreditation” status, a site visit will be conducted in the second year of programs that are four or more years in duration and again prior to the first class of students/residents graduating. Programs that are less than four (4) years in duration will be site visited again prior to the first class of students/residents graduating.

An institution which has made the decision to initiate and seek accreditation for a program that falls within the Commission on Dental Accreditation’s purview is required to submit an application for accreditation. “Initial accreditation” status may then be granted to programs which are developing, according to the accreditation standards.

Because accreditation is voluntary, a program may withdraw its application for accreditation at any time prior to the Commission taking action regarding an accreditation status. The initial accreditation status is granted based upon one or more site evaluation visit(s) and until the program is fully operational. When an accreditation status has been granted, the program has the right to ask that the status be discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of programs, application forms, deadlines for submission and accreditation standards. Program administrators and faculty are encouraged to consult with Commission staff during this initial process.

An application fee must be submitted with a program’s application for initial accreditation. Programs should contact the Commission office for the current fee schedule.

The following steps apply:

1. An application for accreditation is completed by the program and submitted to the Commission on Dental Accreditation, along with appropriate documentation and application fee. Provided that the application is in order, the first opportunity for the Commission to consider the program is generally 12 to 18 months following the Commission’s formal acknowledgment of receipt of the application, initiation of the review process, and following an initial site visit.

2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet the Accreditation Standards and has
sufficiently addressed and documented the Criteria for Consideration of An Application for
Accreditation before proceeding to the next step of the application process.

3. If it is determined that the Criteria for Consideration of An Application for Accreditation have
been sufficiently addressed and documented, and that the program, as proposed, appears to
have the potential to meet the Accreditation Standards, a site visit is scheduled four (4) to
seven (7) months following completion of the application review.

4. Substantive changes to the proposed program that occur between the date of submission of the
application and scheduled site visit, if one is warranted, must be reported to the Commission
immediately, will require further review, and may result in a delay of the site visit.

5. After the site visit has been conducted, the visiting committee submits a draft report to the
Commission office.

6. Following the site visit, the preliminary draft of the site visit report is transmitted to the
institution for consideration and comment.

7. The visiting committee’s report and the institution’s response to the preliminary report, should
one be submitted, are transmitted to the discipline-specific Review Committee for
consideration at its meeting prior to the Commission meeting.

8. The Commission then considers the Review Committee’s report and takes action on the
accreditation status.

9. The Commission’s action regarding accreditation status and the final site visit report are
transmitted to the institution within thirty (30) days of the Commission’s meeting.

Time Limitation for Review of Applications: The review of an application will be terminated
if an institution fails to respond to the Commission’s requests for information for a period of six
(6) months. In this case, the institution will be notified that the application process has been
terminated. If the institution wishes to begin the process again, a new application and
application fee must be submitted.

Revised: 8/22; 2/22; 2/21; 8/16; 2/16; 8/13; 7/08, 8/02, 7/01; Reaffirmed: 8/23; 8/18; 8/13; 8/11,
8/10

1. Enrollment Of Students In A Developing Program Prior To Granting Of Initial
Accreditation Status:

An additional purpose of accreditation recognized by the United States Department of
Education (USDE) is the protection of the public through the identification of qualified
personnel to staff the health care system. Therefore, the Commission on Dental
Accreditation established accreditation classifications, which have proven to be acceptable to
educational institutions. Published definitions are a widely recognized means for carrying
out accreditation functions.

“Initial accreditation” status is an accreditation classification that is applicable to developing
programs. It is granted when a proposed or developing program demonstrates that it has the
potential to meet the accreditation standards.
For this reason, the Commission is firm in its policy that the developing program must not enroll students/residents until “initial accreditation” status has been obtained. If a program enrolls students/residents without first having been granted “initial accreditation” status, the Commission will not accept the application for accreditation until after the first enrolled class has graduated. In addition, the Commission expects that the program will notify all students/residents enrolled of the possible ramifications of enrollment in a program operating without accreditation. The Commission will also notify the applicable state board of dentistry.

When “initial accreditation” status is denied and the program wishes to reapply, it is the responsibility of the institution to make use of all possible resources, including consultation with the Commission on Dental Accreditation. (Refer to the Policy on Public Disclosure and Confidentiality for additional information regarding the announcement of an action to deny accreditation).

Revised: 2/16; 7/08, 8/02, 7/96; Reaffirmed: 8/23; 8/18; 8/13; 8/10, 7/07, 7/01; CDE: 12/74:19

2. **Time Limitation For Initial Accreditation:**

The classification of “initial accreditation” granted to dental and dental-related educational programs will be terminated at the end of two (2) years following the projected enrollment date if students/residents have not been enrolled. (See the Commission’s Policy on Non-Enrollment of First Year Students for further information).

Revised: 8/02; Reaffirmed: 8/23; 8/18; 8/13; 8/10; CODA: 05/80:12
CRITERIA FOR CONSIDERATION OF AN APPLICATION FOR ACCREDITATION

The application for accreditation of a dental or dental-related program is considered complete when the program has demonstrated the potential to meet the Accreditation Standards and when the following criteria, as applicable, have been adequately addressed and documented in the application:

a. A dean/program director/program administrator, as applicable, who meets the requirements of the discipline-specific standards, has been appointed at the time the application is submitted and at least six (6) months prior to a projected accreditation site visit. Should the dean/program director/program administrator change during the application review, the program must notify the Commission immediately and a delay of six (6) months for a projected site visit (should one have been directed) will be applied.

b. The program is sponsored by an institution that, at the time of the application, complies with the discipline-specific accreditation standards related to institutional accreditation.

c. A strategic plan/outcomes assessment process, which will regularly evaluate the degree to which the program’s stated goals and objectives are being met, is developed and documented, including the program’s expected measures for student/resident/fellow achievement and schedule for ongoing program review.

d. The long and short-term financial commitment of the institution to the program is documented and is sufficient to support the program’s stated goals and objectives during development and long-term.

e. If the program will rely on support from entities outside of the institution to comply with the Accreditation Standards or program requirements (e.g., access to clinical facility or resources for required instruction), contractual agreements are drafted and signed providing assurance that a program dependent upon the resources of a variety of institutions and/or extramural clinics and/or other entities has adequate support. The program must document that support from outside entities does not compromise its authority as the sponsor of the program.

f. Policies related to student/resident/fellow admission process and due process procedures are developed and documented.

g. A projection of the number, qualifications, assignments and appointment dates of faculty is developed and is sufficient to support the program during development and long-term. The program must provide evidence of availability of adequate faculty and a hiring plan.
h. An explanation is included of how the curriculum was developed including who developed
the curriculum and the philosophy underlying the curriculum. If curriculum materials are
based on or are from an established education program, documentation that permission was
granted to use these materials is provided.

i. The curriculum must be mapped for all years of the program, including documentation of all
competencies that will be required in each course. Curriculum materials for each course in
all years of the program must be presented and include general and specific course and
instructional objectives, learning activities, evaluation instruments (including, as applicable,
sample tests, quizzes, and grading criteria). All evaluation instruments for laboratory, pre-
clinical, clinical, and clinical enrichment experiences are developed and included.

j. Class schedule(s) for all years noting how each class will utilize the facility are developed
and provided, including a mapping of facility utilization when the program is in full
operation. If the capacity of the facility does not allow all students/residents/fellows to be in
laboratory, pre-clinical laboratory and/or clinic at the same time, a plan documenting how
students/residents/fellows will spend laboratory, pre-clinical and/or clinical education
sessions has been developed and is included.

k. As applicable, formal diagrams or blueprints of the didactic, laboratory, pre-clinical
laboratory and clinical facilities, and equipment needs are developed to support the
anticipated enrollment date. An equipment procurement timeline and/or construction
timeline has been developed and documented to support the anticipated enrollment date.

l. As applicable, policies and procedures related to clinical operation including but not limited
to ionizing radiation, infection control and hazardous material, and bloodborne and infectious
diseases are developed and documented.

m. As applicable, the adequacy of the patient caseload in terms of size, variety and scope to
support required clinical experiences is available and documented. The program’s patient
classification system, patient recruitment system, and student/resident/fellow patient
experience tracking system are developed and documented.

Revised: 8/23; 8/22; 2/22; 8/16; 7/08, 8/03; Reaffirmed: 8/19; 8/13; Adopted: 8/02

J. SITE VISITORS

2. Criteria For Nomination Of Site Visitors: For predoctoral dental education programs, the
Commission solicits nominations for site visitors from the American Dental Education Association
to serve in five of six roles on dental education program site visits. The site visitor roles are Chair,
Basic Science, Clinical Science, Curriculum, and Finance. Nominations for the sixth role, national
licensure site visitor, are solicited from the American Association of Dental Boards.
For advanced dental education programs, the Commission solicits nominations for site visitors from the discipline-specific sponsoring organizations and their certifying boards.

For allied dental education programs, the American Dental Education Association is an additional source of nominations that augments, not supersedes, the nominations from the Commission’s other participating organizations, American Dental Assistants Association (ADAA), American Dental Hygienists’ Association (ADHA) and National Association of Dental Laboratories (NADL).

The Commission requests all agencies nominating site visitors to consider regional distribution, gender and minority representation and previous experience as a site visitor. Although site visitors are nominated by a variety of sources, the Commission carefully reviews the nominations and appoints site visitors on the basis of need in particular areas of expertise. The pool of site visitors is utilized for on-site evaluations, for special consultations and for special or Review Committees.

Appointments are made at the Winter (January/February) Commission meeting and become effective upon Commission action and completion of site visitor mandatory training.

In addition to the discipline-specific criteria noted below, the following criteria apply to all site visitor nominees.

**Criteria for Educator Site Visitor Nominees.** The following are criteria for educator site visitor nominees:

- Commitment to predoctoral, advanced, and/or allied dental education;
- Active involvement in an accredited predoctoral, advanced, or allied dental education program as a full- or part-time faculty member;
- Subject matter experts with formal education and credentialed in the applicable discipline; and

**Criteria for Practitioner Site Visitor Nominees.** The following are criteria for practitioner site visitor nominees:

- Commitment to predoctoral, advanced, and/or allied dental education;
- Current active license and work effort as a practitioner or clinical instructor; and
- Formal education and credential in the applicable discipline.

Adopted 4/22

A. Predoctoral Dental Education: The accreditation of predoctoral dental education programs is conducted through the mechanism of a visiting committee. Membership on such visiting
committees is general dentistry oriented rather than discipline or subject matter area oriented. The composition of such committees shall be comprised, insofar as possible, of site visitors having broad expertise in dental curriculum, basic sciences, clinical sciences, finance, national licensure (practitioner) and one Commission staff member. The evaluation visit is oriented to an assessment of the educational program’s success in training competent general practitioners.

Although a basic science or clinical science site visitor may have training in a specific basic science or discipline-specific advanced dental education area, it is expected that when serving as a member of the core committee evaluating the predoctoral program, the site visitor serves as a general dentist. Further, it is expected that all findings, conclusions or recommendations that are to be included in the report must have the concurrence of the visiting committee team members to ensure that the report reflects the judgment of the entire visiting committee.

In appointing site visitors, the Commission takes into account a balance in geographic distribution as well as representation of the various types of educational settings and diversity. Because the Commission views the accreditation process as one of peer review, predoctoral dental education site visitors, with the exception of the national licensure site visitor, are affiliated with dental education programs.

The following are criteria for the six roles of predoctoral dental education site visitors:

Chair:
- Must be a current dean of a dental school or have served as dean within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission and as a previous site visitor.

Basic Science:
- Must be an individual who currently teaches one or more biomedical science courses to dental education students or has done so within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

Clinical Science:
- Must be a current clinical dean or an individual with extensive knowledge of and experience with the quality assurance process and overall clinic operations.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.
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Curriculum:
- Must be a current academic affairs dean or an individual with extensive knowledge and experience in curriculum management.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

Finance:
- Must be a current financial officer of a dental school or an individual with extensive knowledge of and experience with the business, finance and administration of a dental school.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

National Licensure:
- Should be a current clinical board examiner or have served in that capacity within the previous three (3) years.
- Should have an interest in the accreditation process.

Revised: 8/18; 2/18; 2/16; 8/14; 1/99; Reaffirmed: 8/19; 8/10, 7/07, 7/01; CODA: 07/05, 05/77:

B. Advanced Dental Education: In the disciplines of dental public health, dental anesthesiology, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics, sponsoring organizations are advised that candidates recommended to serve as site visitors be board certified and/or have completed or participated in a CODA-accredited advanced dental education program in the discipline and must have experience in advanced dental education as teachers or administrators. Each applicable Review Committee will determine if board certification is required. Some sponsoring organizations have established additional criteria for their nominations to the Commission.

C. Allied Dental Education in Dental Hygiene: In appointing site visitors, the Commission takes into account a balance in geographic distribution, representation of the various types of educational settings, and diversity. Because the Commission views the accreditation process as one of peer review, the dental hygiene education site visitors are affiliated with dental hygiene education programs.

The following are criteria for selection of dental hygiene site visitors:
- a full-time or part-time appointment with a dental hygiene program accredited by the Commission on Dental Accreditation;
- a baccalaureate or higher degree;
- background in educational methodology;
• accreditation experience through an affiliation with a dental hygiene education program
  that has completed a site visit; and
• accreditation experience within the previous three (3) years.

Revised: 8/21; 8/18; 8/16; 8/14; Reaffirmed: 8/19; 8/10; Adopted: 7/09

D. Allied Dental Education in Dental Assisting: The following are criteria for selection of dental
  assisting site visitors:
  • certification by the Dental Assisting National Board as a dental assistant;
  • full-time or part-time appointment with a dental assisting program accredited by the
    Commission on Dental Accreditation;
  • equivalent of three (3) years full-time dental assisting teaching experience;
  • baccalaureate or higher degree;
  • demonstrated knowledge of accreditation; and
  • current background in educational methodology.

Revised: 8/18; 8/16; 8/14; 2/13, 1/08, 1/98, 2/02; Reaffirmed: 8/19; 8/10, 7/08; CODA:
  07/95:5

E. Allied Dental Education in Dental Laboratory Technology: The following are criteria for
  selection of dental laboratory technology site visitors:
  • background in all five (5) dental laboratory technology specialty areas: complete
dentures, removable dentures, crown and bridge, dental ceramics, and orthodontics;
  • background in educational methodology
  • knowledge of the accreditation process and the Accreditation Standards for Dental
    Laboratory Technology Education Programs;
  • Certified Dental Technician (CDT) credential through the National Board of Certification
    (NBC); and
  • full or part-time appointment with a dental laboratory technology education program
    accredited by the Commission on Dental Accreditation or previous experience as a
    Commission on Dental Accreditation site visitor.

Revised: 8/18; 8/14; Reaffirmed: 8/19; 8/10; Adopted: 07/09

F. Allied Dental Education in Dental Therapy: The following are criteria for selection of dental
  therapy site visitors:
  • a full-time or part-time appointment with a predoctoral dental or allied dental education
    program accredited by the Commission on Dental Accreditation or an accredited (or
    recognized) dental therapy program;
  • a baccalaureate or higher degree;
  • background in educational methodology;
  • accreditation experience through an affiliation with a dental therapy, allied, or predoctoral
    dental program that has completed a site visit;*
  • accreditation experience within the previous three (3) years;*
• must either be a licensed dentist educator (general dentist) or licensed dental therapist educator; and

• the “licensed dentist educator” may be predoctoral dental educator site visitors (i.e., a general dentist educator who serves as curriculum or clinical predoctoral site visitor) or allied dental educator site visitors.

*temporarily waived for dental therapist educator position until after CODA determines there exists an adequate supply of site visitors. accredits a minimum of three (3) dental therapy education programs.

Dental therapy site visit team consist of three (3) members as follows: one (1) dental therapist educator, one (1) predoctoral dentist educator (curriculum or clinical site visitor), and one (1) additional site visitor that could be either a second dental therapist educator, second predoctoral dentist educator, or an allied dentist educator. If needed due to lack of dental therapy educator availability, such that if a dental therapy educator cannot be identified in accordance with Commission policy then the three-person site visit team may be composed of predoctoral educators and allied dentists, three (3) people total in any combination.

Revised: 8/23; 2/21; 8/18; 8/16; Reaffirmed: 8/19; Adopted: 02/16

G. MATERIALS AVAILABLE FROM THE COMMISSION

These materials are available from the Commission on Dental Accreditation upon request.

• Application for initial accreditation for each discipline
• Accreditation standards documents for each discipline
• Self-study documents for each discipline
• Accredited Program Listing:
  o Predoctoral Dental Education Programs,
  o Allied Dental Education Programs, and
  o Advanced Dental Education Programs
• Annual Reports for Predoctoral Advanced, and Allied Dental Education are available online, including:
  o Supplement: Dental School Tuition, Admission and Attrition
  o Supplement: Dental School Faculty and Support
  o Supplement: Dental School Trends
  o Supplement: Dental School Curriculum, Clock Hours of Instruction

Reports listed as confidential include information which was collected with the understanding that the reports would not identify specific educational institutions. Thus, these reports use randomly assigned code numbers for each predoctoral dental education program rather than the name of the institution. Confidential reports include the Supplement: Analysis of Dental School Finances - Financial Report
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Guidelines:

1. Preparation of Reports (Response to Site Visit Reports and Progress Reports)
2. Submitting Teach-Out Reports by Institutions Discontinuing or Closing Commission-Accredited Educational Programs Preparing Phase-out Reports by Institutions Terminating Educational Programs
3. Preparing Requests for Transfer of Sponsorship
4. Reporting Program Changes in Accredited Programs
5. Documentation Guidelines for Selected Recommendations (in site visit reports)
6. Requesting an Enrollment Increase (predoctoral and advanced)
7. Reporting and Approval of Sites Where Educational Activity Occurs (Adopted 2/16)
8. Electronic Submission of Documents
9. Privacy and Data Security Requirements for Institutions
10. Privacy and Data Security Requirements for International Institutions

Outcomes Assessment - a resource packet on assessing outcomes

Revised: 8/23; 8/17; Reaffirmed: 8/22;

A. INFORMATION ON THE COMMISSION’S WEBSITE

The following information is posted on the Commission’s website as indicated. Some of these items are mandated by the Commission, while others are merely viewed as a service to accredited programs.

The following items are routinely posted following the Commission’s winter meeting:

1. Report of Unofficial Actions of the Commission
2. List of Commissioners and appended biographical information
3. List of Scheduled Site Visits
4. Policy On Third Party Comments
5. Policy on Complaints and Guidelines for Filing a Complaint
6. Summer Commission Meeting – Open Session Announcement and Materials, as available
7. Commission policies, procedures and guidelines for reporting program changes:
   a. Guidelines for Requesting Increase in Enrollment (for all dental and advanced dental education programs)
   b. Policy and Guidelines for Reporting Program Changes In Accredited Programs
   c. Policy and Guidelines on Reporting and Approval of Sites Where Educational Activity Occurs
   d. Policy and Guidelines for Preparing a Teach-Out Report
   e. Policy and Guidelines for Transfer of Sponsorship
   f. Policy and Guidelines for Interruption of Education
   g. Policy and Guidelines for Reporting the Use of Distance Education
   h. BioSketch Templates
C. REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes have a direct and significant impact on the program’s potential ability to comply with the accreditation standards. These changes tend to occur in the areas of finances, program administration, enrollment,
curriculum and clinical/laboratory facilities, but may also occur in other areas. All program changes that could affect the ability of the program to comply with the Accreditation Standards must be reported to the Commission. When a change is planned, Commission staff should be consulted to determine reporting requirements. Reporting program changes in the Annual Survey does not preclude the requirement to report changes directly to the Commission. Failure to report and receive approval in advance of implementing the change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program’s accreditation status.

Advanced dental education programs must adhere to the Policy on Enrollment Increases in Advanced Dental Education Programs. In addition, programs adding off-campus sites must adhere to the Policy on Reporting and Approval of Sites Where Educational Activity Occurs. Guidelines for Reporting and Approval of Sites where Educational Activity Occurs are available from the Commission office. Guidelines for Requesting an Increase in Enrollment in a Predoctoral Dental Education Program, and Guidelines for Reporting Enrollment Increases in Advanced Dental Education Programs, and Guidelines for Reporting Enrollment Increases in Dental Hygiene Education Programs are available from the Commission office.

On occasion, the Commission may learn of program changes which may impact the program’s ability to comply with accreditation standards or policy. In these situations, CODA will contact the sponsoring institution and program to determine whether reporting may be necessary. Failure to report and receive approval prior to the program change may result in further review by the Commission and/or a special site visit, and may jeopardize the program’s accreditation status.

The Commission’s Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breach of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

A Report of Program Change must document how the program will continue to meet accreditation standards. The Commission’s Guidelines for Reporting Program Changes are available on the Commission’s website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported by May 1 or November 1 and must be reviewed by the appropriate Review Committee and approved by the Commission prior to the implementation to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites not owned by the sponsoring institution used to meet accreditation standards or program requirements (See Guidelines on Reporting and Approval
of Sites Where Educational Activity Occurs);

- Changes to Off-Campus Sites that impact the use of the site (e.g. minor site to major site, or termination of enrollment at or discontinued use of major site);
- Transfer of sponsorship from one institution to another;
- Changes in institutional accreditor or pending or final adverse actions. (See Policy on Regard For Decisions of States and Other Accrediting Agencies);
- Moving a program from one geographic site to another, including but not limited to geographic moves within the same institution;
- Program director qualifications not in compliance with the standards. In lieu of a CV, a copy of the new or acting program director’s completed BioSketch must be provided to Commission staff. Contact Commission Staff for the BioSketch template.
- Substantial increase in program enrollment as determined by preliminary review by the discipline-specific Review Committee Chair.
  - Requests for retroactive permanent increases in enrollment will not be considered.
  - Requests for retroactive temporary increases in enrollment may be considered due to special circumstances on a case-by-case basis. Programs are reminded that resources must be maintained even when the full complement of students/residents is not enrolled in the program. (see Policy on Enrollment Increases In Advanced Dental Education Programs and Predoctoral programs see Guidelines for Requesting an Increase in Enrollment in a Predoctoral Dental Education Program);
- Change in the nature of the program’s financial support that could affect the ability of the program to meet the standards;
- Curriculum changes that could affect the ability of the program to meet the standards;
- Reduction in faculty or support staff time commitment that could affect the ability of the program to meet the standards;
- Change in the required length of the program;
- Reduction of program dental facilities that could affect the ability of the program to meet the standards;
- Addition of advanced standing opportunity, part-time track or multi-degree track, or other track offerings;
- Expansion of a developing dental hygiene or assisting program which will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements; and/or
- Implementation of changes in the use of distance education that could affect the ability of the program to meet the standards (see reporting requirements found in the Policy on Distance Education).

The following examples illustrate, but are not limited to, additional program changes that must be reported in writing at least thirty (30) days prior to the anticipated implementation of the change and are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:
• Establishment of Off-Campus Sites owned by the sponsoring institution used to meet accreditation standards or program requirements;
• Expansion or relocation of dental facilities within the same building;
• Change in chief executive officer, chief academic officer, and program director. **For the program director only (new, acting, interim):** In lieu of a CV, a copy of a completed BioSketch must be provided to Commission staff. Contact Commission Staff for the BioSketch template.
• First-year non-enrollment. See Policy on Non Enrollment of First Year Students/Residents.

The Commission recognizes that unexpected changes may occur. If an unexpected change occurs, it **must be reported no more than 30 days following the occurrence.** Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster (See Policy/Guidelines on Interruption of Education). Failure to proactively plan for change will not be considered an unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The Commission uses the following process when considering reports of program changes. Program administrators have the option of consulting with Commission staff at any time during this process.

1. A program administrator submits the report by **May 1 or November 1.**
2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by the Commission.
3. Receipt of the report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review Committee and by the Commission at their next regularly scheduled meeting. Additional information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next site visit.
4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of program changes received from accredited educational programs.

• **Approve the report of program change:** If the Review Committee or Commission does not
identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change(s) have been noted and will be reviewed at the next regularly-scheduled site visit to the program.

• **Approve the report of program change and request additional information:** If the Review Committees or Commission does not identify any concerns regarding the program’s compliance with the accreditation standards, but believes follow up reporting is required to ensure continued compliance with accreditation standards, additional information will be requested for review by the Commission. Additional information could occur through a supplemental report or a focused site visit,

• **Postpone action and continue the program’s accreditation status, but request additional information:** The transmittal letter will inform the institution that the report of program change has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request.

• **Postpone action and continue the program’s accreditation status pending conduct of a special site visit:** If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.

• **Deny the request:** If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for a program change. The institution will be advised that they may re-submit the request of program change with additional information if they choose. If the program change was submitted retroactively, and non-compliance is identified, the program’s accreditation status will be changed. The transmittal letter will inform the institution that the report of program change has been considered, but an area of non-compliance with the accreditation standards has been identified. The program’s accreditation status is changed and additional specific information regarding the identified area(s) of non-compliance will be requested for review by the Commission.

Revised: 8/23; 2/22; 8/21; 2/21; 8/20; 1/20; 8/18; 2/18; 8/17; 8/16; 2/16; 8/15; 2/15; 8/13 2/12, 8/11, 8/10, 7/09, 7/07, 8/02, 7/97; Reaffirmed: 7/07, 7/01, 5/90; CODA: 05/91:11

E. POLICY ON PREPARATION AND SUBMISSION OF DOCUMENTS TO THE COMMISSION

All institutions offering programs accredited by the Commission are expected to prepare documents that adhere to guidelines set forth by the Commission on Dental Accreditation, including required verification signatures by the institution’s chief executive officer, the
institution’s chief academic officer, and program director. These documents may include, but
are not limited to, self-study, responses to site visit/progress reports, initial accreditation
applications, reports of program change, and transfer of sponsorship and exhibits. The
Commission’s various guidelines for preparing and submitting documents, including electronic
submission, can be found on the Commission’s website or obtained from the Commission staff.

In addition, all institutions must meet established deadlines for submission of requested
information. Any information that does not meet the preparation or submission guidelines or is
received after the prescribed deadlines may be returned to the program, which could affect the
accreditation status of the program.

**Electronic Submission of Accreditation Materials:** All institutions will provide the
Commission with an electronic copy of all accreditation documents and related materials, which
conform to the Commission’s Electronic Submission Guidelines. Electronic submission
guidelines can be found on the Commission’s website or obtained from the Commission staff.
Accreditation documents and related materials must be complete and comprehensive.

Documents that fail to adhere to the stated Guidelines for submission will not be accepted and
the program will be contacted to submit a corrected document. In this case, documents may not
be reviewed at the assigned time which may impact the program’s accreditation status.

**Compliance with Health Insurance Portability and Accountability Act (HIPAA).** HIPAA is
the federal law that governs how “Covered Entities” handle the privacy and security of patients’
protected health information (PHI). HIPAA Covered Entities include health care providers that
send certain information electronically as well as certain health plans and clearinghouses. The
Commission may be deemed a “Business Associate” of institutions that are HIPAA Covered
Entities. A Business Associate is an individual or entity that performs a function or activity on
behalf of a HIPAA Covered Entity involving the use or disclosure of individually identifiable
health information. Business Associates must comply with certain provisions of the HIPAA
Security, and Privacy and Breach Notification Rules provisions and implement training
programs. The Commission “HIPAA Policy and Procedure Manual” is updated periodically. All
Commission site visitors, Review Committee members, Commissioners, and staff are required to
complete a CODA HIPAA training exercise on a yearly basis.

The program’s documentation for CODA must not contain any patient protected health
information (PHI) or sensitive personally identifiable information (PII). If the program submits
documentation that does not comply with the policy on PHI or PII, CODA will assess an
administrative processing fee of $4,000 per program submission to the institution; a program’s
resubmission that continues to contain PHI or PII will be assessed an additional $4,000
administrative processing fee.
D. DUE PROCESS RELATED TO APPEAL OF ACCREDITATION STATUS DECISIONS

An institution/program may request a special appearance (hearing) before the appropriate Review Committee in order to supplement the written information about the program which has already been provided to the Review Committee. (See Due Process Related to Review Committee Special Appearance).

If the Review Committee’s recommended accreditation status to the Commission is “approval with reporting requirements,” “approval with reporting requirements, intent to withdraw,” or if the Review Committee recommends denying a requested program change, the Review Committee will make a recommendation to the Director and Chair of the Commission and indicate whether an appearance before the full Commission is appropriate.

If representatives of the institution choose to appear before the Commission, they may present arguments that the Review Committee made an error in judgment, based on the information available, in making the accreditation status or action recommendation. Alternately, representatives of the institution may choose to appear before the Commission to address the Commission’s questions related to the Review Committee’s recommendation. During the special appearance before the Commission, no new information regarding correction of deficiencies subsequent to the Review Committee special appearance may be presented. The institution’s representative(s) may attend the Commission meeting only during the time assigned for the hearing.

If the Commission determines the program accreditation status is “approval with reporting requirements,” “approval with reporting requirements, intent to withdraw,” or denies a requested program change, and the institution/program believes that the Commission has made an error in judgment regarding accreditation status or action, a special appearance (hearing) before the Commission may be requested sixty (60) days prior to the Commission meeting. The special appearance (hearing) before the Commission would be held at the next regularly scheduled meeting. At the hearing, representatives of the institution may present arguments that the Commission, based on the information available when the decision was made, made an error in judgment in determining the accreditation status of the program. The Director of the Board of Commissioners must receive any written evidence or argument at least thirty (30) days prior to the hearing. Under these circumstances, no new information regarding correction of deficiencies subsequent to the previous Commission meeting may be presented. The institution’s
representative(s) may attend the Commission meeting only during the time assigned for the

hearing.

The decision of the Commission on the accreditation status of the program after this special

appearance is final.

Revised: 8/23; 2/23; 8/18; 8/16; Reaffirmed: 8/21; 8/10

II. REVIEW COMMITTEES AND BOARD OF COMMISSIONERS

A. REVIEW COMMITTEES AND REVIEW COMMITTEE MEETINGS

1. Structure: The chair of each Review Committee will be the appointed Commissioner from

the relevant discipline.

i. The Commission will appoint all Review Committee members.

a. Review Committee positions not designated as discipline-specific will be

appointed from the Commission where feasible, e.g. a public representative on the

Commission could be appointed to serve as the public member on the Dental

Laboratory Technology Review Committee; an ADA appointee to the

Commission could be appointed to the Dental Assisting Review Committee as the

general dentist practitioner.

b. Discipline-specific positions on Review Committees will be filled by appointment

by the Commission of an individual from a small group of qualified nominees (at

least two) submitted by the relevant national organization, discipline-specific

sponsoring organization or certifying board. Nominating organizations may elect

to rank their nominees, if they so choose. If fewer than two (2) qualified

nominees are submitted, the appointment process will be delayed until such time

as the minimum number of required qualified nominations is received.

ii. Consensus is the method used for decision making; however if consensus cannot be

reached and a vote is required, then the Chair may only vote in the case of a tie


iii. Member terms will be staggered, four year appointments; multiple terms may be served

on the same or a different committee, with a one-year waiting period between terms. A

maximum of two (2) terms may be served in total. The one-year waiting period between

terms does not apply to public members.

iv. One public member will be appointed to each committee. Following consideration of

workload, public members may concurrently serve on more than one (1) review

committee.

v. The size of each Review Committee will be determined by the committee’s workload.

vi. As a committee’s workload increases, additional members will be appointed while

maintaining the balance between the number of content experts and non-content experts.

Committees may formally request an additional member through New Business at
Standing Committee on Documentation and Policy
Commission Only
CODA Summer 2023

Review Committee/Commission meetings. If an additional member is approved, this member must be a joint nomination from the professional organization and certifying board, as applicable.

vii. Conflict of interest policies and procedures are applicable to all Review Committee members.

viii. Review Committee members who have not been on a site visit within the last two (2) years prior to their appointment on a Review Committee should attend the Commission’s site visitor training workshop and observe at least one site visit within their first year of service on the Review Committee.

ix. In the case of less than 50% of discipline-specific experts, including the Chair, available for a review committee meeting, for specified agenda items or for the entire meeting, the Review Committee Chair may temporarily appoint an additional discipline-specific expert(s) with the approval of the CODA Director. The substitute should be a previous Review Committee member or an individual approved by both the Review Committee Chair and the CODA Director. The substitute would have the privileges of speaking, making motions, and voting.

x. Recommendations to the Commission from the Review Committee must be taken at meetings in which there is both a quorum and at least one (1) discipline-specific expert, other than the Chair, present.

xi. Consent agendas may be used by Review Committees, when appropriate, and may be approved by a quorum of the Review Committee present at the meeting.

Revised: 8/23; 8/22; 8/20; 1/20; 8/18; 8/17; 2/15; 1/14, 2/13, 8/10, 7/09; 7/08; 7/07; 7/06

Adopted: 1/06
B. COMMISSION AND COMMISSION MEETINGS

The Commission and its Review Committees meet twice each year to consider site visit reports and institutional responses, progress reports, information from annual surveys, applications for initial accreditation, and policies related to accreditation. These meetings are held in the winter and the summer.

Reports from site visits conducted less than 90 days prior to a Commission meeting are usually deferred and considered at the next Commission meeting. Commission staff can provide information about the specific dates for consideration of a particular report.

The Commission has established policy and procedures for due process which are detailed in the Due Process section of this manual.

Revised: 8/17; 8/14; 7/06, 7/96; Reaffirmed: 8/22; 8/10; Adopted: 7/96

1. Composition and Criteria

Composition

The Board of Commissioners shall consist of:

Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency.

Four (4) members who are active, life or retired members of this Association and also active members of the American Association of Dental Boards shall be selected by the American Association of Dental Boards. None of these members shall be a faculty member of any dental education program.

Four (4) members who are active, life or retired members of this Association and also active members of the American Dental Education Association shall be selected by the American Dental Education Association. None of these members shall be a member of any state board of dental examiners or jurisdictional dental licensing agency.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (1) licensed dental hygienist selected by the American Dental Hygienists’ Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students, Residents and Fellows of the American Dental Education Association,
one (1) dentist who is board certified in the respective discipline-specific area of practice and is selected by each of the following organizations: American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Oral Medicine, American Academy of Orofacial Pain, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontists, American Society of Dentist Anesthesiologists; one (1) dentist who is jointly appointed by the American Dental Education Association and the Special Care Dentistry Association, and four (4) members of the public who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. The Director of the Commission shall be an ex-officio member of the Board without the right to vote.

Criteria (All Appointees)

- Ability to commit to one (1) four (4) year term;
- Willingness to commit ten (10) to twenty (20) days per year to activities, including training, comprehensive review of print and electronically delivered materials, and travel to Commission headquarters;
- Ability to evaluate an educational program objectively in terms of such broad areas as curriculum, faculty, facilities, student evaluation and outcomes assessment;
- Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; HIPAA Training, Licensure Attestation, and Professional Conduct Policy and Prohibition Against Harassment);
- Ability to conduct business through electronic means (email, Commission Web Sites); and
- Active, life or retired member of the American Dental Association, where applicable.

Public/Consumer Commissioner:

- A commitment to bring the public/consumer perspective to Commission deliberations. The appointee should not have any current or past (within the past three years) formal or informal connection to the profession of dentistry; also, the appointee should have an interest in, or knowledge of, health-related and accreditation issues. In order to serve, the appointee must not be a:
2. Policy On Absence From Commission Meetings: When a Commissioner notifies the Director that he/she will be unable to attend a meeting of the Commission, the Director will notify the Chair. The Chair determines if another individual should be invited to attend the meeting in the Commissioner’s absence. A substitute will be invited if the Commissioner’s discipline would not otherwise be represented. This individual must be familiar with the Commission’s policies and procedures; and therefore, must be a current or former member of the appropriate Review Committee and must represent the same discipline or appointing organization as the absent Commissioner. In the event that these criteria cannot be met, the Commission Chair may elect not to invite another individual to the meeting. The substitute would have the privileges of speaking, introducing business, making motions, and voting.

Revised: 8/17; 8/10, 7/97; Reaffirmed: 8/22; 7/07, 7/01; CODA: 12/86:14

3. New Commissioner Orientation and Training: Newly appointed Commissioners will undergo a six-month training period prior to beginning their official term. This training includes attendance at a Commission meeting, at the discipline-specific review committee meeting and the Commission’s site visitor training workshop within their first year of service on the Review Committee, and an appropriate site visit.

Reaffirmed: 8/23; 8/22; 8/17; 8/14; Adopted: 8/11
COMMISSION ON DENTAL ACCREDITATION

POLICY ON TEMPORARY USE OF ALTERNATIVE SITE VISIT METHODS

On March 13, 2020, a national emergency was declared due to the COVID-19 pandemic. As a result of the continued impact on travel, the Commission on Dental Accreditation (CODA) has determined temporary use of alternative site visit (i.e., virtual or hybrid site visit) methods may be necessary to fulfill the Commission’s obligation to conduct accreditation site visits to programs that are currently accredited by, or apply for accreditation by, the Commission. The term of this policy shall be in effect upon CODA approval and until the termination date of the temporary flexibility granted through the United States Department of Education.

Alternative site visit methods may be used to conduct site visits to U.S.-based dental education programs seeking accreditation (applicant programs) as well as regular reaccreditation and special focused site visits, as applicable. The conduct of a site visit using alternative methods will be based on travel, health and safety concerns and/or restrictions in the geographic location(s) that may be visited by the Commission’s staff and volunteers, or for other reasons deemed appropriate by the Commission during the pandemic (for example, institutional, local, state, or federal directives).

Alternative site visit methods may not be used for any portion of the international accreditation process, including but not limited to the CODA Preliminary Accreditation Consultation Visit (PACV) process and the CODA predoctoral dental education international accreditation process.

Alternative site visits may be entirely virtual (all site visitors remote), or hybrid (at least one on-site Commission site visitor in the discipline), as determined by the Commission in consultation with the program and site visit committee, and subject to the Commission’s final decision.

- Virtual site visits will require an on-site visit by a Commission site visit team (with 1-2 team members and, as necessary, Commission staff), as dictated by the Commission. The on-site visit to the educational program will occur within a reasonable amount of time following the conduct of a virtual site visit unless cause exists to conduct the visit earlier, subject to CODA’s site visit schedule and ongoing health, safety, and/or travel concerns and/or restrictions. During the in-person visit, the Commission reserves the right to review the portions of the program that could not be completed virtually (e.g. facility tours, clinic observations, educational activity site tours, confidential document reviews, patient record reviews, etc.) and any areas in which concerns were raised during the virtual site visit, or other standards, policies

...
and/or procedures that may arise during the course of the in-person site visit.

- Hybrid site visits will be structured to include all components of the site visit process, with both virtual and on-site review of the program by Commission site visitors. As such, the Commission will view the hybrid site visit as equivalent to an on-site visit, with no secondary visit required based solely upon the methodology used to conduct the site visit.

- Following the virtual (followed by a later on-site visit) or hybrid site visit, the program’s next regular reaccreditation on-site visit will be scheduled seven (7) years following the date of the virtual or hybrid site visit in all disciplines except oral and maxillofacial surgery (residency and fellowship), which will be scheduled five (5) years following the date of the virtual or hybrid site visit. The Commission reserves the right to conduct an earlier visit to the program in accordance with Commission policies and procedures (e.g. special focused site visit, pre-graduation site visit).

Generally, for all alternative site visit methods, the Commission’s current policy and procedure related to the conduct of a site visit and Commission review of site visit reports, progress reports, and other due process noted in the Evaluation and Operational Policies and Procedures will apply.

The following principles apply to the temporary use of alternative site visit methods:

- The program will be issued a preliminary draft site visit report following the site visit, regardless of site visit format, in accordance with Commission policy. The preliminary draft site visit report will be provided to the Commission along with the program’s response, should one be submitted, and the Commission will make an accreditation decision based on this report.

- When Accreditation Standards are revised during the period in which the program is submitting progress reports for either the virtual, hybrid or in-person site visit, the program will be responsible for demonstrating compliance with the new standards. Further, identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

- In order to conduct a virtual or hybrid site visit, the program being site visited must host the visit using their meeting technology (Zoom is preferred). If the program cannot comply with technological support, the site visit will be delayed and the program must submit a formal request for extension of accreditation using the Report of Program Change, which will be considered by the Commission at its next regular meeting.

- All virtual/hybrid site visits will be conducted using the time zone of the program being visited, documenting all time zones using CODA’s site visit schedule template.

- Audio and/or video recording of the site visit is strictly prohibited.
• The Commission will dictate the portions of a site visit that will be conducted using alternative site visit methods.
  o The following applies to the conduct of a **virtual-only site visit:**
    ▪ The Commission and its site visit team will dictate the final schedule of the site visit.
    ▪ Tours of vacant facilities may be conducted virtually. However, all clinical observations and tours that may involve access to patients, will be conducted on-site only.
    ▪ All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will not be reviewed virtually.
    ▪ Student/Resident/Fellow interviews will be conducted virtually.
    ▪ All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.
  o The following applies to the conduct of a **hybrid site visit:**
    ▪ The Commission and its site visit team will dictate the final schedule of the site visit.
    ▪ All clinical observations and tours that may involve access to patients, will be conducted by the on-site visitor only. Tours of vacant facilities may be conducted virtually for the entire visiting committee.
    ▪ All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will be reviewed on-site only.
    ▪ Student/Resident/Fellow interviews will be conducted virtually and on-site.
    ▪ All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s
accreditation file, unless necessary to document a site visit finding.

The following protocol will be applied to the in-person site visit following a virtual site visit:

- **Virtual Regular Site Visit** – A program that conducted its regular (5 or 7 year cycle) site visit virtually will have an on-site visit within a reasonable amount of time.

- **Virtual Special Focused Site Visit** – Since this type of site visit involves a special situation and does not alter the date of the program’s regular site visit, there will be no requirement to conduct the in-person site visit unless the Commission deems necessary.

- **Virtual New Program (Application) Site Visit:**
  - Developing Program – A developing program’s pre-enrollment site visit will be followed by a pre-graduation site visit. Additionally, programs that are four years in length are required to have a mid-initial accreditation site visit. Given the next site visit to a developing program will occur at the pre-graduation or mid-initial accreditation stage, there will be no requirement to conduct the in-person new program site visit unless the Commission deems necessary.
  - Fully Operational Program – A fully operational program will engage in a regular site visit and, if granted accreditation, will be placed on a regular site visit cycle (5 or 7 year cycle). Given the new program site visit conducted virtually and timeline for the next visit could be 5 to 7 years, this type of program will have an on-site visit within a reasonable amount of time.

To ensure continuity of the review, one (1) site visitor who attended the virtual site visit to a single discipline should conduct the on-site follow-up visit. If two (2) or more programs were virtually visited at an institution, the team could consist of two (2) site visitors, total, representing at least two (2) disciplines. If a visitor who attended the virtual visit cannot be identified, any active site visitor in the discipline(s) may conduct the on-site follow-up visit. The final team composition for the on-site follow-up will be dictated by the Commission and may also include a virtual Commission staff.

The in-person follow-up visit will focus on the areas of the site visit that may have been difficult to accomplish virtually. A template schedule will be developed to include the following components for all follow-up in-person site visits: 1) introduction to the visit; 2) tour of facilities (including educational activity sites, as needed); 3) clinical observations; 4) program records review related to items that could not be fully reviewed virtually (confidential document reviews, patient record reviews, etc.); and 5) review of the program’s progress on areas of noncompliance cited during the virtual site visit. Related to areas of noncompliance cited during the virtual site visit, it will be the Commission, through review of the program’s ongoing progress reports and the findings of the on-site visit, which will determine the program’s compliance. Additionally, while not the focus of the in-person follow-up visit, if compliance concerns arise regarding additional Standards beyond those cited during the virtual site visit, the site visitor(s) will review the program’s compliance in these areas.
A template Site Visit Schedule and template Site Visitor Evaluation Report specific to the on-site visit process following a virtual site visit will be provided through the Commission office.

Revised: 8/23; 2/22; Adopted February 12, 2021
Background: The Standing Committee on Communication and Technology met on Monday, June 26, 2023 via a virtual meeting. The following Commissioners serving on the Standing Committee participated in the discussion: Dr. Joel Berg (chair), Dr. Carolyn Brown, Mr. Noah Williams, Dr. Barbara Krieg-Menning, Dr. Brent Larson, and Ms. Martha McCaslin. Dr. Willie Keith Beasley and Dr. Amid Ismail were unable to attend. Dr. Sherin Tooks, senior director, CODA, and Ms. Kathleen Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner, and Ms. Kelly Stapleton, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA were also in attendance.

The Committee began its meeting with a review of the Standing Committee’s charge. The Committee discussed the following items:

CODA Website Analytics: The Standing Committee reviewed the Commission’s website analytics for the period of January 1, 2023 through June 1, 2023. The Committee noted these analytics may further enhance the work of the Committee by including more specific information about CODA’s website, rather than information on browser type, referrers, outbound links, and source links to CODA’s website. The Committee believed a review of analytics data collected and reported may be warranted, following development of the Commission’s next Communication Plan, so that the Standing Committee can monitor the impact of CODA’s communications through visits to CODA’s website.

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

CODA Communication Plan: A subcommittee of the Standing Committee (Drs. Joel Berg, Brent Larson and Barbara Krieg-Menning), Dr. Sanjay Mallya, CODA chair, Dr. Maxine Feinberg, CODA vice chair, Dr. Sherin Tooks, CODA senior director, and Commission managers, met on May 5, 2023 and May 31, 2023 to develop the Communication and Technology Survey. The subcommittee discussed the goals of the communication plan, which included providing the communities of interest with relevant information on the process, operations, and purview of the Commission, and to provide updates on meetings, current events, and training. The subcommittee noted that the Commission’s communication strategy through video (both synchronous and asynchronous), written documentation, and updates to the broad community of interest, for informational and educational purposes, will be further developed through the next Communication Plan. The audiences of the Commission include educational programs (i.e., program directors, faculty, and site visitors), and the broad community of interest (i.e., dental organizations, dental boards, state agencies and associations, students, patients, and the public), as noted by the subcommittee.

The subcommittee considered the last Communication Survey of 2017, as well as the draft questions and the list of groups surveyed. Following considerable discussion and review of the
survey, the subcommittee developed a revised Communication Survey for consideration by the Standing Committee.

The subcommittee believed that, following consideration, the Standing Committee should recommend that the Commission announce the survey following its August 2023 meeting. A second reminder announcement could be sent one (1) week prior to distribution of the survey. The Commission could distribute the survey in late September/October 2023, with a three-week deadline for completion and reminder at the mid-point for those who have not responded. Following data collection, a report of findings and recommendations related to the next Communication Plan would be developed in Fall 2023 and presented to the Commission in Winter 2024.

At its June 26, 2023 meeting, the Standing Committee reviewed and discussed the draft communication survey prepared by the subcommittee of the Standing Committee on Communication and Technology. The Standing Committee finalized the communication survey (Appendix 1) and determined that an announcement of the survey should occur one (1) month and one (1) week prior to dissemination. The Standing Committee agreed that the survey be distributed in late September/October 2023, with a three-week deadline for completion and reminder at the mid-point for those who have not responded. As such, the Standing Committee will proceed with CODA’s directive to develop a communication plan and will disseminate the survey (Appendix 1) in Fall 2023. A report and draft communication plan will be provided to the Commission in Winter 2024.

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

Electronic Accreditation Platform: The Standing Committee discussed the Commission’s continued need to identify, secure, develop and support a long-term solution for an electronic accreditation tool. An electronic accreditation platform was implemented in February 2021 to support the submission of applications and self-study documents from programs, and access of these materials by site visit team members. It was noted that a robust, comprehensive, and easy-to-use electronic accreditation platform is vital to CODA’s ongoing mission, as evidenced in CODA’s most recent 2022-2026 Strategic Plan goal that the Commission be “efficient in managing the accreditation processes, both internal and external.” The Standing Committee learned that CODA’s Senior Director continues to work with ADA Legal and Information Technology staff to develop a contract with a potential vendor.

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

Commission Actions:

Prepared by: Dr. Sherin Tooks
2023 Commission on Dental Accreditation Communications Survey

Announcement for 2023 Commission on Dental Accreditation Communications Survey
(One Month Prior to Distribution)

At its Summer 2023 meeting, the Commission on Dental Accreditation considered the report of its Standing Committee on Communication and Technology, specifically related to the Commission’s next Communication Survey. As an important community of interest of the Commission, you will receive a link to the Commission’s Communication Survey within the next month. The Commission requests your participation in the survey to help inform its next Communication Plan. Your response will remain completely confidential and will be presented to CODA in aggregate form only. We look forward to hearing from you.

Signed, CODA Chair

Announcement for 2023 Commission on Dental Accreditation Communications Survey
(One Week Prior to Distribution)

Within the past month, we contacted you related to the upcoming Commission on Dental Accreditation Communication Survey. As an important community of interest of the Commission, we request your participation in the survey to help inform its next Communication Plan. You will receive a link to the Commission’s Communication Survey within the next week. The survey will take approximately 5 minutes to complete. Your response will remain completely confidential and will be presented to CODA in aggregate form only. We look forward to hearing from you.

Signed, CODA Chair

2023 Commission on Dental Accreditation Communications Survey

Introduction to Survey
The Commission on Dental Accreditation (CODA) serves the public and dental professions by developing and implementing accreditation standards that promote and monitor continuous quality and improvement of dental education programs. The Commission functions independently and autonomously of the American Dental Association in matters of developing and approving accreditation standards, making accreditation decisions on educational programs, and developing and approving procedures that are used in the accreditation process. The Commission on Dental Accreditation is recognized by the United States Department of Education as the national programmatic accrediting agency for dental and dental-related education programs.

Instructions
Thank you for participating in the 2023 Commission on Dental Accreditation Communications Survey. This survey will take approximately 5 minutes to complete. CODA wishes to assess and improve its communication initiatives to communities of interest. Your answers will help CODA make informed decisions about the development of its communication strategies. Your response will remain completely confidential and will be presented to CODA in aggregate form only.
Please complete all questions by selecting the appropriate response that best describes your situation. Please note that the "Next" and "Back" buttons will allow you to move from one page to another. When you have completed the survey successfully, you will reach the completion page which will notify you that your responses have been submitted.

**Primary Affiliation (to be embedded in the survey invitation for each recipient)**
- American Dental Association (member or volunteer leader at local, state, or national)
- Allied Dental Association (Dental Assisting, Dental Hygiene, Dental Laboratory Technology, Dental Therapy)
- Allied Dental Certifying Organization
- American Association of Dental Boards
- American Dental Education Association
- American Student Dental Association
- Chiefs of Federal Dental Services
- CODA Volunteer (site visitor, review committee member, commissioner, appeal board member)
- CODA Accredited Program (CEO, CAO, program director)
- Dental Specialty Association (one of the 12 NCRDSCB-recognized specialties)
- Dental Specialty Certifying Board (one of the 12 NCRDSCB-recognized specialties)
- General Dentistry Association (AEGD, GPR)
- State Board of Dentistry
- State Dental Association Executives

1. How familiar are you with the work of the Commission on Dental Accreditation (CODA) overall?
   - Extremely familiar
   - Moderately familiar
   - Not at all familiar

2. How familiar are you with:

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<th>Extremely Familiar</th>
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<tr>
<td>CODA’s accreditation policies and procedures</td>
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<td>Your ability to provide</td>
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### Communication and Technology Committee

**Commission Only**  
**Summer 2023**

3. For each statement below, please indicate whether you believe this is a role of CODA.

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<tr>
<th>Statement</th>
<th>Yes, this is a role of CODA</th>
<th>No, this is not a role of CODA</th>
<th>Not sure</th>
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<tr>
<td>Accreditation certifies that an individual is capable of practicing dentistry.</td>
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<td>Accreditation is a peer-review process that determines whether dental education programs meet certain quality standards.</td>
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<td>Accreditation determines whether dental graduates are competent to begin the practice of dentistry.</td>
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4. How well informed would you say you are regarding the latest CODA proceedings, activities, and policies?
   - Extremely informed
   - Moderately informed
   - Not at all informed

5. What accreditation information is important to your work? (select all that apply)
   - Policy changes
   - Process changes
   - Accreditation Standards changes
   - Current issues in higher education
6. How often do you read the following resources? If you have not heard of a resource, select “Not familiar”.

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<th>Resource</th>
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<td>CODA Annual Report</td>
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7. What are your primary sources for receiving information about CODA? (select up to 3)
   - CODA website
   - CODA meeting major actions/meeting minutes
   - CODA newsletter or blast emails
   - CODA presentations (e.g. webinars)
   - Word of mouth
   - Phone call with CODA staff
   - Another dental organization
   - I don’t usually seek information related to CODA (Exclusive option; if selected no other choice may be selected)

8. How would you describe the frequency of CODA Communication?
   - Too frequent
   - Adequate and timely
   - Not frequent enough
   - Not applicable; I do not follow CODA Communications

9. Which of the following information would you like to receive from CODA? (select all that apply)
   - Process to revise Accreditation Standards
   - Revisions to Accreditation Standards
   - Accreditation status of programs
   - Accreditation business/policy updates
   - Requirements/criteria for being a Commission volunteer
   - Schedule of accreditation site visits
   - Meeting minutes from CODA semi-annual meetings
   - Training for program directors
   - Training for CODA volunteers
   - Updates to communities of interest
   - Not interested / None of the above
10. What is your preferred method of receiving CODA communications in the future? (select all that apply)
   - E-mail
   - CODA website
   - CODA newsletter or similar methods
   - Social media
   - Not interested in receiving CODA communications

11. What is your preferred method for receiving CODA training in policies and procedures? (select all that apply)
   - Webinar: Live
   - Webinar: On-demand
   - In-person training at the ADA Building
   - In-person training at dental meetings (ADEA, ADA, etc.)
   - Not applicable

12. If CODA were to engage in any of these social media sites/tools, how likely would you be to utilize them?

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<thead>
<tr>
<th>Social Media Sites/Tools</th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
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REPORT OF THE STANDING COMMITTEE ON NOMINATIONS

**Background:** An ongoing responsibility of the Standing Committee on Nominations (Nominations Committee) includes recommendations to the Commission on Dental Accreditation (CODA) of qualified nominations to vacant positions on Review Committees and, in the case of public members, to vacant positions on Review Committees, the Commission, and the Appeal Board. Based upon review of position qualifications and submitted nominations, the Committee submits recommendations to the Commission for appointment of individuals.

**July 24, 2023 Meeting:** The Standing Committee on Nominations met on Monday, July 24, 2023 via a virtual meeting. The following members of the Nominations Committee were present: Dr. George Kushner (chair), Dr. Eva Anadioti, Dr. Indraneel Bhattacharyya, Ms. Martha McCaslin, and Dr. Marshall Titus. Dr. Amid Ismail, Dr. Barbara Krüeg-Menning, and Dr. Nancy Rosenthal were unable to attend. Dr. Sherin Tooks, senior director, Ms. Marjorie Hooper, operations coordinator, and Ms. Jamie Asher Hernandez, Ms. Katie Navickas, Ms. Yesenia Ruiz, and Ms. Kelly Stapleton, managers, CODA were in attendance. Ms. Peggy Soeldner, manager, CODA, was unable to attend. Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, was also in attendance.

The Standing Committee considered the Criteria for Commission and Review Committee Members and the Policy on Simultaneous Service (**Appendix 1**), nominee qualifications, and upcoming vacancies on Review Committees and the Commission (**Appendix 2**). Additionally, nominating organization rankings were considered, as applicable.

Following consideration and discussion, the Committee recommends the Commission appoint the following individuals:

**Nomination Committee Recommendation:** It is recommended that the Commission on Dental Accreditation appoint the following nominees to open positions on the Commission’s Review Committees, and public members to the Board of Commissioners:

**General Practice Residency Educator (one (1) vacancies) for Review Committees on Post Graduate Dental Education (PGD RC).**
- Dr. Robert Hollowell
  Alternate: Dr. Nadejda Stefanova Stephens

**Predoctoral Dental Education Educator (one (1) vacancy for the Review Committee on Predoctoral Dental Education (PREDOC RC))**
- Dr. Sillas Duarte
  Alternate: Dr. Wendy Woodall
General Dentist (four (4) vacancies) for the Review Committees on Dental Assisting Education (DA RC), Oral and Maxillofacial Pathology Education (OMP RC), Oral and Maxillofacial Radiology Education (OMR RC), and Prosthodontics Education (PROS RC).
- Dr. Dara Rogers
- Dr. Jennifer Boyce
- Dr. Philip Rinaudo
- Dr. Tena Phillips
Alternate: Dr. Tiffany McPheeters

Dentist Practitioner (one (1) vacancy) for the Review Committee on Dental Hygiene Education (DH RC)
- CODA Commissioner practitioner
  Dr. Ngoc Chu – CODA Commissioner
  Alternate: Dr. Nancy Rosenthal – CODA Commissioner

Dentist Educator (one (1) vacancy) for the Review Committee on Dental Hygiene Education (DH RC)
- Dr. James Harrison
Alternate: none

Dental Assisting Educators (two (2) vacancies) for the Review Committee on Dental Assisting Education (DA RC)
- Ms. Heather Seghi
- Ms. Staci Schory
Alternate: Ms. Jill Holland

Dental Hygiene Educator (one (1) vacancy) for the Review Committee on Dental Hygiene Education (DH RC)
- Ms. Joanne Pacheco
Alternate: Ms. Joanna Campbell

Public Members (eight (8) vacancies) for the Review Committees on Predoctoral Dental Education (PREDOC RC), Post Graduate Dental Education (PGD RC), Dental Hygiene Education (DA RC), Endodontics Education (ENDO RC), Orthodontics and Dentofacial Orthopedics Education (ORTHO RC), Pediatric Dentistry Education (PED RC), and Prosthodontics Education (PROS RC); and one (1) vacancy for the Appeal Board.
- CODA Commissioner Public Members
- Dr. Kevin Haubrick
- Dr. Linda Casser
- Mr. Marty Nicholson
- Dr. Carole Palmer
• Dr. Tia Young
• Tabled further reviews until additional qualified nominations are received.

**Nomination Committee Recommendation:** It is recommended that the Commission on Dental Accreditation appoint the following individuals, nominated by sponsoring organizations and/or boards, to the relevant review committees to fill discipline-specific vacancies:

**American Association of Endodontists (AAE) and American Board of Endodontics (ABE) Joint Nominee (one (1) vacancy) for the Review Committee on Endodontics Education (ENDO RC), nominated by the American Association of Endodontists (AAE) and American Board of Endodontics (ABE)
• Dr. Timothy Kirkpatrick
Alternate: Dr. Bekir Karabucak

**American Association of Oral and Maxillofacial Surgeons (AAOMS) and American Board of Oral and Maxillofacial Surgery (ABOMS) Joint Nominee (one (1) vacancy) for the Review Committee on Oral and Maxillofacial Surgery Education (OMS RC), nominated American Association of Oral and Maxillofacial Surgeons (AAOMS) and American Board of Oral and Maxillofacial Surgery (ABOMS).
• Dr. Vincent Perciaccante
Alternate: Dr. David Powers

**American Association of Orthodontists (AAO) Nominee (one (1) vacancy) for the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC), nominated by the American Association of Orthodontists (AAO).
• Dr. Juan Palomo
Alternate: Dr. Sundaralingam Premaraj

**American Board of Periodontology (ABP) Nominee (one (1) vacancy) for the Review Committee on Periodontics Education (PERIO RC), nominated by the American Board of Periodontology (ABP).
• Dr. Wayne Kye
Alternate: Dr. Hsun-Liang (Albert) Chan

**Streamlining and Simplifying the Nomination Scoring Process:** At its Summer 2022 meeting, the Commission considered the report of the Standing Committee on Nominations related to a brief discussion on the scoring system used to determine which nominations to forward to the Commission. The Committee noted that when a large number of nominations are received, for example in the general dentist category, it becomes difficult to distinguish nominations in a meaningful way. The Nominations
Committee believed further study of the scoring process and potential development of additional mechanisms could be discussed through an Ad Hoc Committee of the Nominations Committee. Additionally, reviewing the current nomination form to include, for instance, information on licensure standing, private practice experience, and teaching experience to provide additional information on the nominee’s qualifications for review committee specific requirements. At its Summer 2022 meeting, the Commission directed the Nominations Committee to review its scoring process to better align with the needs of the Committee’s review.

The Nominations Committee conducted meetings on May 1, 2023 and July 24, 2023, during which the topic of streamlining and simplifying the nomination scoring process was discussed. During the May 1, 2023 meeting, all members were present except Dr. Amid Ismail, Dr. Barbara Krieg-Menning and Dr. Nancy Rosenthal. Dr. Sanjay Mallya, chair, and Dr. Maxine Feinberg, vice chair, ex officio, CODA, were in attendance along with Dr. Sherin Tooks, senior director, CODA, and Ms. Katie Navickas, Ms. Peggy Soeldner, and Ms. Kelly Stapleton managers, CODA, and Ms. Marjorie Hooper, operations coordinator, CODA. The members in attendance during the July 24, 2023 meeting are indicated above.

The Committee began with a reminder of its charge to review the nomination scoring process and considered the Criteria for Commission and Review Committee Members, the Review Committee and Public Member Nomination Forms, and the current scoring system.

The Committee discussed the nomination scoring system and noted that the current mechanisms used to evaluate nominees could be streamlined. The Committee believed that the intent of the pre-review is that each Committee member consider nominations to verify each nominee’s eligibility and to determine the choice(s) of appointees and alternates. These Committee member assessments serve as a starting point for Committee discussion of vacant positions. Therefore, the Committee believed the scoring should be streamlined to identify whether the individual meets the required criteria to serve, and whether the individual should be selected to fill an open position or be an alternate. The Committee will further discuss nominees and the members’ initial reviews during its regular meetings, as it has done in the past. The Committee believed streamlining the scoring system will create an efficient evaluation process.

Additionally, the Committee considered the Review Committee and Public Member Nomination Forms and noted that the reference section of the form provides extraneous information since neither the CODA staff, nor the Nomination Committee members use the references in the evaluation. Following discussion, the Committee believed the reference section in the Review Committee and Public Member Nomination Forms should be removed. The Committee also believed the Nomination Form, and CODA announcements of vacant positions should reiterate CODA’s ongoing expectations that
nominees be well-rounded individuals and encourage diversity of individuals nominated, whenever possible.

**Nomination Committee Recommendation:** It is recommended that the Commission on Dental Accreditation adopt and implement immediately the proposed revision to the nomination scoring process whereby the Nomination Committee members will identify if a nominee meets the required criteria to serve, and whether the individual should be selected to fill an open position or be an alternate, with further discussion of nominees at its regular meetings.

It is further recommended that the Commission on Dental Accreditation direct staff to immediately revise and implement the Review Committee and Public Member Nomination Forms to remove the request for references, and to encourage well-rounded and diverse nominees.

Prepared by: Dr. Sherin Tookes and Ms. Marjorie Hooper
REPORT OF THE AD HOC COMMITTEE ON FACULTY TO STUDENT RATIOS IN ACCREDITATION STANDARDS

Background: At its Winter 2023 meeting, the Commission on Dental Accreditation (CODA) considered the January 16, 2023 letter from 17 state dental associations (Appendix 1), related to workforce shortages in dental assisting and dental hygiene, and requesting that the Commission:

- Immediately make the faculty to student ratio in the Dental Hygiene Accreditation Standards (Section 3-6) the same as the faculty to student ratios in the Dental Therapy Accreditation Standards (Section 3-5) and the Dental Assisting Accreditation Standards (Section 3-8). The result of this change would be that the Accreditation Standards for all three auxiliary professions would be identical with a faculty to student ratio of 1 to 6.
- Establish an ad hoc group to draft a clear rationale for setting faculty to student ratios for all CODA Accreditation Standards for which faculty to student ratios exist. This ad hoc group should, at a minimum, consider the following factors:
  - Should there be variation in the faculty to student ratios in the Accreditation Standards based upon the complexity of procedures in which students are being trained?
  - Should there be variation in the faculty to student ratios in the Accreditation Standards based upon technology used for training students?
  - At what ratio is ensuring appropriate technical instruction and evaluation compromised?
  - Are there any factors within the control of educational programs that warrant variance in the faculty to student ratios?
- Solicit robust feedback from the broader dental community on establishing rationale for setting faculty to student ratios for Accreditation Standards that include faculty to student ratios. ASCDE and other organizations will gladly assist CODA in this stakeholdering effort.
- Ensure that faculty to student ratios in CODA’s Accreditation Standards that utilize faculty to student ratios are consistent with whatever rationale is finalized by the Commission.

At its Winter 2023 meeting, the Commission discussed the letter, and the number of new programs and enrollment increases that have been requested, particularly in dental hygiene, over the past three (3) years. The Commission also discussed several additional factors that may contribute to the current workforce issues in dental assisting and dental hygiene, including facility capacity during the COVID-19 pandemic, the lack of licensure for dental assisting within many states, and other factors. Some Commission members believed it was not the Commission’s role, as an accrediting agency, to oversee workforce demands. Other Commission members believed that the ratios should be reviewed to ensure the educational quality of the program is sustained without being restrictive to educational programs. The Commission also concluded that the state dental associations should provide additional information on factors that relate to workforce shortages. Following discussion, the Commission directed that a formal letter be sent to the state dental associations requesting additional information on the request, and
that an Ad Hoc Committee be established to consider ratios within the Commission’s Accreditation Standards.

Following the Commission’s Winter 2023 meeting, the Commission contacted the 17 state dental associations and requested data from each of them related to: 1) an analysis of all factors other than faculty to student ratios that have been reviewed and addressed by each state related to workforce shortages and all related data; and 2) analysis of the impact that a change in faculty to student ratios would have on addressing shortages in dental assisting and dental hygiene workforce members in the state, and all related data (Appendix 2).

Additionally, the Commission directed the formation of the Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards. The Ad Hoc Committee met on May 10, 2023, June 21, 2023, and July 26, 2023. Members of the Ad Hoc Committee included: Ms. Lisa Mayer (chair), Dr. Amid Ismail, Dr. George Kushner, Dr. Brent Larson, Ms. Martha McCaslin (absent May 10 and July 26), Dr. Monica Nenad, Dr. Nancy Rosenthal, and Dr. Timmothy Schwartz. Dr. Sanjay Mallya (absent June 21 and July 26), chair, and Dr. Maxine Feinberg (absent July 26), vice chair, Commission on Dental Accreditation (CODA), ex-officio, attended as available. Dr. Sherin Took, senior director, and Ms. Jamie Asher Hernandez, Ms. Katie Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner (absent July 26), and Ms. Kelly Stapleton, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, CODA, also attended the meetings.

Below is the Ad Hoc Committee’s report and recommendations to the Commission following its meetings.

**Report and Recommendations of the Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards:** The Ad Hoc Committee reviewed its charge and the information collected to support the work of the Committee for each of its three (3) meetings. The Committee reviewed the communication from the 17 state dental associations (Appendix 1) and CODA’s response letter to the state associations (Appendix 2). Additionally, the Ad Hoc Committee considered the May 1, 2023 response letter from 19 state dental associations in response to the Commission’s request for additional information (Appendix 3) and a letter from the American Dental Association’s Council on Dental Education and Licensure (CDEL) dated February 16, 2023, related to the Commission’s review of this matter (Appendix 4). The Committee also reviewed excerpts of the Dental Hygiene and Dental Assisting Review Committees’ Reports to the Commission in Summer 2022, related to CODA’s initial review of a May 19, 2022 letter from the state dental associations requesting the Commission to consider revisions to the Standards (Appendix 5). The Ad Hoc Committee also considered the current Accreditation Standards for all disciplines that include a faculty to student ratio, the Frequency of Citings data collected and reported by the Commission each Summer pertaining to the number of times Accreditation Standards are cited, and Annual Survey data regarding enrollment and graduation rates for allied dental education programs.
The Ad Hoc Committee discussed the materials provided and the current workforce shortage in allied personnel within the practicing community, which precipitated the request for a change in faculty to student ratios. The Ad Hoc Committee noted that from 2019 through 2022, the Commission accredited seven (7) new dental assisting programs and 14 new dental hygiene programs. Additionally, based on an estimation of recent CODA meeting actions from Winter 2022 to Winter 2023, the Commission reviewed 35 dental hygiene reports for enrollment increase resulting in 310 approved additional enrollments, with an additional 14 reports under consideration as of Winter 2023, that could result in an additional 156 approved enrollments for a total of 466 additional dental hygiene positions available within educational programs. The Committee noted that while programs are requesting increases in enrollment, the annual survey data suggests that programs are not achieving the full capacity of student positions. The Committee discussed whether facility size limitations, the ability to hire faculty based upon factors such as salary and benefits, or other factors may affect current enrollment capacity within programs. Additionally, it was noted that a significant number of allied dental professionals left the workforce during the COVID-19 pandemic.

The Ad Hoc Committee believed the decline in workforce may be multi-factored, not simply a result of accreditation requirements for faculty to student ratios, but also academic and other requirements for faculty. In review of the Frequency of Citings data for dental hygiene, the Ad Hoc Committee noted a low number of citations related to faculty to student ratios (approximately 10% in Summer 2022), which appeared to suggest that hiring faculty may not be a concern for most programs. Alternately, it was noted that in dental assisting, it may be difficult to find faculty with required educational degrees. The Ad Hoc Committee recalled that the Commission directed a public call for comment on proposed revisions to the Dental Assisting Standards related to the faculty degree requirement during Spring 2023, for consideration at the Summer 2023 Commission meeting.

The Committee also noted the Commission’s mission to serve the public and dental professions by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. The Committee noted that historically the Commission has considered revisions to its Accreditation Standards through regular review of the Standards (validity and reliability) as well as individual requests for revision. The Commission has not previously established any policies or procedures to dictate the methodology for the standards revision process; however, many factors are taken into consideration when considering a revision to Accreditation Standards, including standards pertaining to faculty to student ratios. Proposed revisions to educational standards originate from a review by the Commission, or suggestion by an external party, with an opportunity for the broad communities of interest to review and comment on the revisions prior to potential implementation by the Commission. The Commission considers the comments received and may either adopt the proposed revisions, revise and recirculate the proposed revisions, or make no changes to the Standards. It was also noted that proposed revisions may be forwarded to the Commission from dental organizations following their own review process with input from various stakeholders, including educational programs.
The Ad Hoc Committee also noted the chronology of revisions to the Accreditation Standards for Dental Hygiene Education Programs (DH), noting faculty to student ratios have been cited within the Standards since at least the early 1980s.

In the 1989 Standards; DH Standard 7.2: “To assure development of clinical competence and to insure maximum protection of the patient, the faculty to student ratio for preclinical, clinical and radiographic sessions should not exceed one to six. Faculty to student ratios for laboratory sessions in dental science courses such as tooth morphology and dental materials should not exceed one to fifteen.”

In 2005, the Dental Hygiene Standards state: “The faculty to student ratios for preclinical, clinical and radiographic sessions should not exceed one to six, and laboratory sessions in the dental science courses should not exceed one to fifteen to ensure development of clinical competence and to ensure maximum protection of the patient.”

In July 2007 (following the 2006 Validity and Reliability Study), the Commission adopted revisions which took effect in January 2009; DH Standard 3-6: “The faculty to student ratios for preclinical, clinical and radiographic clinical and laboratory sessions must not exceed one to five. Laboratory sessions in the dental science courses must not exceed one to ten to ensure the development of clinical competence and maximum protection of the patient, faculty and students.”

In February 2015, revisions were adopted with immediate implementation, no circulation to the communities of interest; DH Standard 3-6: “The faculty to student ratios for preclinical, clinical and radiographic clinical and laboratory sessions must not be less than one to six. Faculty to student ratios for laboratory sessions in dental materials courses must not be less than one to twelve to ensure the development of clinical competence and maximum protection of the patient, faculty and students.”

In August 2015, the Commission, through its Dental Hygiene Review Committee (DH RC) considered the February 2015 revision, noting that the change received informal questions and concerns from the educational community, and, in retrospect, the proposed revision would have benefitted from circulation for public comment. The proposed revisions were circulated to the communities of interest; DH Standard 3-6: “The faculty to student ratios for preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every to six five students. Faculty to student ratios for laboratory sessions in for dental materials courses, there must not be less than one faculty for every to twelve to ten students to ensure the development of clinical competence and maximum protection of the patient, faculty and students.”
In Summer 2016, the Commission noted the vast majority of comments spoke in favor of the proposed revisions to add clarity to the standard and return to the one (1) to five (5) faculty to student ratios. The revisions were adopted with implementation July 1, 2017; DH Standard 3-6: **The faculty to student ratios for in preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every to six five students. Faculty to student ratios for laboratory sessions in for dental materials courses, there must not be less than one faculty for every to twelve to ten students to ensure the development of clinical competence and maximum protection of the patient, faculty and students.**

In Winter 2021, the time of the last comprehensive review of Dental Hygiene Standards, there was no revision to the requirement, only a revision to the layout of the Standard, effective July 1, 2022; DH Standard 3-5: **The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public.**

1. In preclinical and clinical sessions, the ratio must not exceed one (1) faculty to five (5) students.
2. In radiography laboratory sessions, the ratio must not exceed one (1) faculty to five (5) students.
3. In other dental sciences laboratory sessions, the ratio must not exceed one (1) faculty to 10 students.”

Following lengthy discussion, the Ad Hoc Committee believed additional information was warranted through a survey to gather information on CODA-accredited programs’ perceptions of the requirements for faculty to student ratios and the potential impact on educational programs. The Ad Hoc Committee sought to obtain information on the potential impact on quality of dental education, if any, should faculty to student ratios be revised. The Ad Hoc Committee noted that the state dental associations previously provided information to the Commission, with a focus related to workforce shortages, and the state associations were provided an opportunity to respond to the Commission with additional requested information (Appendix 3). Considering the information received, the Ad Hoc Committee determined that the CODA survey would focus on the impact to CODA-accredited educational programs that would be affected by, and have the best understanding of, the impact to the educational program should the Commission implement changes to the Accreditation Standards related to faculty to student ratios.

The Ad Hoc Committee developed and distributed the Survey of Allied Dental Education Programs Related to Faculty to Student Ratios (Appendix 6). On June 30, 2023, an announcement was sent to all CODA-accredited dental assisting, dental hygiene, dental laboratory technology, and dental therapy programs informing program directors of the survey, which would be sent to these individuals on Wednesday, July 5, 2023, with a response deadline of Friday, July 21, 2023. Respondent data was embedded to link the respondent to the correct discipline that they administer; additionally, for directors who administer dental assisting and dental hygiene programs, the survey allowed separate responses for each program.
Survey response data is found in Appendix 7 (all programs), Appendix 8 (Question 4, by program type), Appendix 9 (dental hygiene), Appendix 10 (dental assisting), and Appendix 11 (dental laboratory technology). To protect the confidentiality of respondents, program-specific data from dental therapy education program directors was not independently reported; however, dental therapy data was included in Appendix 7 and Appendix 8 for all respondent programs.

Summary and Analysis of Ratio Survey Data: The Ad Hoc Committee noted that the survey was distributed to a total of 582 allied dental education programs, with responses from 431 programs, resulting in a response engagement rate of 74%. Partial and unfinished surveys were not included in the data.

- 71% \((N=302)\) of all responding programs reported current ability to hire and retain a sufficient number of qualified faculty.
  - Of the 121 respondents who indicated inability to hire and retain a sufficient number of qualified faculty, 70% \((N=85)\) did not believe an adjustment to the faculty to student ratio would assist the program in hiring and retaining a sufficient number of qualified faculty.

Further Analysis:
A majority of Dental Hygiene and Dental Assisting programs indicated current ability to hire and retain a sufficient number of qualified faculty; however, a majority of dental laboratory technology programs indicated an inability to hire and retain a sufficient number of qualified faculty.

- Almost half of all responding programs \((48%; N=206)\) indicated an interest in increasing enrollment in the next one (1) to two (2) years.

Further Analysis:
A majority of Dental Assisting and Dental Laboratory Technology programs indicated an interest in increasing enrollment in the next one (1) to two (2) years. A slight majority \((54\%)\) of Dental Hygiene programs indicated no interest in increasing enrollment in the next one (1) to two (2) years.

- The top three \((3)\) factors that currently **negatively** affect all programs’ enrollment are: (1) capacity of the program’s facility, \(N=138\); (2) ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA standards, \(N=132\); and (3) student attrition, \(N=124\).

Further Analysis:
**Dental Hygiene:** 1) capacity of the program’s facility; 2) ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA standards; 3) cost of education to students.

**Dental Assisting:** 1) student interest in the program; 2) student attrition; 3) ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA standards.
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Dental Laboratory Technology: 1) program funding; 2) capacity of the program facility; ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA standards; and student interest in the program (tied).

- The top three (3) factors that currently **positively** affect all programs’ enrollment are: (1) student interest in the program, N=247; (2) program funding, N=156; and (3) ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA standards, N=139.

**Further Analysis:**

Dental Hygiene: 1) student interest in the program; 2) program funding; 3) capacity of the program’s facility.

Dental Assisting: 1) capacity of the program’s facility; 2) student interest in the program; 3) program funding.

Dental Laboratory Technology: 1) student attrition and student enrollment (tied)

- Of the 420 respondents who indicated how likely or unlikely an increase in faculty to student ratios would impact their program:
  - 259 (62%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **unlikely** to enhance the student learning experience;
  - 215 (51%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **unlikely** to support the quality of patient care;
  - 208 (50%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **unlikely** to support faculty recruitment and retention;
  - 179 (43%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **likely** to help the program address the local workforce shortage, while 152 (36%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **unlikely** to help the program address the local workforce shortage; and
  - 160 (38%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **unlikely** to align with the current capacity of the program’s facility, while 154 (37%) indicated an increase in faculty to student ratios (more students per faculty) would be somewhat or extremely **likely** to align with the current capacity of the program’s facility.

**Further Analysis:**

Dental Hygiene: For each category noted above, the majority of respondents indicated “**somewhat or extremely unlikely.**”

Dental Assisting: The majority of respondents indicated “**somewhat or extremely unlikely**” for enhancement of student learning, while the other categories were “**somewhat or extremely likely,**” or “**neither likely nor unlikely.**”
Dental Laboratory Technology: The majority of respondents indicated “somewhat or extremely unlikely” for enhancement of student learning and support for faculty recruitment and retention, while the other categories were “somewhat or extremely likely,” or “neither likely nor unlikely.”

- 268 of 422 respondents (64%) indicated that the Accreditation Standards are appropriate as written related to the faculty to student ratios; 84 respondents (20%) indicated the ratio should be revised to permit less students per faculty, while 62 respondents (15%) indicated the ratio should be revised to permit more students per faculty.

Further Analysis:

Dental Hygiene and Dental Assisting: An overwhelming majority of Dental Hygiene (N=167; 65%) and Dental Assisting (N=96, 61%) programs that responded indicated the Standards are appropriate as written.

Dental Laboratory Technology: Three (3) of the six (6) respondent Dental Laboratory Technology programs indicated that the ratios should be revised to permit more students per faculty, while two (2) programs indicated the Standards are appropriate and written and one (1) program had no opinion.

The Ad Hoc Committee also noted that, although not requested, the Commission office received unsolicited comments from 10 allied dental education program directors. All comments expressed concern with an increase in the faculty to student ratios for dental hygiene, citing facility limitations, decreased quality of student educational experiences, decreased patient care, and a potential negative effect on faculty retention rates, among the concerns of dental hygiene programs. Additionally, several programs noted concern related to the Dental Hygiene Standard requiring clinical faculty to hold a baccalaureate degree. To protect the confidentiality of the programs, the Ad Hoc Committee determined that the comments will not be distributed publicly.

Ad Hoc Committee Conclusions and Recommendations: At its final meeting, the Ad Hoc Committee considered all previously reviewed materials as well as the survey data results and communications submitted to the Commission office. The Committee engaged in a discussion related to the data, which indicated very little support for a revision of the allied Standards related to faculty to student ratios. The Ad Hoc Committee also noted that a revision of faculty to student ratios would be “somewhat or extremely unlikely” to enhance the student learning experience for all program disciplines affected. For dental hygiene, a change in ratio would also be “somewhat or extremely unlikely” to support the quality of patient care, support faculty recruitment and retention, or align with the current capacity of the programs’ facilities, according to the recent CODA study.

The Ad Hoc Committee believed there could be other solutions to the workforce shortage rather than making a change to faculty to student ratios, which could affect the quality of dental education. The Committee noted several options for programs such as: 1) requesting an increase in student enrollment, 2) expansion of existing facilities on campus to support enrollment increases, and 3) expansion to off-campus major educational activity sites with additional student
enrollment increases, for example. The Ad Hoc Committee noted that nearly half of all respondent programs indicated considering an increase in enrollment in the next one (1) to two (2) years. The Committee also noted the establishment of several new dental hygiene and dental assisting programs, as noted elsewhere in this report. The Ad Hoc Committee discussed whether state dental associations, or others, could work with CODA-accredited allied dental education programs to assist programs with resources for enrollment increases as another method by which the workforce shortages could be addressed while maintaining quality dental education.

Following consideration, the Ad Hoc Committee concluded that the Commission should not make immediate changes to the faculty to student ratios in the Accreditation Standards for allied dental education programs. The data provided by educational programs does not support a revision to the Standards at this time. However, the Ad Hoc Committee believed its report should be forwarded to each allied dental education Review Committee for further consideration, including determination if revisions of Accreditation Standards are warranted.

The Ad Hoc Committee also concluded that the Commission does not need to develop a policy or process for rationale that must be followed when revising Accreditation Standards related to faculty to student ratios. The Ad Hoc Committee noted that several factors are already considered by Review Committees and the Commission when revising Accreditation Standards, including but not limited to the specific requirements of training in the discipline, emerging technology, and expected educational outcomes for graduates. Each Review Committee, which includes individuals within the discipline of dentistry as well as practitioners, educators, general dentists, and public members consider and propose revisions to the educational Standards, which are then circulated to the broad communities of interest for comment. The feedback from the various communities of interest is subsequently considered by the Commission after which the nationally accepted Standards are adopted and implemented. All educational programs accredited by CODA are held to the nationally accepted Accreditation Standards for the discipline. Again, taking into consideration the request of the state dental associations, the Ad Hoc Committee believed its report should be forwarded to each allied dental education Review Committee for further consideration and review, including determination if revisions of Accreditation Standards are warranted.

Related to the state dental associations’ request to solicit feedback through stakeholder efforts, the Ad Hoc Committee noted that the Commission considered the initial request of the state dental associations as well as the supplemental information requested by CODA, following its Winter 2023 consideration of this issue. Additionally, through the work of the Ad Hoc Committee, a national study was disseminated to all program directors of CODA-accredited allied dental education programs, which resulted in a response engagement rate of 74%. The Committee believed that sufficient information was gathered from the stakeholders related to this topic to formulate the conclusions and recommendations submitted in this report to the Commission. Nonetheless, the Ad Hoc Committee encourages the Commission to forward to each allied dental education Review Committee the report of this Committee for further
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consideration and review, including determination if revisions of Accreditation Standards are warranted.

Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards

Recommendations: It is recommended that the Commission on Dental Accreditation direct there be no development of a policy or process for rationale that must be followed when revising Accreditation Standards related to faculty to student ratios.

It is further recommended that the Commission on Dental Accreditation direct the Report of the Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards be provided to the Review Committees that oversee dental assisting, dental hygiene, dental laboratory technology, and dental therapy education for further consideration and review, including determination if revisions of Accreditation Standards are warranted, with a report to the Commission in Winter 2024.

It is further recommended that the Commission on Dental Accreditation send a copy of the Report of the Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards to the state dental associations.

Commission Action:

Prepared by: Dr. Sherin Tooks
January 16, 2023

Dr. Sanjay Mallya, Chair
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Sent via email only

Dear Dr. Mallya,

Prior to its August 2022 meeting, the Review Committee on Dental Hygiene Education to the Commission on Dental Accreditation (Hygiene Committee) and the Review Committee on Dental Assisting Education to the Commission on Dental Accreditation (Assisting Committee) received and reviewed two letters from several state dental associations. The letters recommended that the Commission on Dental Accreditation (CODA) modify Sections 3-4 and 3-8 in the Accreditation Standards for Dental Assisting Education Programs and Sections 3-6 and 3-7 in the Accreditation Standards for Dental Hygiene Education Programs.

In summary, these letters asked CODA to reconsider the faculty to student ratios and the explicit requirement for a baccalaureate degree for certain program faculty as opposed to more exact qualifications in both Accreditation Standards. Ultimately, both committees decided to take no action on the recommendations presented and these decisions were approved by CODA on consent without discussion.

CODA did make brief written commentary about the discussions of the respective committees available electronically as the committee meetings are not open to the public. The following excerpts are pulled from the committees’ reports to CODA.

From the “Report of the DA RC, Page 300, Subpage 4, CODA Summer 2022”:

Related to the requested revisions to faculty to student ratios (Standard 3-8), the DA RC noted that teaching ratios have a long-standing history within the CODA Accreditation Standards for allied dental education programs. The ratios are in place to ensure appropriate instruction and supervision of students as a critical component to the quality of education and skill development, as well as to ensure protection of the student.

From the “Report of the DH RC, Page 400, Subpages 4-5, CODA Summer 2022”:

Related to the requested revisions to faculty to student ratios (Standard 3-5), the DH RC noted that teaching ratios have a long-standing history within the CODA Accreditation Standards for allied dental education programs. The ratios are in place to ensure appropriate instruction and supervision of students as a critical component to the quality of education and skill development, as well as to ensure protection of the student and patient. Further, several disciplines within CODA’s
purview have standards related to teaching ratios, including advanced dental education programs in oral and maxillofacial surgery and orthodontics and dentofacial orthopedics. Following discussion, the DH RC believed there should be no change to the Standards related to faculty to student ratios.

On November 30, 2022, CODA chair Dr. Sanjay Mallya, CODA vice chair Dr. Maxine Feinberg, and CODA director Dr. Sherin Tooks met virtually with the American Society of Constituent Dental Executives (ASCDE) to discuss CODA’s work and to answer questions posed by ASCDE members. ASCDE appreciated CODA leadership participating in the virtual meeting and providing useful background material.

During the November 30 meeting, there was significant discussion surrounding CODA’s methodology or rationale for specifically setting the faculty to student ratios used in its various Accreditation Standards. This was of particular interest since some ASCDE members, in researching faculty to student ratios in various accreditation standards, have found that CODA is the only health care profession accrediting body that utilizes explicit faculty to student ratios.

CODA leadership was unable to articulate any specific methodology or rationale for determining the faculty to student ratios for dental therapy (1 to 6), dental hygiene (1 to 5), or dental assisting (1 to 6) other than their “long-standing history” in the Accreditation Standards. When specifically asked what rationale can executive directors share with questioning members on why dental therapy (with a scope that includes surgical, irreversible procedures) has a higher ratio than dental hygiene, Dr. Tooks responded that there is no rationale that can be shared.

The totality of written and verbal comments provided by CODA to the state dental associations in 2022 on faculty to student ratios indicate that CODA has no consistent methodology or oversight for establishing faculty to student ratios. It is clear that CODA believes that faculty to student ratios are necessary, but there is no apparent criteria for why 1 to 5 or 1 to 6 is appropriate for dental auxiliary education and a ratio of 1 to 4, 1 to 7, or some other ratio is inappropriate. Furthermore, CODA cannot articulate what facets of dental hygiene education necessitate a lower faculty to student ratio than dental therapy or dental assisting.

The undersigned states are writing to request CODA take the following actions:

- Immediately make the faculty to student ratio in the Dental Hygiene Accreditation Standards (Section 3-6) the same as the faculty to student ratios in the Dental Therapy Accreditation Standards (Section 3-5) and the Dental Assisting Accreditation Standards (Section 3-8). The result of this change would be that the Accreditation Standards for all three auxiliary professions would be identical with a faculty to student ratio of 1 to 6.
- Establish an ad hoc group to draft a clear rationale for setting faculty to student ratios for all CODA Accreditation Standards for which faculty to student ratios exist. This ad hoc group should, at a minimum, consider the following factors:
Should there be variation in the faculty to student ratios in the Accreditation Standards based upon the complexity of procedures in which students are being trained?

Should there be variation in the faculty to student ratios in the Accreditation Standards based upon technology used for training students?

At what ratio is ensuring appropriate technical instruction and evaluation compromised?

Are there any factors within the control of educational programs that warrant variance in the faculty to student ratios?

- Solicit robust feedback from the broader dental community on establishing rationale for setting faculty to student ratios for Accreditation Standards that include faculty to student ratios. ASCDE and other organizations will gladly assist CODA in this stakeholdering effort.
- Ensure that faculty to student ratios in CODA’s Accreditation Standards that utilize faculty to student ratios are consistent with whatever rationale is finalized by the Commission.

Community and technical colleges across the country cite dental hygiene and dental assisting education programs as amongst the most expensive programs to operate. A major driver of the costs of these programs is the costs of faculty, especially when Accreditation Standards require a low faculty to student ratio like 1 to 5. Without clear rationale for why these exact ratios are required beyond “long-standing history”, many are left wondering whether patients and public are best served by CODA Accreditation Standards or should alternatives be considered?

Our nation is facing a severe shortage of dental hygienists and assistants; this shortage has been exacerbated by the COVID-19 pandemic. Currently, 95% of dentists seeking to hire a hygienist and 87% of dentists seeking to hire an assistant find the hiring process to be extremely or very challenging. A 2020 study by the American Dental Hygienists’ Association (ADHA) found that the pandemic resulted in a voluntary contraction of the U.S. dental hygiene workforce by an estimated 3.75%, or approximately 7,500 dental hygienists. Furthermore, an October 2022 study by the American Dental Association (ADA), ADHA, and the Dental Assisting National Board found one-third of the hygienists and assistant workforce indicated they expect to retire in five years or less. The severe shortage of hygienists and assistants is having a negative impact on access to care, with patients having to wait months to receive preventive dental care in both private practice and public health settings. This shortage and the need to make impactful, timely changes cannot be overstated.

Across the country, we are taking a multifaceted approach to increase the dental hygiene and assisting workforce. Our aforementioned recommendations are an important complement to our current strategy. While we believe our request will not, by itself, eliminate the current workforce shortages, we do believe these changes will be a catalyst in expanding workforce in alignment with CODA’s articulated Mission, Vision, and Values of collegiality, consistency, integrity, quality, and transparency.

Thank you for your consideration.
Respectfully,

Alaska Dental Society  
California Dental Association  
Colorado Dental Association  
Connecticut State Dental Association  
Idaho State Dental Association  
Illinois State Dental Society  
Minnesota Dental Association  
Missouri Dental Association  
Montana Dental Association  
New Mexico Dental Association  
North Dakota Dental Association  
Oregon Dental Association  
Rhode Island Dental Association  
Tennessee Dental Association  
Virginia Dental Association  
Washington State Dental Association  
Wisconsin Dental Association

c: Dr. Sherin Tooks, director, Commission on Dental Accreditation  
ADA Council on Dental Practice  
ADA Council on Dental Education and Licensure  
Dr. George R. Shepley, president, American Dental Association  
Dr. Raymond A. Cohlmia, executive director, American Dental Association  
American Society of Constituent Dental Executives

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https://www.adha.org/prd_docs/Feb-2021_JDH_EmployPatterns_DH_COVID.pdf

https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/dental_workforce_shortages_labor_market.pdf?rev=6025d77df184e6c95dc7c6d4a5e3&hash=225FCBBCCB67174AAFC760FE2287322D
Via Electronic Mail

March 20, 2023

**State Dental Associations:** Alaska, California, Colorado, Connecticut, Idaho, Minnesota, Missouri, Montana, New Mexico, North Dakota, Oregon, Rhode Island, Tennessee, Virginia, Washington State, Wisconsin

State Dental Associations:

The Commission on Dental Accreditation (CODA), at its February 10, 2023 meeting, considered the letter submitted by Mr. Bracken Killpack, Executive Director, Washington State Dental Association on behalf of the State Dental Associations of Alaska, California, Colorado, Connecticut, Idaho, Minnesota, Montana, New Mexico, North Dakota, Oregon, Rhode Island, Tennessee, Virginia, Washington State, Wisconsin.

The Commission reviewed the request of the 17 state dental associations asking the Commission to modify its Accreditation Standards for allied dental education programs to address workforce shortages in dental assisting and dental hygiene. Specifically, the state dental associations requested that the Commission:

- **Immediately make the faculty to student ratio in the Dental Hygiene Accreditation Standards (Section 3-6) the same as the faculty to student ratios in the Dental Therapy Accreditation Standards (Section 3-5) and the Dental Assisting Accreditation Standards (Section 3-8).** The result of this change would be that the Accreditation Standards for all three auxiliary professions would be identical with a faculty to student ratio of 1 to 6.
- **Establish an ad hoc group to draft a clear rationale for setting faculty to student ratios for all CODA Accreditation Standards for which faculty to student ratios exist.** This ad hoc group should, at a minimum, consider the following factors:
  - Should there be variation in the faculty to student ratios in the Accreditation Standards based upon the complexity of procedures in which students are being trained?
  - Should there be variation in the faculty to student ratios in the Accreditation Standards based upon technology used for training students?
  - At what ratio is ensuring appropriate technical instruction and evaluation compromised?
  - Are there any factors within the control of educational programs that warrant variance in the faculty to student ratios?
- **Solicit robust feedback from the broader dental community on establishing rationale for setting faculty to student ratios for Accreditation Standards that include faculty to student...**
ratios. ASCDE and other organizations will gladly assist CODA in this stakeholdering effort.

- Ensure that faculty to student ratios in CODA’s Accreditation Standards that utilize faculty to student ratios are consistent with whatever rationale is finalized by the Commission.

Following consideration and discussion of this matter, the Commission directed a communication to the State Dental Associations requesting information for the Commission’s further consideration. **Specifically, the Commission requests data from each of the 17 State Dental Associations related to: 1) an analysis of all factors other than faculty to student ratios that have been reviewed and addressed by each state related to workforce shortages and all related data; and 2) analysis of the impact that a change in faculty to student ratios would have on addressing shortages in dental assisting and dental hygiene workforce members in the state, and all related data. Please provide this information in one (1) comprehensive report, separated by state, no later than May 1, 2023, and submit the information to my office through email at tookss@ada.org.**

Additionally, the Commission directed an Ad Hoc Committee be appointed to further review faculty to student ratios within the Accreditation Standards, with a report to the Commission upon completion of the Committees work.

If I can be of assistance to you or members of your staff, please contact me at 312-440-2940 or by email, at tookss@ada.org.

Sincerely,

Sherin Tooks, Ed.D., M.S.
Senior Director
Commission on Dental Accreditation

cc: Dr. Sanjay M. Mallya, chair, Commission on Dental Accreditation (CODA)
    Dr. Maxine Feinberg, vice chair, CODA
    Alaska – Alaska Dental Society
        President - Dr. Courtney Schwartz - courtneyschwartz2021@gmail.com
        Executive Director – Dr. David Logan - dlogan@akdental.org
    California – California Dental Association
        President – Dr. John Blake - jblake@cdhc.org
        Executive Director – Mr. Peter A. DuBois - peter.dubois@cda.org
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Colorado – Colorado Dental Association
   President – Dr. Lindsay Compton - lindsay.compton.dds@gmail.com
   Interim Executive Director – Ms. Molly Pereira - molly@cdaonline.org

Connecticut – Connecticut State Dental Association
   President – Dr. Bethaney Brenner - president@csda.com
   Executive Director – Ms. Kathlene Gerrity - kgerrity@csda.com

Idaho – Idaho State Dental Association
   President – Dr. Kim Keller - kkbeller65@gmail.com
   Executive Director – Mr. Mike Mitchell - director@theisda.org

Minnesota – Minnesota Dental Association
   President – Dr. Tim Holland - timholland@hollandfamilydental.com
   Executive Director – Mr. Carmelo Cinqueonce - info@mndental.org

Missouri – Missouri Dental Association
   President – Dr. Jeremy Bowen - jbcmb03@sbcglobal.net
   Executive Director – Ms. Vicki Wilbers - vicki@modentalmail.org

Montana – Montana Dental Association
   President – Dr. Ronald Davis - gpddson@gmail.com
   Executive Director – Mr. Webb Brown - webb@montanadental.org

New Mexico – New Mexico Dental Association
   President – Dr. Kelley Ryals – belle2222@aol.com
   Executive Director – Dr. Tom Schripsema - tschrip@nmdental.org

North Dakota – North Dakota Dental Association
   President – Dr. Carrie Orn - carrieorn@yahoo.com
   Executive Director – Mr. William R. Sherwin - wsherwin@smilenorthdakota.org

Oregon – Oregon Dental Association
   President – Dr. Mark Miller - rhinodmd@gmail.com
   Executive Direct – Dr. Barry Taylor - btaylor@oregondental.org

Rhode Island – Rhode Island Dental Association
   President – Dr. Gregory Stepka - gregstepka@gmail.com
   Executive Director – Ms. Christy Durant - cdurant@ridental.org

Tennessee – Tennessee Dental Association
   President – Dr. Mitch Baldree - mitch@baldreedd.com
   Executive Director – Ms. Andrea Hayes - andrea@tnentalassociation.org

Virginia – Virginia Dental Association
   President – Dr. Cynthia Southern - docsouthern50@gmail.com
   CEO – Mr. Ryan L. Dunn - dunn@vadental.org

Washington State – Washington State Dental Association
   President – Dr. John L. Gibbons - jkagib@comcast.net
   Executive Director – Mr. Bracken R. Killpack - bracken@wsda.org

Wisconsin – Wisconsin Dental Association
President – Dr. Chris Johnson - ejohnson@wda.org
Executive Director – Mr. Mark Paget - mpaget@wda.org
May 1, 2023

Dr. Sherin Tooks, Senior Director
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Sent via email only

Dear Dr. Tooks,

The following letter is the formal response from 19 state dental associations (two additional associations have signed on since our January 16, 2023 letter was submitted) to your letter dated March 20, 2023.

The undersigned states applaud CODA’s decision to form an Ad Hoc Committee to further review faculty to student ratios within the Accreditation Standards. We would appreciate further clarity on the scope of work of this Ad Hoc Committee and, more specifically, whether the following points from our January 16, 2023 letter have been included in this scope:

- Establish an ad hoc group to draft a clear rationale for setting faculty to student ratios for all CODA Accreditation Standards for which faculty to student ratios exist. This ad hoc group should, at a minimum, consider the following factors:
  - Should there be variation in the faculty to student ratios in the Accreditation Standards based upon the complexity of procedures in which students are being trained?
  - Should there be variation in the faculty to student ratios in the Accreditation Standards based upon technology used for training students?
  - At what ratio is ensuring appropriate technical instruction and evaluation compromised?
  - Are there any factors within the control of educational programs that warrant variance in the faculty to student ratios?
- Solicit robust feedback from the broader dental community on establishing rationale for setting faculty to student ratios for Accreditation Standards that include faculty to student ratios. ASCDE and other organizations will gladly assist CODA in this stakeholdering effort.
- Ensure that faculty to student ratios in CODA’s Accreditation Standards that utilize faculty to student ratios are consistent with whatever rationale is finalized by the Commission.

Furthermore, we also request information on the composition of the Ad Hoc Committee and the extent to which the work, deliberation, and development of a report will be transparent to stakeholders.

During its discussion of our January 16, 2023 letter, the Commission requested the following:
Specifically, the Commission requests data from each of the 17 State Dental Associations related to: 1) an analysis of all factors other than faculty to student ratios that have been reviewed and addressed by each state related to workforce shortages and all related data; and 2) analysis of the impact that a change in faculty to student ratios would have on addressing shortages in dental assisting and dental hygiene workforce members in the state, and all related data. Please provide this information in one (1) comprehensive report, separated by state, no later than May 1, 2023, and submit the information to my office through email at tookss@ada.org.

Leadership from the undersigned state dental associations met to discuss the Commission’s request and sincerely questions the relevance of this extensive request for select, state-by-state workforce data for several reasons:

- First, statements from Commission members during its Winter 2023 meeting and from you during the Winter 2023 meeting and in previous statements indicate that the Commission does not believe it has a role in or obligation to address workforce shortages. How does requesting extensive workforce data from state dental associations petitioning the commission to modify Accreditation Standards comport with the Commission’s position that said data is not germane to its work? The undersigned states respectfully request an explanation as to how this data request furthers the work of the Ad Hoc Committee or the Commission more broadly.

- Second, assuming that the Commission does articulate how and why such a data request is germane to its work, why is the request for data limited exclusively to states that signed the January 16, 2023 letter? What rationale can the Commission provide for limiting its interest in data to this arbitrary data set and not national data?

- Third, with the request articulated in the March 20, 2023 letter, the Commission has established a behavior of requesting extensive data without clearly defined rationale. This behavior is having a chilling effect on the ability of the undersigned state dental associations to collect the requested data from allied health programs that follow CODA’s Accreditation Standards as it potentially portends that even more extensive data may be requested by the Commission without a clear rationale. Because of this chilling effect, the undersigned state dental associations will keep information shared in this response high level and anonymous.

Without further clarification from the Commission, the undersigned state dental associations will limit our response to the Commission to this letter.

1) an analysis of all factors other than faculty to student ratios that have been reviewed and addressed by each state related to workforce shortages and all related data

Our nation is facing a severe shortage of dental hygienists and assistants; this shortage has been exacerbated by the COVID-19 pandemic. Currently, 95% of dentists seeking to hire a hygienist and 87% of dentists seeking to hire an assistant find the hiring process to be extremely or very challenging. A 2020 study by the
American Dental Hygienists’ Association (ADHA) found that the pandemic resulted in a voluntary contraction of the U.S. dental hygiene workforce by an estimated 3.75%, or approximately 7,500 dental hygienists\(^{\text{iii}}\) which is approximately equal to the number of dental hygiene graduates in one calendar between 2014-2019\(^{\text{iv}}\). Furthermore, an October 2022 study by the American Dental Association (ADA), ADHA, and the Dental Assisting National Board found one-third of the hygienists and assistant workforce indicated they expect to retire in five years or less\(^{\text{v}}\). The severe shortage of hygienists and assistants is having a negative impact on access to care, with patients having to wait months to receive preventive dental care in both private practice and public health settings.

Looking forward into the next decade, data show that the dental allied health shortage will get worse without drastic action. According to U.S. Bureau of Labor Statistics (BLS), the number of dental hygiene and dental assisting jobs will grow faster than average between 2021-2031 (9\(^{\text{vi}}\) and 8\(^{\text{vii}}\) respectively) compared to dentist that will grow as fast as average (6\(^{\text{viii}}\)). The following table shows the BLS data for the number of annual job openings for each profession compared to the number of 2019 graduates from accredited programs according to the American Dental Education Association (ADEA).

<table>
<thead>
<tr>
<th>Profession</th>
<th>BLS Annual Job Openings (2021-2031)</th>
<th>Number of Graduates from Accredited Programs (2019)</th>
<th>Percentage of Annual Graduates from Accredited Programs to Annual Openings(^{\text{ix}})</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Dentistry*</td>
<td>5,100(^{\text{x}})</td>
<td>6,350(^{\text{xi}})</td>
<td>125.0%</td>
</tr>
<tr>
<td>Dental Hygiene</td>
<td>16,300(^{\text{xii}})</td>
<td>7,311(^{\text{xiii}})</td>
<td>44.9%</td>
</tr>
<tr>
<td>Dental Assisting</td>
<td>56,400(^{\text{xiv}})</td>
<td>4,688(^{\text{xv}})</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

*The BLS data are unclear on whether dental specialties are included in its “dentistry” dataset. For the purpose of this analysis, we assume that all annual job openings are for general dentistry.

Across the country, each of the undersigned states is taking action to increase the dental hygiene and dental assistant workforces. Collectively, these approaches include the following broad components, though not every approach is being considered in every state:

- Advocating for state, federal, and private funding to expand training capacity at existing dental hygiene and assisting programs.
- Advocating for state, federal, and private funding to create new dental hygiene and assisting programs.
- Developing public information campaigns, with an emphasis on historically underrepresented groups, to increase awareness about career opportunities in dental assisting and dental hygiene.
- Advocating for adjustments in scope of practice for allied health professions to facilitate career laddering and long-term workforce retention. Examples of this work include establishing expanded function dental assistants.
Advocating for adjustments in state credentialing and laws that simplify or reduce barriers to becoming a dental hygienist or assistant.

Developing training materials that aid dental offices in on-the-job training for dental assistants, where permitted by law.

Advocating increased licensure or credential reciprocity for dental assistants and dental hygienists that move to another state or jurisdiction.

Advocating for the establishment of the Dentist and Dental Hygienist Compact.

Supporting dental offices in providing employee benefits that aid in recruitment and retention of dental hygienists and assistants.

2) **analysis of the impact that a change in faculty to student ratios would have on addressing shortages in dental assisting and dental hygiene workforce members in the state, and all related data.**

Community and technical colleges across the country cite dental hygiene and dental assisting education programs as amongst their most expensive programs to operate. A major driver of the costs of these programs is the costs of faculty, especially when Accreditation Standards require a low faculty to student ratio like 1 to 5 for dental hygiene. Adjusting the dental hygiene ratio to match the ratio of dental assisting would create a theoretical 20% increase in the national training capacity of dental hygienists without requiring the employment of additional faculty.

In preparing this response to the Commission’s information request, it has come to our attention that at some point after 2004 the faculty to student ratio for dental hygiene was adjusted from 1 to 6 to 1 to 5. Although we are not sure of the exact time or rationale for this adjustment, we do know that multiple dental hygiene education facilities were designed in configurations that are multiples of 6 instead of multiples of 5. These configurations would allow these programs to add chair capacity within their existing floorplans.

Fundamentally, we believe that dental hygiene and dental assisting programs should have increased flexibility in determining the appropriate size of their programs, which is consistent with the Accreditation Standards for undergraduate dental education. In our conversations with several dental assisting programs that have opted to continue operations without accreditation we believe increased flexibility is a driving factor for this decision.

While we believe that adjusting or eliminating faculty to student ratios in dental allied health education will not, by itself, eliminate the current workforce shortages, we do believe these changes will be a catalyst in expanding workforce in alignment with CODA’s articulated Mission, Vision, and Values of collegiality, consistency, integrity, quality, and transparency.

**Additional Request for Information**

The undersigned state dental associations request additional information from the Commission as it relates to the Dental Hygiene Accreditation Standards Section 3-6. At what date was the faculty to student ratio in Section 3-6 adjusted from 1 to 6 to 1 to 5? In addition, what rationale was provided at the time that this adjustment was made?
made and what public comments were submitted in support and in opposition to the adjustment? We respectfully request that all material related to this request be shared with the undersigned states as well as the newly created Ad Hoc Committee.

Thank you for your consideration.

Respectfully,

Alaska Dental Society
California Dental Association
Colorado Dental Association
Connecticut State Dental Association
Idaho State Dental Association
Illinois State Dental Society
Minnesota Dental Association
Missouri Dental Association
Montana Dental Association
Nebraska Dental Association
New Jersey Dental Association
New Mexico Dental Association
North Dakota Dental Association
Oregon Dental Association
Rhode Island Dental Association
Tennessee Dental Association
Virginia Dental Association
Washington State Dental Association
Wisconsin Dental Association

c: Commission on Dental Accreditation
   ADA Council on Dental Practice
   ADA Council on Dental Education and Licensure
   Dr. George R. Shepley, president, American Dental Association
   Dr. Raymond A. Cohlmia, executive director, American Dental Association
   American Society of Constituent Dental Executives

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The percentage of annual graduates from accredited programs to annual openings was calculated by dividing the number of graduates from accredited programs by BLS annual job openings.
February 16, 2023

Dr. Sanjay Mallya, Chair
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Dear Dr. Mallya,

The ADA Council on Dental Education and Licensure has subject matter responsibility on behalf of the Association for matters related to the accreditation of dental, advanced dental and allied dental education programs. At its January 26-27, 2023 meeting, the Council reviewed the correspondence dated January 16, 2023 to the Commission on Dental Accreditation from seventeen state dental associations requesting consideration of the appropriateness of faculty-to-student ratios cited in Accreditation Standards.

The Council also recognizes the current workforce challenges facing the profession and educational institutions and supports the letter requesting CODA to re-evaluate and re-examine the current faculty-to-student ratios applied in the accreditation standards, including an assessment, rationale, and data to support specific ratios.

It is my understanding that the Commission had a thoughtful discussion about the letter from the state dental associations at its February 10, 2023 meeting and directed that an ad hoc committee be appointed to consider the suitability of faculty-to-student ratios in accreditation standards. Thank you for your consideration of this important matter.

Sincerely,

James Nickman, DDS, MS
Chair, Council on Dental Education and Licensure

JN:ms/tb

Cc: Alaska Dental Society
    California Dental Association
    Colorado Dental Association
    Connecticut State Dental Association
    Idaho State Dental Association
    Illinois State Dental Society
    Minnesota Dental Association
    Missouri Dental Association
    Montana Dental Association
    New Mexico Dental Association
    North Dakota Dental Association
    Oregon Dental Association
Rhode Island Dental Association
Tennessee Dental Association
Virginia Dental Association
Washington State Dental Association
Wisconsin Dental Association

Dr. Susan Kass, Chair, CODA Review Committee on Dental Hygiene Education
Dr. Sherin Tooks, Senior Director, Commission on Dental Accreditation
Dr. Hana Alberti, Senior Director, Council on Dental Practice
Dr. Najia Usman, Vice-chair, Council on Dental Education and Licensure
Dr. Meaghan Strotman, Director, Council on Dental Education Licensure
Dr. George R. Shepley, President, American Dental Association
Dr. Raymond A. Cohlmia, Executive Director, American Dental Association
EXCEPNTS OF DENTAL HYGIENE AND DENTAL ASSISTING REVIEW COMMITTEES REPORTS TO CODA (SUMMER 2022)

Excerpt Dental Hygiene Review Committee Report to CODA (Summer 2022)

Consideration of Proposed Revisions to Accreditation Standards for Dental Hygiene Education Programs (p. 403): At its Winter 2022 meeting, the Review Committee on Dental Hygiene Education (DH RC) and Commission on Dental Accreditation (CODA) reviewed the November 12, 2021 letter from Ms. Margaret Lemaster, dental hygiene program director, requesting that the Commission consider proposed revisions to Standards 2-14 and 3-7 of the Accreditation Standards for Dental Hygiene Education Programs. The proposed revision to Dental Hygiene Standard 3-7 (Standard 3-6 of the Accreditation Standards implemented July 1, 2022) suggested that the Commission require all full-time faculty to possess a master’s degree or be in the process of obtaining a master’s degree. Currently, Standard 3-6 requires that “Full-time and part-time faculty of a dental hygiene program must possess a baccalaureate or higher degree. All part-time clinical and dental science laboratory faculty appointed prior to July 1, 2022 are exempt from this degree requirement.” Following consideration of the proposed revision, the DH RC recommended proposed revision to Standards 2-14 and 3-6, which were considered by the Commission at its Winter 2022 meeting and returned to the Dental Hygiene Review Committee for further consideration at the request of the Dental Hygiene Commissioner since it was identified that the proposed revision to Standard 3-6 would exempt all full-time and part-time dental hygiene faculty from the degree requirement.

Subsequently, on April 27, 2022, the Commission received a request from Dr. Warren Gabaree, department head of dental programs, for review of Dental Hygiene Standard 3-6 of the Accreditation Standards to be implemented July 1, 2022 related to the qualifications of full-time faculty. Additionally, on May 19, 2022, the CODA received a letter from Mr. Bracken Killpack, executive director, Washington State Dental Association, on behalf of 16 state dental associations, to consider proposed revisions to allow programs to determine their faculty to student ratios (Standard 3-6; Standard 3-5 effective July 1, 2022) and to determine the qualifications necessary for clinical faculty (Standard 3-7; Standard 3-6 effective July 1, 2022) from the Accreditation Standards for Dental Hygiene Education Programs. The state dental associations believe that a severe shortage of dental hygienists could be addressed, in part, through changes to the above noted Standards. Following publication of the Commission’s Summer 2022 policy on this matter, the Commission received (on June 27, 2022) a letter from the ADA’s Council on Dental Education and Licensure (CDEL) requesting the Commission to consider reviewing the Accreditation Standards (Appendix 1).

At this meeting, the DH RC reconsidered its Winter 2022 proposed revisions to Standards 2-14 and 3-6 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 3, Policy Report p. 403), along with the letters received in the Commission office (Appendices 1, 4, and 5, Policy Report p. 403; and Appendix 1).
Related to the requested revisions to faculty to student ratios (Standard 3-5), the DH RC noted that teaching ratios have a long-standing history within the CODA Accreditation Standards for allied dental education programs. The ratios are in place to ensure appropriate instruction and supervision of students as a critical component to the quality of education and skill development, as well as to ensure protection of the student and patient. Further, several disciplines within CODA’s purview have standards related to teaching ratios, including advanced dental education programs in oral and maxillofacial surgery and orthodontics and dentofacial orthopedics. Following discussion, the DH RC believed there should be no change to the Standards related to faculty to student ratios.

Related to the requested revisions to faculty qualifications (Standard 3-6), the DH RC reviewed its Winter 2022 proposed revisions and determined that the proposed revisions to require full-time faculty to hold a master’s degree or be enrolled in a master’s degree program should not move forward at this time. In review of the recent letters suggesting modification to Standard 3-6, the DH RC noted the recent multi-year review and revision process leading to the current Dental Hygiene Standards that took effect on July 1, 2022. The DH RC believed the revision was appropriately vetted, considered by CODA’s broad communities of interest, and is reflective of the educational background that supports faculty and students in dental hygiene education programs. Following discussion, the DH RC believed there should be no change to the Standards related to faculty qualifications.

Finally, related to Dental Hygiene Standard 2-14 (all types of classifications of periodontal disease), the DH RC reviewed its Winter 2022 proposed revisions and engaged in a lengthy discussion related to the new terminology to classify periodontal disease. Following discussion, the DH RC recommended the proposed revision to Standard 2-14 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 2) be circulated to the communities of interest for six (6) months, for review and comment, with a Hearing conducted in conjunction with the October 2022 American Dental Association meeting, with comments reviewed at the Commission’s Winter 2023 meetings.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct there be no revision to Standard 3-5 (faculty to student ratios) and Standard 3-6 (faculty qualifications) of the Accreditation Standards for Dental Hygiene Education Programs.

It is further recommended that the Commission on Dental Accreditation direct circulation of the proposed revision to Standard 2-14 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 2) to the communities of interest for six (6) months, for review and comment, with a Hearing conducted in conjunction with the October 2022 American Dental Association meeting, with comments reviewed at the Commission’s Winter 2023 meetings.
**Commission Action**: The Commission on Dental Accreditation directs there be no revision to Standard 3-5 (faculty to student ratios) and Standard 3-6 (faculty qualifications) of the Accreditation Standards for Dental Hygiene Education Programs.

The Commission on Dental Accreditation further directs circulation of the proposed revision to Standard 2-14 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 10) to the communities of interest for six (6) months, for review and comment, with a Hearing conducted in conjunction with the October 2022 American Dental Association meeting, with comments reviewed at the Commission’s Winter 2023 meetings.

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**Excerpt Dental Assisting Review Committee Report to CODA (Summer 2022)**

**Consideration of Proposed Revisions to the Accreditation Standards for Allied Dental Education Programs in Dental Assisting (p. 303)**: On May 19, 2022, the Commission on Dental Accreditation received a letter from Mr. Bracken Killpack, executive director, Washington State Dental Association, on behalf of 15 state dental associations, to consider proposed revisions for the removal of the faculty to student ratios for clinical settings (Standard 3-8) and the requirement that the program administrator possess a baccalaureate degree or higher degree (Standard 3-4) from the Accreditation Standards for Dental Assisting Education Programs. The state dental associations believe that a severe shortage of dental assistants could be addressed, in part, through changes to the above noted Standards.

Following publication of the Commission’s Summer 2022 policy on this matter, on June 27, 2022, the Commission received a letter from the ADA’s Council on Dental Education and Licensure (CDEL) (Appendix 1) in regard to the 15 state dental associations and further requesting the Commission to consider proposed revisions to Standard 2-1 that would allow dental assisting programs and their sponsoring postsecondary institutions to determine solely the program’s admission criteria, procedures and policies. With this change, a sponsoring postsecondary institution and program would have the prerogative to matriculate high school students wishing to enroll, perhaps on a part-time basis, in an accredited dental assisting program. The Council believed that such a change would allow programs to determine their specific admission requirements which may increase their enrollments and help to alleviate the ongoing workforce shortage of dental assistants.
At this meeting, the DA RC considered the letters received in the Commission office (Appendix 1, Policy Report p. 303, and Appendix 1). The DA RC first noted that there was no data to support the recommendations to revise the CODA standards as submitted by the state dental associations.

Related to the requested revisions to faculty to student ratios (Standard 3-8), the DA RC noted that teaching ratios have a long-standing history within the CODA Accreditation Standards for allied dental education programs. The ratios are in place to ensure appropriate instruction and supervision of students as a critical component to the quality of education and skill development, as well as to ensure protection of the student. The DA RC also noted that most states do not require graduation from a Commission-accredited dental assisting program for licensure and/or employment. Therefore, there is likely little to no correlation between workforce shortages and CODA Standards, and no information was provided to suggest otherwise. Following discussion, the DA RC believed there should be no change to the Standards related to faculty to student ratios.

Related to the requested revisions to program administrator qualifications (Standard 3-4), the DA RC discussed the program administrator qualifications and determined these qualifications are reflective of the educational background that supports students in dental assisting education programs. The Committee also discussed that many educational institutions that sponsor dental assisting education programs require a program administrator to have a baccalaureate degree to serve as a program administrator. Institutions may also require that faculty have degrees higher than the degree offered to their students. The Committee also noted that holding a baccalaureate degree enhances the quality of education. Following discussion, the DA RC believed there should be no change to the Standards related to program director qualifications at this time.

Related to the requested revisions to admissions including the requirement for a high-school diploma or its equivalent (Standard 2-1), the DA RC discussed the rationale for this requirement and discussed the need for more data regarding how changing this standard may impact the program. The DA RC noted that in some states students cannot perform dental assisting skills and functions until they reach a certain age, which is often post-secondary. Additionally, the DA RC noted that CODA-accredited dental assisting programs may admit students through advanced standing policies and procedures when those students have completed equivalent didactic, laboratory and preclinical content prior to admission in the CODA-accredited program. Following discussion, the DA RC believed there should be no change to the Standard related to admissions at this time.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct there be no revision to Standard 2-1 (admissions), Standard 3-8 (faculty to student ratios), and Standard 3-4 (program administrator qualifications) of the Accreditation Standards for Dental Assisting Education Programs.

**Commission Action:** The Commission on Dental Accreditation directs that there be no revision to Standard 2-1 (admissions), Standard 3-8 (faculty to student ratios), and
Standard 3-4 (program administrator qualifications) of the Accreditation Standards for Dental Assisting Education Programs.
Dear Program Director,

We are writing to inform you that on Wednesday, July 5, 2023, you will receive a confidential Survey of Allied Dental Education Programs Related to Faculty to Student Ratios, from the Commission on Dental Accreditation. The Commission is seeking information on the impact of faculty to student ratios in the Accreditation Standards on the allied dental education programs under the Commission’s purview. We ask that you complete the survey by end of the day Friday, July 21, 2023. Additional details, and a link to the survey, will be provided on July 5, 2023. Thank you, in advance, for providing the Commission with important feedback from dental education programs.

Sherin Tooks, Ed.D., M.S. tookss@ada.org
Senior Director, Commission on Dental Accreditation & US Department of Education Compliance
Commission on Dental Accreditation (CODA)
312-440-2940 office

Marjorie Hooper hooperm@ada.org
Coordinator, CODA Operations
Office of the Director
Commission on Dental Accreditation (CODA)
312.440.4653 (office)

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CODA Staff Notes:
Imbedded Data to present survey questions as follows:
1. Single discipline Program director - Block 2 only
2. Dual discipline Program director - Block 1, 2, 3, & 4

Survey of Allied Dental Education Programs Related to Faculty to Student Ratios

Default Question Block

Introduction

In winter 2023, the Commission on Dental Accreditation (CODA) considered a letter from 17 state dental associations related to workforce shortages, specifically in dental assisting and dental hygiene. The state dental associations asked the Commission to revise the faculty to student ratio in allied Accreditation Standards to be identical (1 faculty to 6 students) in all disciplines, and to draft clear rationale for setting faculty to student ratios.

Following consideration, the Commission directed establishment of the Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards. The Commission is seeking information on the impact of faculty to student ratios in the Accreditation Standards on the allied dental education programs under the Commission’s purview, through a brief survey of program directors.

Instructions

Thank you for participating in the 2023 Commission on Dental Accreditation (CODA) Survey on Faculty to Student Ratios in Allied Dental Education. CODA wishes to assess the impact of the current faculty to student ratios in the accreditation standards on allied dental education programs within its purview. Your answers will help CODA make informed decisions about the faculty to student ratios within the Accreditation Standards. Your response will remain completely confidential and will be presented to CODA in aggregate form only.

Please answer all questions by selecting the response that best describes your program’s situation. Note that the “Next” and “Back” buttons will allow you to move from one page to another. This survey will take approximately 5 minutes to complete. When you have completed the survey successfully, you will reach the completion page which will notify you that your responses have been submitted.

Block 2

Is your CODA-accredited program currently able to hire and retain a sufficient number of qualified faculty?

☐ Yes  ☐ No

If no, do you believe adjustments to the faculty to student ratio will assist the program in hiring and retaining a sufficient number of qualified faculty?

☐ Yes  ☐ No

Does your program have an interest in increasing enrollment in the next one (1) to two (2) years?

☐ Yes  ☐ No

How do each of the factors listed below currently affect your program’s enrollment?

<table>
<thead>
<tr>
<th>Factor</th>
<th>Positive Effect</th>
<th>No Effect</th>
<th>Negative Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity of the program’s facility</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA Standards</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Program funding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Program patient pool</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Qualtrics Survey Software

<table>
<thead>
<tr>
<th>Positive Effect</th>
<th>No Effect</th>
<th>Negative Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Interest in the program</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Student attrition</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Cost of education to the student</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

How likely or unlikely would an increase in faculty to student ratios (i.e., adding more students while keeping current faculty levels) impact your program in each of the following ways?

<table>
<thead>
<tr>
<th>Extremely likely</th>
<th>Somewhat likely</th>
<th>Neither likely nor unlikely</th>
<th>Somewhat unlikely</th>
<th>Extremely unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Align with the current capacity of the program’s faculty</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Help the program address the local workforce shortage</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Support faculty recruitment and retention</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Support quality of patient care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Enhance the student learning experience</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Do you believe the faculty to student ratios required in the Accreditation standards for your discipline are appropriate as written?

- [ ] Yes, the Standards are appropriate as written
- [ ] No, the ratios should be revised to permit more students per faculty
- [ ] No, the ratios should be revised to permit less students per faculty
- [ ] No opinion

Block

If you are the director of both a dental assisting and dental hygiene program, please respond to the survey for each discipline.

Please answer the following questions related to your Dental Assisting program.

Block 3

Please answer the following questions related to your Dental Hygiene program.

Block 4

Is your CODA-accredited dental hygiene program currently able to hire and retain a sufficient number of qualified faculty?

- [ ] Yes
- [ ] No

If no, do you believe adjustments to the faculty to student ratio will assist the dental hygiene program in hiring and retaining a sufficient number of qualified faculty?

- [ ] Yes
- [ ] No

Does your dental hygiene program have an interest in increasing enrollment in the next one (1) to two (2) years?

- [ ] Yes
- [ ] No
<table>
<thead>
<tr>
<th>How do each of the factors listed below currently affect your dental hygiene program's enrollment?</th>
<th>Positive Effect</th>
<th>No Effect</th>
<th>Negative Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity of the program's facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CODA Standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program patient pool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student interest in the program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of education to the student</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How likely or unlikely would an increase in faculty to student ratios (i.e., adding more students while keeping current faculty levels) impact your dental hygiene program in each of the following ways?

<table>
<thead>
<tr>
<th></th>
<th>Extremely likely</th>
<th>Somewhat likely</th>
<th>Neither likely nor unlikely</th>
<th>Somewhat unlikely</th>
<th>Extremely unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Align with the current capacity of the program's facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help the program address the local workforce shortage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support faculty recruitment and retention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support quality of patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance the student learning experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you believe the faculty to student ratios required in the Dental Hygiene Accreditation Standards are appropriate as written?

-  Yes, the Standards are appropriate as written
-  No, the ratios should be revised to permit more students per faculty
-  No, the ratios should be revised to permit less students per faculty
-  No opinion
SURVEY OF ALLIED DENTAL EDUCATION PROGRAMS RELATED TO FACULTY TO STUDENT RATIOS

Combined DA, DH, DLT and DT response*
*Includes dual (DA & DH) appointed program director responses for each discipline
74% engagement: 431 of the 582 Allied programs submitted a response (partial/unfinished response not included)

Is your CODA-accredited program currently able to hire and retain a sufficient number of qualified faculty? 201

If no, do you believe adjustments to the faculty to student ratio will assist the program in hiring and retaining a sufficient number of qualified faculty? 126

Does your program have an interest in increasing enrollment in the next one (1) to two (2) years? 266
### Ad Hoc Faculty to Student Ratios in Accreditation Standards

**Commission Only**

**Summer 2023**

#### How do each of the factors listed below currently affect your program’s enrollment?  
![Bar chart showing factors affecting enrollment](chart1)

#### How likely or unlikely would an increase in faculty to student ratios (i.e., adding more students while keeping current faculty levels) impact your program in each of the following ways?  
![Bar chart showing impact of increased ratios](chart2)

#### Do you believe the faculty to student ratios required in the Accreditation Standards for your discipline are appropriate as written?  
![Bar chart showing responses to faculty to student ratios](chart3)
All Programs Response: How likely or unlikely would an increase in faculty to student ratios impact your program in each of the following ways:

<table>
<thead>
<tr>
<th>Response</th>
<th>Extremely &amp; Somewhat likely</th>
<th>Neither likely nor likely</th>
<th>Extremely &amp; Somewhat unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Align with the current capacity of the program’s facility</td>
<td>194</td>
<td>106</td>
<td>160</td>
</tr>
<tr>
<td>Help the program address the local workforce shortage</td>
<td>179</td>
<td>89</td>
<td>152</td>
</tr>
<tr>
<td>Support faculty recruitment and retention</td>
<td>134</td>
<td>98</td>
<td>208</td>
</tr>
<tr>
<td>Support quality of patient care</td>
<td>83</td>
<td>122</td>
<td>215</td>
</tr>
<tr>
<td>Enhance the student learning experience</td>
<td>107</td>
<td>54</td>
<td>259</td>
</tr>
</tbody>
</table>
Dental Hygiene Programs Response: How likely or unlikely would an increase in faculty to student ratios impact your program in each of the following ways:

- Align with the current capacity of the program’s facility: Extremely & Somewhat likely 84, Neither likely nor likely 55, Extremely & Somewhat unlikely 114
- Help the program address the local workforce shortage: Extremely & Somewhat likely 88, Neither likely nor likely 52, Extremely & Somewhat unlikely 113
- Support faculty recruitment and retention: Extremely & Somewhat likely 55, Neither likely nor likely 51, Extremely & Somewhat unlikely 147
- Support quality of patient care: Extremely & Somewhat likely 49, Neither likely nor likely 45, Extremely & Somewhat unlikely 159
- Enhance the student learning experience: Extremely & Somewhat likely 38, Neither likely nor likely 25, Extremely & Somewhat unlikely 380
Dental Assisting Programs Response: How likely or unlikely would an increase in faculty to student ratios impact your program in each of the following ways:

- Align with the current capacity of the program's facility:
  - Extremely & Somewhat likely: 66
  - Neither likely nor unlikely: 49
  - Extremely & Somewhat unlikely: 43

- Help the program address the local workforce shortage:
  - Extremely & Somewhat likely: 85
  - Neither likely nor unlikely: 36
  - Extremely & Somewhat unlikely: 37

- Support faculty recruitment and retention:
  - Extremely & Somewhat likely: 58
  - Neither likely nor unlikely: 44
  - Extremely & Somewhat unlikely: 56

- Support quality of patient care:
  - Extremely & Somewhat likely: 84
  - Neither likely nor unlikely: 71
  - Extremely & Somewhat unlikely: 53

- Enhance the student learning experience:
  - Extremely & Somewhat likely: 56
  - Neither likely nor unlikely: 28
  - Extremely & Somewhat unlikely: 74
Dental Laboratory Technology Programs Response: How likely or unlikely would an increase in faculty to student ratios impact your program in each of the following ways:

<table>
<thead>
<tr>
<th>Response</th>
<th>Extremely &amp; Somewhat Likely</th>
<th>Neither Likely nor Likely</th>
<th>Extremely &amp; Somewhat unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Align with the current capacity of the program's facility</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Help the program address the local workforce shortage</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Support faculty recruitment and retention</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Support quality of patient care</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Enhance the student learning experience</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Legend:
- Extremely & Somewhat likely
- Neither likely nor likely
- Extremely & Somewhat unlikely
SURVEY OF ALLIED DENTAL EDUCATION PROGRAMS RELATED TO FACULTY TO STUDENT RATIOS

Dental Hygiene Response*
*includes dual (DA & DH) appointed program director response for DH only
76% engagement: 257 of the 338 DH programs submitted a response (partial/unfinished response not included)

Is your CODA-accredited program currently able to hire and retain a sufficient number of qualified faculty?

Yes: 186
No: 71

If no, do you believe adjustments to the faculty to student ratio will assist the program in hiring and retaining a sufficient number of qualified faculty?

Yes: 28
No: 161

Does your program have an interest in increasing enrollment in the next one (1) to two (2) years?

Yes: 117
No: 127
SURVEY OF ALLIED DENTAL EDUCATION PROGRAMS RELATED TO FACULTY TO STUDENT RATIOS

Dental Assisting Response*
*includes dual (DA & DH) appointed program director response for DA only
70% engagement: 161 of the 229 DA programs submitted a response (partial/unfinished response not included)

Is your CODA-accredited program currently able to hire and retain a sufficient number of qualified faculty?

If no, do you believe adjustments to the faculty to student ratio will assist the program in hiring and retaining a sufficient number of qualified faculty?

Does your program have an interest in increasing enrollment in the next one (1) to two (2) years?
### Ad Hoc Faculty to Student Ratios in Accreditation Standards

#### Commission Only

**Summer 2023**

### How do each of the factors listed below currently affect your program’s enrollment? (SAE)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Negative</th>
<th>No Effect</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity of the program’s facility</td>
<td>33</td>
<td>59</td>
<td>67</td>
</tr>
<tr>
<td>Cost of education to the student</td>
<td>26</td>
<td>74</td>
<td>40</td>
</tr>
<tr>
<td>Ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by CDA Standard</td>
<td>71</td>
<td>29</td>
<td>5</td>
</tr>
<tr>
<td>Program funding</td>
<td>21</td>
<td>79</td>
<td>10</td>
</tr>
<tr>
<td>Program patient pool</td>
<td>62</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>Student interest in the program</td>
<td>69</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>Student retention</td>
<td>69</td>
<td>31</td>
<td>0</td>
</tr>
</tbody>
</table>

### How likely or unlikely would an increase in faculty to student ratios (i.e., adding more students while keeping current faculty levels) impact your program in each of the following ways? (SAE)

<table>
<thead>
<tr>
<th>Impact</th>
<th>Extremely Likely</th>
<th>Somewhat Likely</th>
<th>Neither Likely nor Unlikely</th>
<th>Somewhat Unlikely</th>
<th>Extremely Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Align with the current capacity of the program’s facility</td>
<td>66</td>
<td>34</td>
<td>10</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Help the program address the local workforce shortage</td>
<td>40</td>
<td>49</td>
<td>36</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>Support faculty enrollment and retention</td>
<td>44</td>
<td>36</td>
<td>28</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Support quality of patient care</td>
<td>13</td>
<td>51</td>
<td>24</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>Enhance the student learning experience</td>
<td>28</td>
<td>28</td>
<td>28</td>
<td>40</td>
<td>0</td>
</tr>
</tbody>
</table>

### Do you believe the faculty to student ratios required in the Accreditation Standards for your discipline are appropriate as written? (SAE)

<table>
<thead>
<tr>
<th>Belief</th>
<th>Yes, the Standards are appropriate as written</th>
<th>No, the ratios should be reduced to permit more students per faculty</th>
<th>No, the ratios should be reduced to permit less students per faculty</th>
<th>No option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of responses</td>
<td>91</td>
<td>28</td>
<td>91</td>
<td>2</td>
</tr>
</tbody>
</table>
SURVEY OF ALLIED DENTAL EDUCATION PROGRAMS RELATED TO FACULTY TO STUDENT RATIOS

Dental Laboratory Technology Response

66% engagement: 6 of the 3 13 DLT programs submitted a response (partial/unfinished response not included)

- Is your CODA-accredited program currently able to hire and retain a sufficient number of qualified faculty? [ ] [ ● ]

- If no, do you believe adjustments to the faculty to student ratio will assist the program in hiring and retaining a sufficient number of qualified faculty? [ ] [ ● ]

- Does your program have an interest in increasing enrollment in the next one (1) to two (2) years? [ ] [ ● ]
Ad Hoc Faculty to Student Ratios in Accreditation Standards
Commission Only
Summer 2023

How do each of the factors listed below currently affect your program's enrollment?

- Capacity of the program's facility
- Cost of education to the student
- Ability to hire and retain a sufficient number of qualified faculty to maintain ratios required by COSEH Standards
- Program funding
- Program patient load
- Student interest in the program
- Student relations

How likely or unlikely would an increase in faculty to student ratios (e.g., adding more students while keeping current faculty levels) impact your program in each of the following ways?

- Align with the current capacity of the program's facility
- Help the program address the local workforce shortage
- Support faculty enrollment and retention
- Support quality of patient care
- Enhance the student learning experience

Do you believe the faculty to student ratios required in the Accreditation Standards for your discipline are appropriate as written?
REPORT OF THE AD HOC COMMITTEE ON VOLUNTEERISM

Background: At its August 2021 meeting, the Commission on Dental Accreditation (CODA) considered the Report of the Standing Committee on Nominations, noting that the Standing Committee expressed concerns regarding the difficulty in obtaining public member representation on the Commission and its Review Committees. Following consideration of the Report of the Standing Committee on Nominations, the Commission directed formation of an Ad Hoc Committee to further study the topic of volunteerism and stipend for all Commission volunteers, at all levels of the Commission, including its site visitors, review committee members, and Board of Commissioners. The Ad Hoc Committee considered the topic of volunteerism and submitted a report to the Commission in Winter 2022 (Appendix 1). The Commission concurred with the recommendations of the Ad Hoc Committee. Due to unforeseen circumstances, the work of the Ad Hoc Committee was delayed.

In Spring 2023, the Ad Hoc Committee on Volunteerism continued its work. The Committee met on May 23, 2023 and August 4, 2023. Committee members included: Dr. Barbara Krieg-Menning (chair), Dr. Scott DeRossi, Ms. Martha McCaslin (absent May 23), Dr. Monica Nenad, Dr. Miriam Robbins, Dr. Nancy Rosenthal (absent May 23), and Dr. Marshall Titus (absent May 23 and August 4). Dr. Carol Anne Murdoch-Kinch attended the May 23, 2023 meeting only, and is no longer a member of the Commission. Dr. Sanjay Mallya, chair, Commission on Dental Accreditation (CODA), ex-officio, attended the August 4, 2023 meeting. Dr. Sherin Tooks, senior director, and Ms. Jamie Asher Hernandez (absent August 4), Ms. Katie Navickas (absent May 23), Ms. Yesenia Ruiz (absent August 4), Ms. Peggy Soeldner, and Ms. Kelly Stapleton (absent August 4), managers, CODA, were also in attendance.

The Ad Hoc Committee reviewed its charge and prior report to the Commission, including recommendations and actions taken by the Commission in Winter 2022. The Committee discussed the two (2) remaining areas of consideration, as follows.

The Ad Hoc Committee again noted CODA’s directive for a financial comparative analysis study, which will occur later this year through the Finance Committee and will include consideration of the Commission’s funding model to determine the impact of a stipend and honorarium on the Commission’s operational budget. The Ad Hoc Committee noted that the comparative analysis could also include a review of methods by which other agencies compensate volunteers (volunteer compensation strategies) and related funding mechanism. Consideration of the amount of stipend awarded and eligibility for stipend (i.e., currently only awarded for volunteer travel) should be considered, including a consideration of stipends for non-travel CODA volunteerism, and heavy workload to prepare for CODA meetings and activities such as site visits. The Committee believed the Commission should review this topic at a future date in conjunction with the work of the Finance Committee. However, the Standing Committee acknowledged that the amount of stipend awarded to volunteers would not likely equate to an individual’s personal income for missed work.
The Ad Hoc Committee also considered the Commission’s directive that past and current site visitors and current Review Committee members be surveyed to determine barriers to service, perceptions and attitudes toward volunteering, and links of volunteerism to service, promotion and tenure within their institutions. The Ad Hoc Committee noted, anecdotally, that volunteerism has declined due to lack of time, inability to get approval to volunteer and/or travel, and other personal and professional commitments, as barriers to volunteerism. Prior to consideration of a survey to Commission volunteers, the Ad Hoc Committee conducted an informal survey of other accrediting agencies, noting that some agencies are also struggling with volunteerism while others appear to have sufficient volunteers. Challenges of volunteerism affecting some accrediting agencies are like those of the Commission. Some agencies provide stipends greater than the Commission, while other agencies acknowledge difficulty in providing a stipend commensurate with an individual’s daily salary. The Ad Hoc Committee again noted that volunteering within the Commission requires many hours of preparation in addition to the time spent conducting Commission activities.

The Ad Hoc Committee did not believe that a survey of past and current site visitors and current Review Committee members was warranted at this time, to determine barriers to service, perceptions and attitudes toward volunteering, and links of volunteerism to service, promotion and tenure within their institutions. The Committee noted that a future survey may be appropriate following the Finance Committee’s budget analysis. Additionally, the Committee was informed that in some disciplines volunteerism is returning since the COVID-19 pandemic.

Following consideration, the Ad Hoc Committee concluded that other gestures of appreciation may be appropriate and should be further investigated by the Commission, through its staff, including the following:

- Approaching Dental Deans to express the importance of faculty development and volunteerism with CODA. Additionally, encouraging volunteerism among all dental disciplines within CODA’s purview.
- Exploring a partnership with the American Dental Association to offer Continuing Education (CE) for the Commission’s training programs and activities, as available.
- Communicating CODA’s appreciation for volunteerism through certificates of appreciation and letters to CODA Site Visitors, Review Committee Members, and Commissioners, with copy to the individual’s leadership. This could include a mailed certificate and an electronic thank you card for an individual’s generosity of time and service to CODA, without which CODA would not be able to conduct its accreditation program.

The Ad Hoc Committee concluded its work, with recommendations noted above, and an understanding that the issue of volunteerism would be further considered through the Standing Committee on Finance, as described above.

**Ad Hoc Committee on Volunteerism Recommendations:** It is recommended that the Commission on Dental Accreditation direct continued review of volunteerism through the
Standing Committee on Finance, in conjunction with the financial comparative analysis study.

It is further recommended that the Commission on Dental Accreditation direct Commission staff to communicate the importance of volunteerism to the communities of interest, and to explore additional methods through which the Commission may express appreciation to its volunteers, including offering continuing education, issuing certificates of appreciation, or other methods, as available.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
Background: At its August 2021 meeting, the Commission on Dental Accreditation (CODA) considered the Report of the Standing Committee on Nominations, noting that the Standing Committee expressed concerns regarding the difficulty in obtaining public member representation on the Commission and its Review Committees. The Committee noted that volunteerism has diminished; further, reaching the public audience to obtain nominations for public members has become increasingly difficult. The Committee observed that most volunteers, whether public or within the dental profession, expect to be compensated for the extensive time and effort they must dedicate to the work of the organization for which they are volunteering. The Committee also noted the heavy workload for the Commission’s site visitors, Review Committee members, and Commissioners when conducting the work of the Commission.

Following consideration of the Report of the Standing Committee on Nominations, the Commission directed formation of an Ad Hoc Committee to further study the topic of volunteerism and stipend for all Commission volunteers, at all levels of the Commission, including its site visitors, review committee members, and Board of Commissioners. The Ad Hoc Committee could consider topics including:

1) Investigating whether a stipend can be offered, or increased for volunteerism. The Standing Committee noted that a $75 daily stipend is issued to volunteers; however, this stipend is only available if the volunteer travels for the Commission’s business. Virtual meetings are not eligible for the disbursement of a stipend for volunteer’s efforts.

2) Potential extension of term limits or permitted additional terms. The Standing Committee noted that public volunteers may complete two (2), consecutive four-year terms. Discipline-specific volunteers may complete two (2), four-year terms with a one-year period between terms.

3) Potential assignment of public members to multiple Review Committees. The Standing Committee noted that some Review Committees’ workloads may be such that a single public member could participate as a member of more than one Review Committee during their tenure as a Review Committee Public Member. The Committee noted that they may be positive and negative benefits to this arrangement, which the Commission may wish to further consider.

The Commission Chair appointed the following individuals to the Ad Hoc Committee on Volunteerism: Dr. Barbara Krieg-Menning (chair), Dr. Scott DeRossi, Dr. Susan Kass, Ms. Martha McCaslin, Dr. Carol Anne Murdoch-Kinch, Dr. Miriam Robbins, Dr. Nancy Rosenthal, and Dr. Marshall Titus. The Ad Hoc Committee conducted a virtual meeting on January 5, 2022 and all members were present. Dr. Sherin Tooks, director, CODA, Ms. Jamie Asher Hernandez, Ms. Kirsten Nadler, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, were in attendance.
Below is the Ad Hoc Committee’s report and recommendations to the Commission following its January 5, 2022 meeting.

**Report and Recommendations of the Ad Hoc Committee:**

**Stipend and Honorarium:** The Ad Hoc Committee reviewed its charge and the information that was collected to support the work of the Committee. The Committee began its discussion noting that currently the Commission on Dental Accreditation applies the American Dental Association’s volunteer travel and reimbursement policies and procedures to the volunteer work of the Commission. Under the current volunteer travel and reimbursement policy, CODA volunteers are reimbursed for travel expenses and provided a minimal stipend to offset miscellaneous expenses while traveling. The stipend is provided only when a volunteer travels; therefore, when work is completed virtually there is no reimbursement and no stipend for the efforts of the volunteer. The Committee discussed whether the Commission should adopt an honorarium process by which all CODA volunteers receive an honorarium for their time and work effort, regardless of travel. The honorarium would serve as an acknowledgement and appreciation of the volunteer’s tremendous effort to support the CODA’s mission and accreditation program.

The Ad Hoc Committee noted that since 2015, the Commission has demonstrated fiscal responsibility, covering both direct and indirect expenses. Nonetheless, the Ad Hoc Committee recognized that the shift from a stipend to honorarium, or a combination of both, could have a financial impact on the Commission that must be carefully analyzed prior to a final decision on this matter. The Committee noted that a review of the stipend and honorarium is warranted and, perhaps, the Commission could consider providing the stipend and honorarium when travel is involved, and an honorarium when travel is not involved. The Ad Hoc Committee noted the modification to volunteer reimbursement protocols would require development of an honorarium and policy for its application, which the Committee believed could be $100 per day.

The Ad Hoc Committee believed that further information should be gathered related to the following: 1) the budget impact of adding an honorarium along with the stipend, and policy for the use of each; 2) further study of the reasons for the lack of volunteers (e.g. workload, time, effort, reimbursement, recognition, etc.), cultural changes in volunteerism, and potential long-term impact to CODA accreditation activities; and 3) review of other volunteer models used to sustain volunteerism, such as reimbursement models and use of volunteers (e.g. volunteers versus salaried reviewers).

The Ad Hoc Committee noted that the CODA Standing Committee on Finance could be charged with reviewing the CODA funding model to determine the impact of a stipend and honorarium on CODA’s operational budget. Further, to obtain the necessary information to study the impact of volunteerism on CODA’s work, the Ad Hoc Committee believed that surveys of past and current site visitors and current CODA Review Committee members should be conducted to determine barriers to service, perceptions and attitudes toward volunteering, and links of volunteerism to service, promotion and tenure within their institutions.
Committee Member Term Limits: In further discussion, the Ad Hoc Committee reviewed the Commission’s term limits within the various CODA policies and procedures for Commissioners, Review Committee members, and Site Visitors. The Committee specifically noted that in Review Committees, the public member may complete two (2), consecutive four-year terms. Discipline-specific volunteers may complete two (2), four-year terms with a one-year period between terms. Following discussion, the Ad Hoc Committee concluded that policies and term limitations should be retained; however, the Commission should explore strategies to generate additional public members utilizing external networks.

Public Members on Multiple Review Committees: In its final meeting discussion, the Ad Hoc Committee continued to focus on the difficulty in finding public members to serve on the Commission, noting that CODA’s Board of Commissioners includes four (4) public members and a public member also serves on each CODA’s 17 Review Committees. The Committee discussed the concept of a public member serving on multiple review committees, particularly for the smaller review committees where the workload may not be extensive. Following discussion, the Ad Hoc Committee determined that some Review Committees’ workloads may be such that a single public member could participate as a member of more than one (1) Review Committee during their tenure as a Review Committee Public Member. The Ad Hoc Committee believed that assignment of public members to multiple Review Committees should be permitted. The proposed revision to the policy on Review Committees and Review Committee Meetings is provided in Appendix 1.

Ad Hoc Committee on Volunteerism Recommendations: It is recommended that the Commission on Dental Accreditation direct the Standing Committee on Finance to review the Commission’s funding model to determine the impact of a stipend and honorarium on the Commission’s operational budget, with a report to the Commission in Summer 2022.

It is further recommended that the Commission on Dental Accreditation direct a survey of past and current site visitors and current Review Committee members to determine barriers to service, perceptions and attitudes toward volunteering, and links of volunteerism to service, promotion and tenure within their institutions, with further consideration by the Ad Hoc Committee on Volunteerism and Commission in Summer 2022.

It is further recommended that the Commission on Dental Accreditation direct that term limits for all Commission volunteers be retained, as dictated by current Commission policy.

It is further recommended that the Commission on Dental Accreditation direct that a single public member may serve as a member of more than one (1) Review Committee during their tenure as a Review Committee Public Member, effective immediately, with
revision to the Commission’s Evaluation and Operational Policies and Procedures as noted in Appendix 1.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
II. REVIEW COMMITTEES AND BOARD OF COMMISSIONERS

A. REVIEW COMMITTEES AND REVIEW COMMITTEE MEETINGS

1. Structure: The chair of each Review Committee will be the appointed Commissioner from the relevant discipline.
   
i. The Commission will appoint all Review Committee members.
   
   a. Review Committee positions not designated as discipline-specific will be appointed from the Commission where feasible, e.g. a public representative on the Commission could be appointed to serve as the public member on the Dental Laboratory Technology Review Committee; an ADA appointee to the Commission could be appointed to the Dental Assisting Review Committee as the general dentist practitioner.
   
   b. Discipline-specific positions on Review Committees will be filled by appointment by the Commission of an individual from a small group of qualified nominees (at least two) submitted by the relevant national organization, discipline-specific sponsoring organization or certifying board. Nominating organizations may elect to rank their nominees, if they so choose. If fewer than two (2) qualified nominees are submitted, the appointment process will be delayed until such time as the minimum number of required qualified nominations is received.
   
   ii. Consensus is the method used for decision making; however if consensus cannot be reached and a vote is required, then the Chair may only vote in the case of a tie (American Institute of Parliamentarians Standard Code of Parliamentary Procedures).
   
   iii. Member terms will be staggered, four year appointments; multiple terms may be served on the same or a different committee, with a one-year waiting period between terms. A maximum of two (2) terms may be served in total. The one-year waiting period between terms does not apply to public members.
   
   iv. One public member will be appointed to each committee. Following consideration of workload, public members may concurrently serve on more than one (1) Review Committee.
   
   v. The size of each Review Committee will be determined by the committee’s workload.
   
   vi. As a committee’s workload increases, additional members will be appointed while maintaining the balance between the number of content experts and non-content experts. Committees may formally request an additional member through New Business at Review Committee/Commission meetings. If an additional member is approved, this member must be a joint nomination from the professional organization and certifying board, as applicable.
   
   vii. Conflict of interest policies and procedures are applicable to all Review Committee members.
   
   viii. Review Committee members who have not been on a site visit within the last two (2) years prior to their appointment on a Review Committee should observe at least one site visit within their first year of service on the Review Committee.
   
   ix. In the event that fewer than 50% of discipline-specific experts are present for any one discipline, the decision by a quorum of the Review Committee shall be acceptable. In the case of less than 50% of discipline-specific experts, including the Chair, available for a review committee meeting, for specified agenda items or for the entire meeting, the Review Committee Chair may temporarily appoint an additional discipline-specific expert(s) with the approval of the CODA Director. The substitute should be a previous Review Committee member or an individual approved by both the Review Committee Chair and the CODA Director. The substitute would have the privileges of speaking, making motions and voting.

   x. Consent agendas may be used by Review Committees, when appropriate, and may be approved
by a quorum of the Review Committee present at the meeting.
Revised: 2/22; 8/20; 1/20; 8/18; 8/17; 2/15; 1/14, 2/13, 8/10, 7/09; 7/08; 7/07; Adopted:
1/06
REPORT OF THE AD HOC COMMITTEE ON ALTERNATIVE SITE VISIT METHODS

**Background:** At its August 2020 meeting, the Commission on Dental Accreditation (CODA) considered ongoing operations in response to the COVID-19 pandemic and the impact on site visits. The Commission directed that it pursues alternative site visit methods, as needed to employ in 2021. The Commission further directed investigation and development of policies and procedures for alternative site visit methods, with a report to CODA in Winter 2021. The Commission believed that input from its 14 Review Committees on the elements of a site visit that may be conducted virtually versus the elements that must be reviewed on-site was warranted and, as such, directed that the 14 Review Committees be consulted related to this matter. Finally, the Commission directed the appointment of an Ad Hoc Committee to study virtual site visits, including development of policies and procedures for the conduct of virtual visits, for consideration by the Commission in Winter 2021.

At its Winter 2021 meeting, the Commission considered the Report of the Ad Hoc Committee on Alternative Site Visit Methods. Following extensive discussion, the Commission adopted the Policy on Temporary Use of Alternative Site Visit Methods, manuals for site visitors and educational programs on the Commission’s alternative site visit methods, and an Alternative Site Visit Program Agreement to be signed by each educational program prior to a site visit. The Commission also directed educational webinars and further study of alternative site visit methods for long-term implementation.

Continuing its work in Fall 2021, the Ad Hoc Committee on Alternative Site Visit Methods discussed the 2021 site visits and noted that March through August 2021 site visits were virtual, while August through December 2021 site visits may have been virtual, hybrid (at least one person on-site) or completely on-site depending on health and safety, institutional regulations, and site visitor preference during the COVID-19 pandemic. As required by the United States Department of Education (USDE), the Committee proposed revisions to the Commission’s Policy on Temporary Use of Alternative Site Visit Methods to further clarify the types of site visits, which would require follow-up in-person visits, not only the visit modality (virtual, hybrid, in-person) but also the site visit type (new program, special focused, or regular site visit). The policy revisions also clarified the focus of the return site visit, with a proposed schedule, interviews and observations, and the document review to occur at the in-person follow-up visit.

At its Winter 2022 meeting, the Commission adopted and immediately implemented the proposed revisions to the Policy on Temporary Use of Alternative Site Visit Methods to include protocols for in-person follow-up site visits following virtual site visits. The Commission also directed staff to initiate the follow-up on-site visit planning, and to develop and disseminate to programs and CODA site visitors a template Site Visit Schedule and template Site Visitor Evaluation Report specific to the on-site visit process following a virtual site visit. Finally, to support the continued work of the Ad Hoc Committee, the Commission directed staff to gather data to facilitate the Ad Hoc on Alternative Site Visit Method’s study of alternative site visit methods to identify whether any changes in processes or procedures for the conduct of site visits using alternative methods could be implemented long-term.
Report and Recommendations of the Ad Hoc Committee on Alternative Site Visit Methods:
At its Fall 2022 meeting, the Ad Hoc Committee concluded its meeting with a discussion of long-term considerations to the use of alternative site visit methods. The Committee noted that a lot has been learned from CODA’s use of alternative site visit methods, as well as CODA’s electronic accreditation portal. The Committee believed next steps included obtaining outcomes data so that the results from site visitor and program perspectives could be quantified and the equivalency measured more scientifically to assess the benefits and weaknesses of hybrid versus in-person site visits. For example, frequency of citings data, pre- and post-site visit survey data, and other factors may provide information that the Ad Hoc Committee could consider at a subsequent meeting. As directed by the Commission in Winter 2022, CODA staff was requested to collect information for continued review by the Ad Hoc Committee.

Ad Hoc Committee Meetings of May 23, 2023 and June 20, 2023: The members of the Ad Hoc Committee met on May 23, 2023 and June 20, 2023, with the following members in attendance: Dr. Frank Licari (chair), Dr. Victor Badner, Dr. Joel Berg (absent May 23, 2023), Dr. Barbara Krieg-Menning, Dr. Monica Nenad, Dr. Miriam Robbins, Dr. Timmothy Schwartz, and Dr. Marshall Titus (absent May 23, 2023). The Commission staff, as follows, were also in attendance: Dr. Sherin Tooks, senior director, and Ms. Jamie Asher Hernandez, Ms. Katie Navickas (absent May 23, 2023), Ms. Yesenia Ruiz, Ms. Peggy Soeldner and Ms. Kelly Stapleton, managers, CODA.

The Ad Hoc Committee reviewed background information and its charge for continued review of long-term considerations to the use of alternative site visit methods. The Committee engaged in lengthy discussions related to federal regulations, CODA processes, and future application of alternative site visit methods.

May 23, 2023 Meeting: The Ad Hoc Committee considered the Commission’s progress on the alternative site visit methods that were previously adopted and implemented. The Ad Hoc Committee noted there were 37 allied return site visits, 33 advanced return site visits, and 4 predoctoral return site visits, which were either completed or would be completed by Fall 2023. The Committee also discussed the USDE’s guidance that all recognized accrediting agencies must return to pre-COVID operations within 180 days following the expiration of the declared pandemic; this due date was scheduled for mid-October 2023. The Committee noted that CODA was on-track to meet the USDE’s requirement and, further, that the Commission had returned to in-person site visits.

The Ad Hoc Committee again noted that the USDE requires an on-site visit of all educational programs under the Commission’s purview. The USDE also recently clarified that the hybrid visit concept may only be permitted in special emergency cases (case-by-case) due to circumstances like illness, health conditions of site visitors, or flight cancelations, for example. While noting the current regulations, the Committee discussed the potential for a future review of some on-site visit components shifting to a hybrid modality. The Committee believed that moving toward some virtual components of a site visit, given adequate technology advancements, would allow the Commission to explore alternative site visit methods as a long-
term change. The Committee believed alternative site visit methods would be successful, if permitted, based on the experience of the Commission during the COVID-19 pandemic. For example, the Committee noted that alternative site visit methods are currently used for visitation or conferences with a program’s educational activity sites. Currently, a team may select which sites to visit in-person; however, using virtual methods, a site visit team may be able to expand its access to more sites for review with some visited in-person and others virtually as part of the site visit.

The Ad Hoc Committee believed some components of the site visit could occur virtually in advance of the on-site review, thereby shortening the on-site process. The Committee also recognized that the different disciplines accredited by CODA may require different methods of conducting site visits. For example, due to the nature of dental public health education, this discipline may be accomplished completely virtually. Allied and advanced dental education programs may require more on-site components due to the nature of the site visit team composition. Whereas predoctoral site visit teams may be structured such that some visitors could participate virtually, for example, the finance site visitor.

The Ad Hoc Committee also noted challenges in virtual participation by site visitors. There could be concerns related to uninterrupted availability of a site visit team member who is attending a visit virtually, along with privacy issues, and other considerations that must be reviewed. Another concern noted is the current policy that stipends are issued to site visitors based on miscellaneous expenses resulting from travel. Therefore, a site visitor who participates virtually would not receive a stipend, although they would be required to spend a significant number of hours preparing for and participating in the site visit. The Committee noted anecdotal feedback given to CODA staff on this matter.

The Committee concluded with a discussion of additional information it would like to review to further discuss alternative site visit uses by the Commission as a long-term process of program review. The Committee requested information on alternative site visit methods used by other accrediting agencies, confirmation of the USDE requirements and potential future changes in regulation, and a review of data collected by the Commission on programs’ and site visitors’ perceptions of virtual and hybrid site visits.

June 20, 2023 Meeting: The Ad Hoc Committee considered additional information related to alternative site visit methods, including USDE guidance on potential use of alternative site visit methods, data collected from other accrediting agencies, and feedback from programs and site visitors related to virtual and hybrid site visits.

In review of the USDE guidance, it was noted that the accrediting agency must have enough site visitors on-site to validate all information in the self-study while on-site. In other words, a virtual review must not substitute for a comprehensive on-site review by an adequate number of site visitors who have the expertise to conduct the on-site assessment of the program’s compliance with Accreditation Standards. The Committee also noted that CODA staff continue to support site visit teams virtually and will continue to do so, since staff provide support to the site visit team and are not peer reviewers. Staff virtual support allows for staff to assist more site
visit teams, as needed, while maintaining the staff support role. This protocol was discussed with the USDE, without concern; additionally, the Department noted that staff do not serve as reviewers and the USDE would be concerned if staff served in a reviewer role.

The USDE also indicated that the on-site visit must include a thorough on-site evaluation of every Accreditation Standard. The accrediting agency may not rely on the virtual component (in advance of an in-person visit) to confirm compliance in lieu of the on-site verification. The Committee further discussed the logistics of site visit team reviews occurring in advance of and during a site visit, noting that this process would significantly increase logistical planning necessary to conduct such an activity. The Committee again reiterated that site visit teams may use virtual meeting capabilities, as appropriate, to interview off-site personnel while being located on-site at the program’s primary educational location.

Related to the methods used by other accrediting agencies, the Ad Hoc Committee noted that some accrediting agencies use virtual site visits for follow-up or special site visits. While CODA could consider this option, most of the Commission’s special focused visits are required to visit facilities where students/residents/fellows spend a considerable amount of time; therefore, a virtual visit may not be appropriate. Overall, the Ad Hoc Committee noted that CODA’s practices at this time align with the other accrediting agencies that are USDE recognized. The Ad Hoc Committee noted that one enhancement for further consideration may be requiring programs to provide a majority of “on-site” information in advance of the site visit through CODA’s portal, and to remove those documents after the site visit. This practice could provide the site visit team with additional program information in advance of the site visit.

Finally, the Ad Hoc Committee considered aggregate program and site visitor feedback from the post-site visit surveys collected while CODA conducted virtual site visits (2021-2022) and hybrid site visits (2021-2023). The Committee noted overwhelmingly positive reviews from programs and site visitors on the site visit process for both virtual and hybrid visits. Additionally, site visitors believed the site visit process was fair and provided an appropriate review of all components of the program being evaluated. Additionally, there were overall favorable comments from both programs and site visitors related to CODA’s E-Accreditation Portal; however, some individually reported difficulty using the system initially.

Following extensive discussion, the Ad Hoc Committee noted that a change to CODA’s current site visit process is not warranted at this time. However, the Committee believed CODA should continue to monitor the Department of Education’s regulations related to site visit processes permitted for use by recognized accrediting agencies. The Committee also believed the ongoing review of CODA’s site visit process, including feedback from programs and site visitors through CODA’s Post Site Visit Survey and the ongoing training of site visitors, aligns with CODA’s strategic plan for continuous quality improvement of the Commission. While no changes are warranted to the site visit process at this time, the Ad Hoc Committee believed that the Commission should consider transitioning the Ad Hoc Committee to the “Standing Committee on Site Visit Process and Training.”
The Ad Hoc Committee noted CODA staff provides training and guidance to programs in all areas noted below, which could also be discussed by the standing committee since there is no current standing committee of the Commission to oversee these important activities.

The new standing committee could provide input into the follow areas of the Commission’s accreditation process:

- Monitor trends and USDE regulations related to CODA’s site visit process;
- Evaluate site visit feedback from site visitors and programs;
- Review and develop protocols and materials to enhance the site visit process;
- Oversee and provide input on training for new and reappointed site visitors;
- Oversee and provide input on training for programs preparing for site visits, including development of the Self-Study, maintaining accreditation records, and documenting compliance; and
- Oversee and provide input to educate new program directors on working with the Commission (live and on-demand).

Following consideration, the Ad Hoc Committee believed the Commission should create a new standing committee, effective immediately.

**Ad Hoc Committee on Alternative Site Visit Methods Recommendations:** It is recommended that the Commission on Dental Accreditation direct that the Ad Hoc Committee on Alternative Site Visits be transitioned to a standing committee of the Commission named the Standing Committee on Site Visit Process and Training, effective immediately.

It is further recommended that the Commission on Dental Accreditation direct the Standing Committee on Site Visit Process and Training be assigned the following charge:

**Standing Committee on Site Visit Process and Training:**

- Monitor trends and USDE regulations related to CODA’s site visit process;
- Evaluate site visit feedback from site visitors and programs;
- Review and develop protocols and materials to enhance the site visit process;
- Oversee and provide input on training for new and reappointed site visitors;
- Oversee and provide input on training for programs preparing for site visits; and
- Oversee and provide input to educate new program directors on working with the Commission.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
REPORT OF THE AD HOC COMMITTEE ON PROFESSIONAL DEVELOPMENT

Background: At the conclusion of its Closed Session during the Winter 2023 meeting, the Commission on Dental Accreditation (CODA) discussed a new business item related to exploration of ways to enhance Commissioner training and opportunities for professional development, like Mega Issue Discussions. Historically, the Commission has conducted Mega Issue Discussions on an ad hoc basis as topics of interest are identified by the Commission. The Commissioners noted a lot of change in dental education within the past few years, including new program directors, CODA site visitors, and the changing dental education landscape, which provides an opportunity for the Commission to learn about these changes and support future innovation through the Commission’s accreditation process.

The Commissioners believed that CODA members should be well informed of advancements in dental education, technology, and other changes as they make decisions related to the effectiveness of educational programs and develop educational policies and procedures for CODA’s accreditation process. To that end, there could be continual updates on various topics that arise in dental education and accreditation. For example, the Commission may discuss ways to better calibrate on the requirements for programs to fulfill the Accreditation Standards. It was noted that the Standards are broad and flexible, but programs may view the requirements in different ways from the Commission and its site visitors.

Following discussion at its Winter 2023 meeting, the Commission directed that an Ad Hoc Committee, including allied dental, advanced dental, and predoctoral dental education Commissioners and others, be established to explore the issue of ongoing professional development of CODA Commissioners, Review Committee members, and Site Visitors, addressing trends in assessment of clinical education, site visitor training, and other topics related to dental education and accreditation.

The Ad Hoc Committee met on May 16, 2023. Members of the Ad Hoc Committee included: Dr. Carol Anne Murdoch-Kinch (chair), Dr. Carolyn Brown, Dr. Scott DeRossi, Dr. Garry Myers, and Dr. Deborah Weisfuse. Dr. Frank Licari, Dr. Paul Luepke, and Ms. Martha McCaslin were unable to attend. Dr. Sanjay Mallya, chair, Commission on Dental Accreditation, ex-officio, attended a portion of the meeting. Dr. Sherin Tooks, senior director, and Ms. Jamie Asher Hernandez, Ms. Katie Navickas, Ms. Yesenia Ruiz, Ms. Peggy Soeldner, and Ms. Kelly Stapleton, managers, CODA, were also in attendance. Below is the Ad Hoc Committee’s report and recommendations to the Commission following its May 16, 2023 meeting.

Report and Recommendations of the Ad Hoc Committee on Professional Development: The Ad Hoc Committee reviewed its charge and the information collected to support the work of the Committee. The Committee discussed the topic of ongoing professional development for CODA volunteers, changes in dental education, potential topics for future discussion by the Commission, and resource allocations that may be required by the Commission in conducting professional development or mega issue sessions.
The Ad Hoc Committee noted that CODA’s review of this topic is timely since programs are reassessing and changing the methods of educating students, student assessment, and utilization of distance education since the COVID-19 pandemic. For example, new ways of assessing student competence and innovations in curriculum design are developing, and Commissioners may benefit from learning about these innovations. It was believed that Commissioners, Review Committee Members, and Site Visitors should have a baseline understanding of current practices in dental education, to ensure the Commission continues to evaluate programs in a fair and consistent manner, given that CODA volunteers (Commissioners, Review Committee Members, and Site Visitors) come from different backgrounds and knowledge levels related to dental education.

The Ad Hoc Committee believed that CODA should consider conducting frequent Mega Issue discussions, or general CODA informational sessions, with one (1) to two (2) hour presentations on general topics of relevance for its Commissioners, Review Committee Members, and Site Visitors. A committee of CODA could develop a topic and consider appropriate external speakers (as needed) to determine the speaker’s appropriateness and authority on the topic. The CODA committee could develop the topics, agenda, and outline for each event.

Potential topics considered by the Ad Hoc Committee included, but are not limited to (in no particular order):

- Fundamentals of accreditation, and CODA processes, roles and responsibilities of volunteers
- Competency assessment and student evaluation in dental education
- Outcomes assessment for programs in dental education
- Diversity, equity, inclusion and belonging in dental education and Accreditation Standards
- Use of educational activity sites in dental education
- Use of simulation in dental education
- Strategies for calibration (faculty calibration)
- Global health and multiculturalism
- Curricula for management of patients with special needs

The Ad Hoc Committee also discussed the methods by which these topics could be shared with Commissioners, Review Committee Members, and Site Visitors. The Committee believed CODA should begin with sessions for Commissioners and expand to Review Committee Members and Site Visitors. It was noted that recording of the sessions would allow sharing within a private, secure area for the Commission’s Review Committee Members and Site Visitors. There may be an opportunity for the Commission to consider video recording and video sharing technologies, such as learning management systems, private YouTube channels, and other tools. However, to begin, the Ad Hoc Committee believed CODA could conduct sessions in real-time with Commissioners during its regular Winter and Summer meetings.

Finally, the Ad Hoc Committee considered the financial implications to the Commission. It was noted that adding an additional half-day to the Commission meeting once per year would result
in a potential cost impact of approximately $16,500. However, building time into the Commission’s current meeting schedule may be another viable option depending on the amount of time needed for the specific topic; in this case, there would be no cost impact to CODA.

Following lengthy discussion, the Ad Hoc Committee believed the Commission should move forward with development of a strategy to further enhance Commissioners, Review Committee Members, and Site Visitors professional development in topics related to dental education and accreditation. The Committee noted that new Commissioners are trained annually, each December; however, the Ad Hoc Committee believed an initial topic of professional development could be a refresher session for all Commissioners on the process of accreditation. Additionally, the Commission could discuss potential future topics for CODA volunteer professional development.

**Ad Hoc Committee on Professional Development Recommendation:** It is recommended that the Commission on Dental Accreditation direct the Ad Hoc Committee on Professional Development or a Standing Committee of the Commission to develop periodic ongoing professional development sessions for CODA Commissioners, Review Committee members, and Site Visitors, addressing topics related to dental education and accreditation.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
REPORT OF THE STANDING COMMITTEE ON
INTERNATIONAL ACCREDITATION

Background: The Standing Committee on International Accreditation (Predoctoral only) has the following charge:

- Provide international consultation fee-based services to international predoctoral dental education programs, upon request.
- Develop and implement international consultation policies and procedures to support the international consultation program.
- Monitor and make recommendations to the Commission regarding changes that may affect its operations related to international issues.

April 7, 2023 Meeting: The Standing Committee on International Accreditation met via conference call on Friday, April 7, 2023.

The following members were present for the meeting: Dr. Terry Fiddler (ADA, Chair), Dr. Carol Anne Murdoch-Kinch (CODA), Dr. Perry Tuneberg (ADA), and Dr. Frank Licari (CODA). Dr. Lawrence Wolinsky, Standing Committee on International Accreditation Consultant. Dr. Bryan Edgar (ADA), was unable to attend. CODA Commissioner: Dr. Maxine Feinberg, vice chair, Commission on Dental Accreditation. CODA Staff: Dr. Sherin Tooks, senior director, CODA, and Ms. Kelly Stapleton, manager, Predoctoral Dental Education, CODA. ADA Staff: Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, ADA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, as available.

The Standing Committee considered the following program during its meeting:

- Saveetha Institute of Medical and Technical Sciences, Chennai, India (PACV Survey)
- Instituto Tecnológico y de Estudios Superiores de Monterrey, Monterrey, Nuevo Leon, Mexico (PACV Survey)

Standing Committee Actions: The Standing Committee on International Accreditation directed that formal letters be sent to the programs reviewed, as applicable, in accordance with the actions taken by the Committee.

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

Prepared by: Dr. Sherin Tooks
Report on Appointment of Commissioners and Appeal Board Members

The Commission on Dental Accreditation received information on the Commissioners and Appeal Board Members whose terms will end at the ADA Annual Meeting and their replacements whose terms will begin at the ADA Annual Meeting.

### 2023

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<th>Retiring Appeal Board Member</th>
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<td>Dr. Patricia Blaton (ADEA)</td>
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<td>Ms. Carmella Hanley (ADAA)</td>
<td>Ms. Sara Stream (ADAA)</td>
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<td>Dr. Sanjay Mallya (AAOMR)</td>
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<td>Mr. Marco Gargano ASDA/ADEA</td>
<td>Mr. Noah Williams (ASDA/ADEA)*</td>
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<td>Dr. Frank Recker (AADB)</td>
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<td>Dr. Susan Kass (ADHA)</td>
<td>Dr. Monica Nenad (ADHA)*</td>
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<td>Dr. Carol Anne Murdoch-Kinch</td>
<td>Dr. Keith Mays*</td>
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<td>Dr. Brent Larson (AAO)</td>
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<td>Dr. Timmothy Schwartz (ADA)</td>
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<td>Dr. Marshall Titus (AADB)</td>
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<td>Dr. Scott DeVito (Public)</td>
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<td>Dr. Barbara Krieg-Menning (Public)</td>
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<th>Retiring Commissioners</th>
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<td>Dr. Victor Badner (AAPHD)</td>
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<td>Dr. Maxine Feinberg (AADB)</td>
<td>Dr. Renee McCoy-Collins (AADB)</td>
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<td>Ms. Martha McCaslin (ADAA)</td>
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<td>Dr. Garry Myers (AAE)</td>
<td>Dr. Fabricio Teixeira (AAE)</td>
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*fulfilling a vacated term of less than 50% and will serve their own term following
**fulfilling a vacated term of more than 50%

**Commission Action**: This report is informational in nature; no action is required.

Prepared by: Dr. Sherin Tooks
ELECTION OF CHAIR AND VICE-CHAIR OF THE COMMISSION

Background: In accord with the Rules of the Commission on Dental Accreditation (CODA) and the Governance and Organizational Manual of the American Dental Association (ADA), the Commission shall elect its own chair.

*ADA Governance Manual, Chapter IX. Commissions*
D. Chairs. Commissions shall elect their own chairs. To be eligible to serve as chair of a commission, the commission member must be an active, life or retired member of this Association.

*CODA Rules, Article V. OFFICERS*
Section 1. OFFICERS: The officers of the Commission shall be a Chair, Vice-chair, a Director and such other officers as the Board of Commissioners may authorize. The Chair and Vice-chair shall be elected by the Board of Commissioners.

Section 2. ELIGIBILITY: The Chair and Vice-chair shall be dentists who are members of the Board of Commissioners. The Chair and Vice-chair shall be active, life or retired members of the American Dental Association.

Section 3. ELECTION AND TERM: The Chair and Vice-chair of the Commission shall be elected annually by the Board of Commissioners. The term of the Chair and Vice-chair shall be one (1) year beginning and ending with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association.

Section 4: DUTIES: The duties of the officers are as follows:

A. CHAIR:
1. Appoint members and chairs of such committees as are necessary for the orderly conduct of business except as otherwise provided in these Rules.
2. Circulate or cause to be circulated an announcement and an agenda for each regular or special meeting of the Board of Commissioners.
3. Preside during meetings of the Board of Commissioners.
4. Prepare or supervise the preparation of an annual report of the Commission.
5. Prepare or supervise the preparation of an annual budget of the Commission.

B. VICE-CHAIR: The Vice-chair of the Commission shall assist the Chair in the performance of his or her duties. If the Chair is unable to attend any given meeting of the Board of Commissioners, the Vice-chair shall preside at the meeting. If the Vice-chair also is unable to attend the meeting, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.
C. VACANCIES: In the event the vacancy involves the Chair, the Vice-chair shall immediately assume all duties of the Chair. In the event the vacancy involves the Vice-chair, a meeting of the Commission shall be convened to select a new Vice-chair.

Section 5. DIRECTOR:

A. Appointment: The Director of the Commission shall be an employee of the American Dental Association selected by the Executive Director of that Association.

B. Duties: The Director of the Commission shall:

1. Prepare an agenda and keep minutes of meetings of the Board of Commissioners.
2. See that all notices are duly given in accordance with the provisions of these Rules or as required by law.
3. Be the custodian of records of the Commission.
4. Manage the office and staff of the Commission.
5. In general shall perform all duties incident to the office of Director.

Dr. Sanjay Mallya will complete his one-year term as Chair of the Commission at the close of the October 2023 ADA Meeting. Dr. Maxine Feinberg will also complete her one-year term as Vice-Chair of the Commission at the close of the October 2023 ADA Meeting. Dr. Mallya’s term with CODA will end in October 2023 and Dr. Feinberg’s term with CODA will in October 2024.

The Commission is requested to elect a Chair for a one-year term that will begin immediately following the 2023 ADA Meeting. In addition, the Commission is requested to elect a Vice-Chair for a one-year term whose term will also begin immediately following the 2023 ADA Meeting.

Appendix 1 provides a listing of current Commissioners. Commissioners’ appointing organizations and their appointment terms are noted.

Commission Action:

Prepared by: Dr. Sherin Tooks
2023 CODA MEMBERSHIP ROSTER

Mallya, Sanjay M., Ph.D., M.D.S., B.D.S., Chair 2023 (AAOMR)
Anadioti, Evanthia, D.D.S., 2025 (ACP)
Badner, Victor M., D.M.D., 2024 (AAPHD)
Beasley, Willie Keith, D.D.S., 2024 (ADA)
Berg, Joel H., D.D.S., 2023 (AAPD)
Bhattacharyya, Indraneel., D.D.S., M.S.D., B.D.S., 2026 (AAOMP)
Bowman-Pensel, Margaret, M.S., 2026 (Public Member)
Brown, Carolyn, D.M.D., 2025 (AADB)
Chu, Ngoc Quang, D.D.S., 2026 (AADB)
Cohen, Joseph, D.D.S. 2025 (AAOP)
DeRossi, Scott, D.M.D., 2025 (AAOM)
Devito, Scott, J.D., Ph.D., 2023 (Public Member)
Feinberg, Maxine, D.D.S., 2024 (AADB)
Giovannitti, Joseph, D.M.D., 2025 (ASDA)
Ismail, Amid I., B.D.S., Dr.P.H., M.B.A., 2023 (ADEA)
Krieg-Menning, Barbara A., Ph.D., M.S.N., B.S.N., 2023 (Public Member)
Kushner, George, D.M.D., 2025 (AAOMS)
Larson, Brent E., D.D.S., 2023 (AAO)
Leone, Cataldo., D.M.D., D.M.S., 2026 (ADEA)
Licari, Frank, D.D.S., 2025 (ADEA)
Luepke, Paul., D.D.S., M.S., 2026 (AAP)
Mayer, Lisa., J.D., 2026 (Public Member)
Mays, Keith, D.D.S., Ph.D.,M.S., 2024 (Adea)
McCaslin, Martha, M.A., 2024 (ADAA)
Myers, Garry L., D.D.S., 2024 (AAE)
Nenad, Monica., D.H.Ed., 2023 (ADHA)
Robbins, Miriam, D.D.S., 2025 (ADEA/SCDA)
Rosenthal, Nancy R., D.D.S., 2025 (ADA)
Schwartz, Timmothy J., D.D.S., 2023 (ADA)
Thompson, Lonni, B.S., 2025 (NADL)
Weisfuse, Deborah., D.M.D., M.S., 2026 (ADA)
Williams, Noah., Mr. B.A., 2023 (ASDA/ADEA)
BOARD OF DIRECTORS REPORT

July 2023
CDAC OPERATIONS REPORT 2023

2023 Survey Site Visits

The number of annual survey site visits continues to increase, primarily as a result of new Dental Specialty and Dental Assisting programs. In 2023, thirty-six (36) in-person site visits were conducted. This included 5 programs at Dalhousie University (DDS, Degree Completion for Internationally Educated Dentists, Periodontics, Oral and Maxillofacial Surgery and entry to practice Dental Hygiene), 6 non-University-based Dental Hygiene Programs, 8 Dental Assisting Programs, 9 Dental Services and 5 General Practice Residency Programs.

Dental Specialties:
- 1 OMFS (Dalhousie University)
- 2 Periodontics (Dalhousie University, University of Alberta)
- 1 Prosthodontics (University of Manitoba)

DDS/DMD:
- 1 (Dalhousie University)

Degree Completion for Internationally Educated Dentists:
- 1 (Dalhousie University)

Dental Hygiene:
- 1 University-based
- 2 College-based (public institutions)
- 4 College-based (private institutions)

Dental Assisting:
- 3 private Colleges
- 5 public Colleges

Dental Internships/Residencies
- 5 General Practice Residencies (Alberta Health Services Foothills, University of Montreal, McGill University, Montreal Children’s, Jewish General)
- 1 Internship (Mt. Sinai)
Health Facilities

- 9 Hospital Services

**Updating Accreditation Standards**

**Dental Hygiene and Dental Assisting**

The Dental Hygiene accreditation standards review working group, and the Dental Assisting accreditation standards review working group, supported by CDAC staff, have been working diligently for the past two years on reviewing and updating accreditation standards.

Included in the revised accreditation standards is wording pertaining to cultural safety and Equity, Diversity, and Inclusion. Following consultation with stakeholder groups and several working group meetings, we are now entering the last phases of the review process. These revised accreditation standards are expected to be effective January 1, 2024.

**Dentistry (DDS/DMD)**

The CDRAF (Canadian Dental Regulatory Authorities Federation) Board, together with the ACFD (Association of Canadian Faculties of Dentistry) are currently updating the Knowledge, Skills, and Abilities Competency document for entry to practice dentists. The process to review and update the DDS/DMD accreditation standards by CDAC will begin in mid-2023.

**Dental Anaesthesia**

On February 17, 2023, the CDRAF (Canadian Dental Regulatory Authorities Federation) Board approved the recognition of Dental Anaesthesia as a specialty of dentistry. Over the next 12 - 18 months, a Working Group of the CDAC Standards Committee will be soliciting support from ACFD (Association of Canadian Faculties of Dentistry), RCDC (Royal College of Dental Surgeons of Canada), CADA (Canadian Academy of Dental Anaesthesia), CODA and the public to develop standards for Dental Anaesthesia Programs.

**2023 ACTIVITY UPDATE**

**Transition To Independence**

In December 2018, a Governance Review Steering Committee (GRSC) was struck to investigate the feasibility of CDAC establishing its independence from the Canadian Dental Association – a relationship that had spanned over 7 decades. In November 2022 the Commission on Dental Accreditation of Canada (CDAC) approved the final report and recommendations of the GRSC for the transition of CDAC to an independent legal entity. This included adoption of a new governance structure and a new proposed funding model.
CDAC was officially registered under the Canada Not-for-Profit Corporations Act on December 31, 2022. The first in-person meeting of the Board of Directors for the new Commission on Dental Accreditation of Canada (CDAC) was held in Ottawa February 25 and 26th.

**GOVERNANCE MODEL**

Under the new Governance Structure, the number of public representatives on CDAC committees has increased from one to six. The Accreditation Review Committees (Dentistry and Dental Specialties, Dental Hygiene, Dental Assisting and Health Facilities and Residencies/Internships) are tasked with the review and approval of accreditation status decisions, independent of the Board of Directors. The mandate of the Standards Committee is to establish, monitor and update accreditation processes and standards for oral health professional education programs and health facilities.

Since its formal incorporation, the Board of Directors has approved the Terms of Reference and membership for all committees. Each Board Committee has developed a preliminary action plan for the upcoming year. The Board has also developed and approved a number of governance policies, including:

- Signing Authority
- Code of Conduct/Conflict of Interest.
  - All Board and Committee members are required to review and sign this annually.
- Whistleblower Policy.
  - This allows for employees, officers, directors and other stakeholders, including the public, to raise, anonymously or not, questions, complaints or concerns about the Corporation’s practices, including fraud, policy violations, any illegal or unethical conduct, and any Corporation accounting, auditing or internal control matters.
- Appeal of Accreditation Decisions Policy.
  - While to date, there have been no appeals, this formal policy outlines the protocol for doing so.
- Concerns about Accredited Programs and Health Facilities Policy.
  - This policy addresses concerns about a CDAC accredited program or health facility which meets the definition of a ‘systemic complaint’ in the Management of complaints guidance.

The new proposed funding model ensures equitable fees for the national credentialing bodies of all three professional groups (Dental Assisting, Dental Hygiene and Dentistry). A funding agreement is in development that will see stable 5-year funding, with provision of accreditation reports upon request. A phased increase of administrative costs for educational programs will be established. This new model will allow for the increased cost of the governance structure while ensuring sustainability of CDAC and allowing for the promotion of innovation.

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<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Role</th>
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<tbody>
<tr>
<td>Dr. Debora Matthews</td>
<td>ACFD</td>
<td>Board Chair, Executive Committee</td>
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<tr>
<td>Ms. Jennifer Tewes</td>
<td>NDAEB</td>
<td>Board Vice Chair, Governance Committee</td>
</tr>
<tr>
<td>Dr. Mintoo Basahti</td>
<td>NDEB</td>
<td>Audit Committee</td>
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<tr>
<td>Ms. Paula Benbow</td>
<td>DA Educators</td>
<td>Chair, Standards Review Committee</td>
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<tr>
<td>Dr. Randall Croutze</td>
<td>CDRAF</td>
<td>Governance Committee</td>
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<tr>
<td>Ms. Mandy Hayre</td>
<td>DH Educators</td>
<td>Audit Committee</td>
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<tr>
<td>Ms. Kieran Jordan</td>
<td>FDHRC (National Examination Ctte)</td>
<td>Governance Committee</td>
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<td>Dr. Glenn Pettifer</td>
<td>FDHRC</td>
<td>Audit Committee</td>
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<td>Ms. April Slotsve</td>
<td>CDARA</td>
<td>Governance Committee</td>
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<tr>
<td>Dr. Mel Schwartz</td>
<td>Facilities/ Residencies</td>
<td>Executive Committee</td>
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<tr>
<td>Mr. Jerry Zhang</td>
<td>Public</td>
<td>Chair, Audit Committee</td>
</tr>
</tbody>
</table>

ACFD: Association of Canadian Faculties of Dentistry  
NDAEB: National Dental Assisting Examination Board  
NDEB: National Dental Examination Board  
CDRAF: Canadian Dental Regulatory Authorities Federation  
FDHRC: Federation of Dental Hygiene Regulators of Canada  
CDARA: Canadian Dental Assisting Regulatory Authorities
Chair Activities
In November 2022, in keeping with our reciprocal accreditation agreement with the Dental Council of Ireland, the Chair and the Executive Director attended the accreditation site visit for the BDS program at Trinity College in Dublin.

In addition to attending Board Meetings for the NDEB, the Chair represents CDAC on a CDRAF Working Group for International Credentialing of Internationally Educated Dentists from non-accredited program. This group is investigating a third pathway (the other two being graduation from a Degree Completion program or completion of the NDEB Equivalency Process) for licensure of internationally educated dentists.

At the invitation of the Canadian Dental Association, several national dental organizations met to determine the need for a ‘National Council’. The mandate of the Council would be to collaborate and respond to emerging issues of mutual concern, such as the recent Federal program for national dental care.

CDAC MEETING SCHEDULE

Annual General Meeting
All CDAC Members (i.e. those groups/organizations with Board nomination rights) will be invited to send representatives to the AGM. Further details and agendas will follow closer to meeting dates.

December 8, 2023 In-person Ottawa
November 29, 2024 In-person TBD
November 28, 2025 In-person TBD

Board of Directors
January 26, 2023 Virtual
February 25-26, 2023 In-person Ottawa
June 15, 2023 In-person Calgary
October 30, 2023 Virtual
December 7-8, 2023 In-person Ottawa
November 28-29, 2024 In-person TBD
November 27-28, 2025 In-person TBD

Accreditation Review Committees
Dental Hygiene and Dental Assisting Committees
November 18, 2023 In-person Ottawa

Health Facilities/Internships and Dentistry Committees
November 19, 2023 In-person Ottawa