INFORMATIONAL REPORT ON ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY PROGRAMS ANNUAL SURVEY CURRICULUM DATA

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

The Curriculum Section of the Commission's Annual Survey is conducted for advanced education in general dentistry (AEGD) and general practice residency (GPR) programs in alternate years. The most recent Curriculum Section was conducted in August/September 2024. Aggregate data of the most recent Curriculum Section for review by the Postdoctoral General Dentistry Review Committee as an informational report is provided in **Appendix 1** for AEGD programs and **Appendix 2** for GPR programs.

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

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

Prepared by: Ms. Peggy Soeldner

2024-25 Advanced Education in General Dentistry Curriculum Survey Results

This report includes data collected in the 2024-25 *Survey of Advanced Dental Education* from 93 advanced dental education programs in advanced education in general dentistry accredited at the time of the survey. One program did not have residents enrolled during the curriculum survey period; data from this program is not included in this report.

21. What percentage of time did first-year students/residents spend in each of the following areas during the 2023-24 residency year?

Field	Minimum	Maximum	Mean	Count
a. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations)	43.0	97.0	75.3	93
b. Dental inpatient care (management of dental inpatients)	0.0	7.0	0.7	93
c. Management of dental inpatients or same-day surgery patients in the hospital operating room suite	0.0	20.0	1.2	93
d. Rotations/Assignments to other services (non-dental)	0.0	15.0	1.6	93
e. Didactics: courses/lectures/conferences/seminars	3.0	47.0	18.9	93
f. Responding to consults	0.0	10.0	1.3	93
g. Other, please specify	0.0	10.0	1.0	93

g. Other, please specify - Text

4% Seminars/Conferences; 0.5% Teaching; 0.5% Research/lit review; 5% Military duties, dental meetings, dental labwork, independent study, Admin responsibilities
Continueing Education, Community Service, and Elective Professional Experiences
Lab & admin
Lab work
Lab, admin, research
Military Training (2)
Research (5)
Supervised teaching
Teaching and investigative work
administration-notes/lab work
conferences, seminars, calibration and training
general military training, online and field training
investigative work

22. Please indicate the total number of clock hours residents spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the 2023-24 residency year.

Clock hours	Minimum	Maximum	Mean	Count
a. Applied pharmacology (Standard 2-2)	0	50	8.3	93
b. Endodontics (Standard 2-2)	2	68	20.5	93
c. Hospital organization and function (Standard 2-10)	0	35	4.5	93
d. Medical risk assessment (Standard 2-6)	0	64	10.1	93
e. Restorative/Operative dentistry (Standard 2-2)	2	87	26.7	93
f. Oral diagnosis/treatment planning (Standard 2-1)	0	288	30.7	93
g. Oral and maxillofacial pathology (Standard 2-4)	0	50	14.6	93
h. Oral and maxillofacial radiology/imaging (Standard 2-1)	0	30	7.8	93
i. Oral and maxillofacial surgery (Standard 2-2)	0	68	17.6	93
j. Pain and anxiety control (Standard 2-2)	0	68	15.7	93
k. Patients with special needs (Standard 2-1)	0	40	8.6	93
l. Periodontics (Standard 2-2)	1	80	21.9	93
m. Physical evaluation (Standards 2-6, 2-7)	0	72	10.9	93
n. Practice management (Standard 2-10)	1	97	16.3	93
o. Preventive dentistry (Standard 2-1)	0	58	7.9	93
p. Restoration of edentulous space (Standard 2-2)	2	96	25.3	93
q. Other, please specify	0	478	26.9	93

q. Other, please specify - Text

Anterior Esthetics, Ceramics, Anxiety, Aging, TMD, and EBD (all 1.5hrs ea); Ethics & Professionalism, Pain Management, and Recognition of Pediatric Dental Emergencies (all 3 hrs ea); Orthodontic Recognition & Comprehensive Care Integration (8 hrs); Principles of Education (12 hrs)
Case conference, ethics, orthodontics, pediatric dentistry, literature review, TMD & facial pain
Community Service, Forensic Dentistry, Ethics, Evidence Based Dentistry, Implant Treatment Planning
Dental Emergencies, Pediatric Dentistry, Orthodontics
Dental Ethics (2)
Dental Sleep Medicine adjunctive ortho
Digital Dentistry (3)
Ethics, Occlusion, Orthodontics, Implants
Financial Considerations, Associateships
Forensic dentistry/teledentistry/ethics/sleep disorders
Forensics
Implant Dentistry
Implant placement, restoration
Implantology seminats

q. Other, please specify - Text

Implantology, Literature Review, Ortho
Implants, infection control, digital dentistry, ortho
Implants/Grafting
Implants: Maintenance, Restoration, Placement
Informed consent/treatment planning
Medical/Dental Interrelationships
Mgt of Medical Emergencies (8), Professional Ethics (6), Implants (16), Dental Materials (4)
Military Readiness, Forensics
Military related medical activities
Mixed Subjects
Multidisciplinary semnars
OFP/TMD/Sleep
Oral Biomaterials
Orofacial pain and Dental Sleep medicine
Orthodontics
Patient case conferences & literature review
Please see below for additional coursework provided to our residents.
Research (20), Ortho (20), Forensics (16)
Sedation/Prosthetics
Sleep Related Disorders
Sleep medicine, digital dentures, scanning, dental implants
TMD and Sleep
TMD, ethics, emergencies, ortho, IPE
TMJ and orofacial pain
Various Topics
cultural competency
ethics/professionalism
implantology
orofacial pain (4); TMD (2); implant therapy (22); medical emergency (7); dental emergency (5)

Comments from AEGD/GPR Curriculum Section page 1

As already mentioned previously, **REDACTED** resident was enrolled with the planned outlined curriculum; however, the **REDACTED**

Hospital organization and function is not a requirement for AEGD programs.

In addition to the required curriculum content by CODA standards, the program also provides residents with instruction in the following topics: Evidence based dentistry - 5 hours; Pediatric Dentistry - 5 hours; Public Health Dentistry - 5 hours; HIV in Dentistry - 1 hour; Ethics & Professionalism - 7 hours; Geriatric Dentistry - 4 hours; TMD & Oral Facial Pain Management - 5 hours; IPE & Oral Health - 1 hour; Teledentistry - 3 hours.

Multiple subject areas named above are often discussed and taught during weekly literature review and treatment planning sessions, including but not limited to: Restorative/Operative Dentistry, Oral/Maxillofacial Radiology/Imaging, Patients with Special Needs, Physical Evaluation, Preventive Dentistry, and Restoration of the Edentulous Space. The clock hours for instruction varies depending on the cases presented and literature review topics (which varies from year to year).

Question e.: Restorative Dentistry includes an 18-hour Directed Professional Reading Course.

Sedation and Prosthetics are grouped together. Sedation = 31 Prosthetics = 6

There is overlap in content. Due to academic days we have approximately 500 scheduled hours for educational activity resulting in 20% of our total AEGD residency time. The total is greater than 500 hours due to consultants, military training, and multiple disciplines being discussed in journal club, patient care conferences, and treatment planning boards.

hours are not including overlap in some areas like applied Pharmacology within the sedation course.

23. Indicate all rotations/assignments to non-dental services in either the sponsoring or affiliated institutions required of the residents.

Length of rotation/assignment (in weeks)	Minimum	Maximum	Mean	Count
a. Anesthesia (GPR Standard 2-5)	0	5	0.3	93
b. Medicine (GPR Standard 2-6)	0	12	0.4	93
c. Emergency Department (Standard 2-6)	0	52	1.9	93
d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5)	0	30	0.7	87

Average hours per week	Minimum	Maximum	Mean	Count
a. Anesthesia (GPR Standard 2-5)	0.0	48.0	7.4	93
b. Medicine (GPR Standard 2-6)	0.0	40.0	1.8	93
c. Emergency Department (Standard 2-6)	0.0	40.0	3.4	93
d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5)	0.0	40.0	3.3	88

d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5) - Text

Camp Bullis, Combat Casualty Care Course, trauma
Community Clinic
ENT
OMS
OR Dentistry
Otolaryngology
Pathology Lab
Plastic Surgery, ENT, Radiation Oncology, Dental Lab, Cardiology
Population Health and equity
RADIOLOGY ALL ABOVE FOR PGY-2
Residents do not rotate or assigned to the emergency department, However, but they do cover hospital emergency department after hours
Same-Day Surgery
Urgent Care
anestesia
practice management

24. Provide the following dental clinic statistics related to outpatient visits for the 2023-24 residency year. Include statistics for both sponsoring and affiliated institution(s). (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
a. Total number of outpatient visits to the dental clinic (include screening/consultative visits)	0	195,220	2,2781.9	93
b. Total number of outpatient visits managed by the residents	0	51,811	6,675.6	93

25. How many patients with special needs did the residents treat during the 2023-24 residency year? (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
	3	13,047	651.3	93

Comments from AEGD/GPR Curriculum Section page 2

25. It is difficult to quantify the exact number of patients with special needs that the residents treat. However, being that this is a **REDACTED** program, the **REDACTED** only provides comprehensive dental care to patients with a certain level of physical or psychological disabilities that make them eligible for dental treatment. Thus, the majority of patients (approximately 60%) require modification to normal dental routines to some extent, and this is how this number was achieved.

All rotations are on site

Medicine Rotation is at Addiction Medicine Department

REDACTED Optional 2nd Year program was temporarily modified to include treatment of Patients with Special Health Care Needs in an OR setting (30 x full days).

Q.24a: please note that the program's data reporting platform cannot synchronize with the data reporting platforms of its clinical training sites and therefore the actual number could not be entered.

Rotations in Anesthesia, Medicine and Emergency Department are not required of AEGD programs.

Special Needs are defined as patients with an ASA classification equal to II or III.

The answer to Q25 is an estimate based on previous years, since our system does not allow for accurate tracking. The AEGD treat all complex cases that are beyond the level of DMD students. This include, patient with disabilities, complex medical histories and HIV positive patients.

The patient population in **REDACTED** have complex medical needs which require some level of modification to dental care. Actual data may be higher than reported. Data is combined as reported by **REDACTED**

The total numbers are for all 3 clinics within the **REDACTED** footprint where residents rotate through.

This is a conservative estimate

We attempt to have the residents see all patients at our specialty clinic. Doing an audit of all patient evaluations seen at **REDACTED** from 1 AUG 2023-31 JUL 2024 resulted in 2565 encounters. I was not the program director during that academic year so I can only estimate the number of those encounters being 80% seen be the residents. The local standard here is that we want resident managing at least 5 medically compromised cases per resident. Since I was not the program director last year I inquired with the previous PD who stated our standard was met.

We do community service as we visit autistic children nursing house and we also see special needs adults

26. How many patients did residents provide comprehensive care to, from treatment plan to completion (as opposed to episodic or emergency care), during the 2023-24 residency year? (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
	2	94,391	2,879.2	93

27. Provide the following emergency care statistics for the 2023-24 residency year identifying the activity level(s) at both the sponsoring and affiliated institution(s). (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
a. The number of dental emergencies treated in the dental clinic by residents				
Sponsoring institution	0.0	21,634	936.7	93
Affiliated institution(s)	0.0	63,056	1,011.6	70
b. The number of dental emergencies treated in the hospital emergency department by all residents				
Sponsoring institution	0.0	1,958	54.7	92
Affiliated institution(s)	0.0	40	1.0	71

28. In which of the following conscious sedation techniques did residents receive instruction and clinical experience during the 2023-24 residency year? (Standard 2-2g)

Instruction	Yes	No	Total
a. Oral	89.2%	10.8%	93
b. Inhalation	83.9%	16.1%	93
c. Intramuscular	31.2%	68.8%	93
d. Intravenous	65.6%	34.4%	93
e. Intranasal	24.7%	75.3%	93
f. Other, please specify	4.3%	95.7%	93

Clinical Experience	Yes	No	Total
a. Oral	79.6%	20.4%	93
b. Inhalation	74.2%	25.8%	93
c. Intramuscular	7.5%	92.5%	93
d. Intravenous	45.2%	54.8%	93
e. Intranasal	5.4%	94.6%	93
f. Other, please specify	3.2%	96.8%	93

f. Other, please specify - Text

Anxiety treatment only - no titration allowed
General Anesthesia
See below
intubation

Comments from AEGD/GPR Curriculum Section page 3

Clinical Sedation schedule started for our Residents in July 2024.
Clinical experience was direct observation in the Oral Surgery Department.
Comp care patients are not tracked as they are in the predoc clusters
Conscious sedation requires a sedation license in the state of **REDACTED**; therefore we do NO conscious sedation
IV sedation does not result in resident credentialing, but they have exposure during their oral surgery rotations.
PGY-2 residents have a clinical rotation in anesthesia at **REDACTED**
Questions 25, 26, 27 are estimates based on the patient population seen. The **REDACTED** web-based appointment software does not specify all of the criteria above.
Residents receive clinical experiences in conscious sedation techniques primarily with oral and inhalation sedation; experience with intravenous sedation is limited.
Residents receive didactic and clinical experience in nitrous oxide, conscious IV sedation, and oral sedation.
Residents received training in starting IV's, but did so under supervision and did not work towards competencies regarding administering medications
nitrous oxide, oral sedation, moderate conscious IV sedation offered in the residency

29. Indicate the total number of each of the following procedures in Preventive Dentistry completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Prophylaxis (D1110, D1120, D4346, D4355)	0	16,407	609.0	93
b. Topical fluoride treatments (D1026 - D1028)	0	4,116	153.8	93
c. Sealants (D1351, D1353)	0	7,795	148.8	93

30. Indicate the total number of each of the following procedures in Restorative/Operative Dentistry completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Amalgam Restorations (D2140, D2150, D2160, D2161)	0	1,023	29.7	93
b. Anterior composites (D2330, D2331, D2332, D2335)	6	20,124	616.5	93
c. Posterior composites (D2391, D2392, D2393, D2394)	8	66,163	1,557.4	93
d. Single unit crowns (D2710, D2712, D2720-D2722, D2740, D2750-D2753, D2780-D2783, D2790-D2792, D2794)	1	6,369	271.8	93
e. Crown cores (cast or prefabricated) (D2952-D2954, D2957)	0	935	38.6	93
f. Crown core build-up, including pins (preparatory work before crown) (D2950)	0	2,713	136.5	93
g. Inlay/Onlay (D2510, D2520, D2530, D2542-D2544, D2610, D2620, D2630, D2642-D2644, D2650-D2652, D2662-D2664)	0	201	12.1	93

31. Indicate the total number of each of the following procedures in Endodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Single canals (anterior) (D3310, D3346)	0	1,812	64.5	93
b. Double canals (bicuspid) (D3320, D3347)	1	1,608	62.8	93
c. Molars (D3330, D3348)	0	2,070	73.0	93
d. Apicoectomies (D3410, D3421, D3425, D3426)	0	28	1.1	93

Comments from AEGD/GPR Curriculum Section page 4

29a: Residents treatment plan prophylaxis and code appropriately, as per practice supervision of a dental hygienist
31: experience also gained via D3221 (4)
A total of 44 posterior root canals were completed(tracked both bicuspid and molars together)
Core buildups are not coded as they are not charged as per **REDACTED** Medicaid rules. Molar teeth are referred to **REDACTED** due to difficulty after pulpotomy
Does not include the W coded single crowns which would add in a large amount of delivered care
I used codes D1206/1208 to answer 29b and D1354 to answer 29c.
we are amalgam free clinic

32. Indicate the total number of each of the following procedures in Periodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Scaling, root planing and curettage (D4341, D4342, D4346, D4910)	0	11,237	269.2	93
b. Gingivectomies (D4210-D4212)	0	382	15.3	93
c. Soft tissue grafts/gingival flap procedures (D4240, D4241, D4270, D4273, D4275, D4276)	0	145	13.6	93
d. Crown lengthening/Bone grafts/osseous surgery/guided tissue regeneration (D4249, D4260, D4261, D4266, D4267)	0	654	44.1	93
e. Apically repositioned flap (D4245)	0	93	3.9	93
f. Bone replacement graft – first site in quadrant (D4263)	0	380	19.2	93
g. Bone replacement graft – each additional site in quadrant (D4264)	0	150	5.0	93
h. Biologic materials to aid in soft tissue and osseous tissue regeneration (D4265, D4266)	0	364	27.0	93

33. Indicate the total number of each of the following procedures in Removable Prosthodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Units/complete dentures (D5110-D5120)	0	2,741	84.3	93
b. Units/immediate dentures (D5130-D5140)	0	242	13.7	93
c. Units/overdentures (D5863-D5866)	0	895	12.4	93
d. Interim complete dentures (D5810, D5811)	0	169	14.0	93
e. Adjustment to dentures and partials (D5410-D5422)	0	3,105	69.0	93
f. Complete denture repairs (D5511, D5512, D5520)	0	110	9.6	93
g. Repairs to partials (D5611-D5671)	0	464	20.8	93
h. Acrylic partial dentures (D5211-D5212, D5221, D5222, D5225, D5226, D5820-D5821)	0	1,981	59.6	93

i. Conventional cast frame partial frame dentures (D5213-D5214, D5223-D5224)	0	1,501	69.7	93
j. Precision or semi-precision partial dentures attachments (D5862)	0	138	6.3	93

34. Indicate the total number of each of the following procedures in Implant Services completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Surgical placement of implant body (D6010, D6013)	0	1,153	98.1	93
b. Prefabricated abutment (including placement) (D6056)	0	217	12.9	93
c. Custom abutment (including placement) (D6057)	0	539	53.5	93
d. Implant retained Removable Prosthodontics (D6110-D6113)	0	92	5.5	93
e. Implant retained Fixed Prosthodontics (D6058-D6077, D6114-D6117)	0	1,088	73.6	93

Comments from AEGD/GPR Curriculum Section page 5

32-f: includes Code D7953. ridge preservation
32: all residents participated in surgeries as part of a rotation
For 32f code D7953 used to count, For 33j code D5867 + D6191 used to count
Minimal procedures were completed by the one enrolled resident due to significant amount of missed time and subsequent program withdrawal at end of fall semester.
Re Question 32 g. and h.: D7953 (Bone Replacement Graft for Ridge Preservation): 7
We hired board certified periodontist and we are starting to do more Periodontal procedures

35. Indicate the total number of each of the following procedures in Fixed Prosthodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
Units/fixed bridgework (D6205-D6794)	0	2,458	93.2	93

36. Indicate the total number of each of the following procedures in Oral and Maxillofacial Surgery completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Uncomplicated extractions (D7111, D7140, D7210, D7250)	6	44,177	2,034.7	93
b. Extractions of impacted teeth (D7220, D7230, D7240, D7241)	0	824	114.5	93
c. Oral Tissue biopsy (D7285, D7286)	0	63	5.3	93
d. Brush biopsy (D7288)	0	58	0.7	93
e. Surgical removal of lateral exostosis (maxilla or mandible) (D7471)	0	30	1.8	93
f. Surgical reduction of osseous tuberosity (D7485)	0	10	0.3	93
g. Surgical reduction of fibrous tuberosity (D7972)	0	4	0.1	93
h. Incision and drainage (D7510, D7511, D7520, D7521)	0	153	9.5	93
i. Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth (D7270)	0	20	0.7	93
j. Alveoplasties (D7310, D7311, D7320, D7321)	0	585	36.4	93
k. Removal of torus palatinus (D7472)	0	22	0.9	93
l. Removal of torus mandibularis (D7473)	0	71	4.8	93
m. Suture of recent small wounds up to 5 cm (D7910)	0	598	9.2	93
n. Complicated suture, up to 5 cm (D7911)	0	577	6.5	93
o. Complicated suture, greater than 5 cm (D7912)	0	98	1.2	93
p. Frenectomy (D7960)	0	41	2.0	93
q. Excision of hyperplastic tissue – per arch (D7970)	0	11	0.6	93
r. Excision of pericoronal gingiva (D7971)	0	20	1.2	93

Comments from AEGD/GPR Curriculum Section page 6

Complicated Oral surgery procedures were completed during month long Oral surgery Rotation.

D8090 ortho -23 D 8670 D 7921 PRF/LPRF D8040 Limited ortho adult- 16 D 7951 Sinus augment D7953 bone graft 34

Extractions number includes both complicated and uncomplicated. Alveoplasties are not coded as they are performed during extractions

OMS takes codes per hospital guidance. These numbers are the best estimate by pulling management reports and consulting with chief of OMS

Sutures were not tracked

37. How many times during the 2023-24 residency year were formal documented evaluations of resident performance conducted? (Standard 2-15)

Field	Minimum	Maximum	Mean	Count
	2	32	4.0	93

38. Please select the response below that best describes the intended outcomes of residents' education. (Standards 1-8, 1-9, 2-2, 2-3)

	Percentage
Goals and objectives	46.2%
Competencies and proficiencies	53.8%
Total	93

Comments from AEGD/GPR Curriculum Section page 7

REDACTED residents and 4 quarterly evaluations. We discuss Goals, Objectives, and competency/proficiency. This evaluation is not only for the AEGD but also a formal **REDACTED** evaluation process.
Competencies and proficiencis are reflective of program goals and objectives
The program bases the curriculum on the goals and objectives of the program. While competency is desired, it is not the structural basis of how the program is designed.
Two evaluations were completed prior to the **REDACTED**
We use both because we have goals and objectives set with lectures that are followed by clinical practice with competencies as a base line standard that are recorded by faculty and proficiencies that allow the resident to operate more independently under general supervision of the faculty.
While goals and objectives are clearly defined, the resident's competency and proficiency is what helps us to determine how much they have progressed.

2024-25 General Practice Residency Curriculum Survey Results

This report includes data collected in the 2024-25 *Survey of Advanced Dental Education* from 162 advanced dental education programs in general practice residency accredited at the time of the survey. Four programs did not have residents enrolled during the curriculum survey period; data from these programs are not included in this report.

21. What percentage of time did first-year students/residents spend in each of the following areas during the 2023-24 residency year?

Field	Minimum	Maximum	Mean	Count
a. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations)	26.0	90.0	64.9	162
b. Dental inpatient care (management of dental inpatients)	0.0	30.0	4.4	162
c. Management of dental inpatients or same-day surgery patients in the hospital operating room suite	0.0	20.0	5.1	162
d. Rotations/Assignments to other services (non-dental)	0.0	33.0	11.0	162
e. Didactics: courses/lectures/conferences/seminars	1.0	32.0	10.3	162
f. Responding to consults	0.0	15.0	4.0	162
g. Other, please specify	0.0	7.0	0.3	162

g. Other, please specify - Text

Community Service and Domiciliary
Community Service and Research
Conferences and Teaching
Hospital orientation
Literature review/Education
Military Training
Outreach (2)
Prosthetic Clinical Assignment
Research
Service
Teaching
Teaching & Investigative work
Teaching dental students
community service
conferences/seminars
labwork, community service, chart review, administrative work
lectures are after hours, 4 weeks of rotations
mobile dentistry, FQHC Rotation

not sure what falls under b vs. c

22. Please indicate the total number of clock hours residents spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the 2023-24 residency year.

Clock Hours	Minimum	Maximum	Mean	Count
a. Applied pharmacology (Standard 2-2)	0	52	8.4	162
b. Endodontics (Standard 2-2)	0	64	13.7	162
c. Hospital organization and function (Standard 2-10)	0	45	7.1	162
d. Medical risk assessment (Standard 2-6)	0	90	15.0	162
e. Restorative/Operative dentistry (Standard 2-2)	0	137	18.5	162
f. Oral diagnosis/treatment planning (Standard 2-1)	1	156	25.8	162
g. Oral and maxillofacial pathology (Standard 2-4)	0	40	11.2	162
h. Oral and maxillofacial radiology/imaging (Standard 2-1)	0	60	7.6	162
i. Oral and maxillofacial surgery (Standard 2-2)	0	72	15.7	162
j. Pain and anxiety control (Standard 2-2)	0	60	11.8	162
k. Patients with special needs (Standard 2-1)	0	62	8.9	162
l. Periodontics (Standard 2-2)	0	88	14.0	162
m. Physical evaluation (Standards 2-6, 2-7)	0	109	14.1	162
n. Practice management (Standard 2-10)	0	95	12.3	162
o. Preventive dentistry (Standard 2-1)	0	58	6.4	162
p. Restoration of edentulous space (Standard 2-2)	1	157	19.0	162
q. Other, please specify	0	265	11.5	162

q. Other, please specify - Text

12 hours literature review
ACLS, PALS, BLS
Conscious Sedation
Conscious Sedation, Oral Biomaterials
Dental Forensics, Sleep Apnea, Implant Dentistry, Oral Facial Pain & TMD
Ethics (2)
Ethics and Professionalism
Ethics-2 hours, TMD/Facial Pain-6 hours
Evidence Based Dentistry
Forensic Dentistry
Forensics
Implant Dentistry
Implant Lecture Series
Implant Training
Implant placement and restoration

q. Other, please specify - Text

Implants (2)
Implants & Prosthodontics
Innovations in Dentistry
Journal Club, Grand Rounds, Dental Service Orientation
Journal Club, Oregon Dental Conference, Kahoot Quizzing, Mortality and Morbidity Conference, Lectures on medical and dental topics not specified above
Journal Club-varying topics, radiation oncology, TMD, sleep medicine, ethics, management of dental emergencies
Lectures pertaining to orthodontics, implantology, orofacial pain and TMD, pediatrics
Literature review
Management of Dental & Medical Emergencies
Medically Complex Patients
OFP/TMD/Sleep 10, Case Review 35, Cultural Complications 6, Dental Trauma 2, Patient Safety 2, Literature Review 10, M&M 4, Wellness 2
Oncology
Oral medicine, Oral Facial Pain
Organized Dentistry, Teaching Methods, Managing Hospital Calls
Orthodontic Assessment
Orthodontics
Orthodontics/TMJ and Occlusion
Outcomes
Pediatric Dentistry
Pediatric Dentistry, Joint Restorative/Surgical Implant, Risk Management
Pediatric lectures, ortho lectures, Ethics, Evidence Based Dentistry courses ..
Professionalism and Ethics
Prosthodontic topics
Research
Research/Librarian Services
Residents receive training in emergency dental visits, radiology and medicine and how it relates to dentistry
Risk Management, Ethics and professionalism
SBIRT
Sleep Apnea
Sleep Medicine, Implants
Sleep Medicine/ Airway
Sleep and Snore Appliance Therapy, Evidence Based Dentistry, Ethics, Dental Photography, Botox Administration, Minor Adult Orthodontics and Clear Aligner Therapy
TMD
TMD Orofacial Pain
TMD/Splint Therapy
TMJ/Facial pain/sleep medicine
Use of Cone Beam CT/Implant Planning

q. Other, please specify - Text

Wellness
elective
implantology
informed consent/ethics/patient advocacy/medical records
laser usage
medicine
oral medicine
orofacial pain, orthodontics
orthodontics 10,pediatric dentistry 6
sleep 4, tmd 4, anesthesia 6, informatics 2, trauma informed care/social determinants of health 3, dental trauma 9
special needs dentistry
various other practice management and practice related topics

Comments from AEGD/GPR Curriculum Section page 1

32 hours of hospital organization/function because of orientation - HR, policies, software integration, etc.
For Q#22, these are best estimates, as these topics are covered by our core courses, program level courses, and supplemented by institution-wide grand rounds.
I like this new question with standard breakdown. We will work to count more even accurately for next year's survey.
Includes lectures, courses, and literature review seminars
Lectures are given at least 3 times a week. Some are hands one and others are purely lectures. Residents are encouraged to attend and discuss cases they are treating
Orofacial pain 12 hrs Orthodontics 4 hrs
didactic hours and lectures are performed by the dental attending staff as well as on line courses and in orientation to the hospital prior to their beginning in dental orientation.

23. Indicate all rotations/assignments to non-dental services in either the sponsoring or affiliated institutions required of the residents.

Length of rotation/assignment (in weeks)	Minimum	Maximum	Mean	Count
a. Anesthesia (GPR Standard 2-5)	1	16	2.6	162
b. Medicine (GPR Standard 2-6)	0	30	2.1	162
c. Emergency Department (Standard 2-6)	0	52	3.9	162
d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5)	0	52	1.9	115

Average hours per week	Minimum	Maximum	Mean	Count
a. Anesthesia (GPR Standard 2-5)	5.0	80.0	38.9	162
b. Medicine (GPR Standard 2-6)	0.0	80.0	31.2	162
c. Emergency Department (Standard 2-6)	0.0	85.0	29.4	162
d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5)	0.0	80.0	16.8	115

d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5) - Text

Cardiology (2)
Community Dentistry/Oral Surgery
Community Service
Conscious Sedation
Dental Emergency Clinic
ENT (5)
Ear, nose and throat
Endo, Ortho
GPR Standard 2-8, AEGD Standard 2-5, Oral Surgery
GPR standard 2-8, Head and Neck)
Geriatric
Head & Neck Oncology
Hospital dentistry(HD)
Hyperbaric med, ENT H/N Rad-Onc
Infectious diseases
Multidisciplinary
OMFS (2)
OMS, Radiology, Pathology
ORL
On call/ Emergency
Oral & Maxillofacial Surgery

d. Other, please specify (GPR Standard 2-8, AEGD Standard 2-5) - Text

Oral Oncology, Special Needs
Oral Pathology
Oral Surgery (2)
Oral Surgery Rotation
Oral Surgery and Maxillofacial Rotation
Oral Surgery, 8 weeks
Oral and Maxillofacial Surgery 4 weeks, Orofacial Pain/TMD/Sleep Dentistry 2 weeks, ISCC Once a week
Otolaryngology
PHLEBOTOMY
Pathology (2)
Pediatric Dentistry OR
Pediatric Department
Pediatric Medicine
Psych/Radiology
Radiation Oncology and Medical Oncology for 2nd year residents
Radiology
Sleep Medicine
Special Care Dentistry
Special Services
Surgery 1week/Radiation Oncology 1 week
VIP Clinic
elective
oral pathology, radiation oncology, radiology
pathology and radiology
specialty clinic

24. Provide the following dental clinic statistics related to outpatient visits for the 2023-24 residency year. Include statistics for both sponsoring and affiliated institution(s). (Standard 2-1)

Number of visits	Minimum	Maximum	Mean	Count
a. Total number of outpatient visits to the dental clinic (include screening/consultative visits)	89	137,283	13,898.7	162
b. Total number of outpatient visits managed by the residents	90	52,378	7,204.5	162

25. How many patients with special needs did the residents treat during the 2023-24 residency year? (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
	0	9,000	1,080.6	162

Comments from AEGD/GPR Curriculum Section page 2

23(c). residents are on-call to the ED approximately 10 days each month (total of 17.3 weeks per year) hourly commitment varies by patient need. 25. Number listed indicates patients seen in the operating room. In the clinic, residents also see many patients with complex medical histories and other special treatment considerations.
25 - is currently difficult to quantify with our current methods
62 patients were for OR treatment
For question 23: Our residents see emergency patients once a week for a 3-4 hour rotation.
I estimate that at least 90% of our patients that we see in our GPR hospital and **REDACTED** clinic meet the definition of special needs provided and require some modification to their treatment.
Medicine Rotation requirement is met through two week Otolaryngology rotation and one week ED rotation.
Oral Pathology rotation instituted spring 2025 Number of special needs patients= number of cases seen in the operating room setting. Does not account for medically complex patients seen in the outpatient setting.
Q#23: One of the two weeks of the 'Medicine ' rotation is in the Emergency Department. Q#25: We are a **REDACTED** facility. Almost all of the patients we see could be classified as special needs. Therefore, the number provided is 90% of the total number of unique patients they treated (1150).
Residents do a rotation in the Sleep Center - 1 week, 16 hours per week
Special Needs are defined as patients with an ASA classification equal to II or III.
Special needs patients is an approximate number (Question 25)
Statistics this year are for ONE resident **REDACTED**
The division saw a decrease in the overall number of hygiene patient seen due to staffing issues. Thus translating to a decrease in the number of special needs individuals typically seen.
These are estimates as there were input errors caused by how the dental clinic software tracks visit. The initial number of visits is treatment numbers and part b was decrease by a factor of 3.
This number is approximated as roughly 30% of our patients fall into the categories of 'special needs', including patients with developmental disabilities, extensive medial conditions/problems and medications, drug users and abusers, HIV, cancer therapies, diabetes, liver and kidney disease, pregnancy and even homeless.
REDACTED dental patients have complex medical problems and many with significant physical limitations.
We do not categorize special needs patients in our service.
We do not identify our DDC/disabled patients by code. We see several a day. Our population is large. We provide OR services for those who cannot be treated in the dental chair.
We see 6 special needs patients a week, in average. Considering 47 weeks, that goes to 270.
We were not able to get an exact number. However, most of the patients who are managed by the residents in the clinic or the operating room are medically, mentally, or physically compromised patients.
operating room special needs cases only included here
pathology and radiology are 1 week each for 20 hours

26. How many patients did residents provide comprehensive care to, from treatment plan to completion (as opposed to episodic or emergency care), during the 2023-24 residency year? (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
	14	34,927	1,623.8	162

27. Provide the following emergency care statistics for the 2023-24 residency year identifying the activity level(s) at both the sponsoring and affiliated institution(s). (Standard 2-1)

Field	Minimum	Maximum	Mean	Count
a. The number of dental emergencies treated in the dental clinic by residents				
Sponsoring institution	0	7,856	978.2	160
Affiliated institution(s)	0	1,926	96.5	99
b. The number of dental emergencies treated in the hospital emergency department by all residents				
Sponsoring institution	0	4,742	322.3	161
Affiliated institution(s)	0	815	29.3	99

28. In which of the following conscious sedation techniques did residents receive instruction and clinical experience during the 2023-24 residency year? (Standard 2-2g)

Instruction	Yes	No	Total
a. Oral	92.0%	8.0%	162
b. Inhalation	94.4%	5.6%	162
c. Intramuscular	56.2%	43.8%	162
d. Intravenous	85.8%	14.2%	162
e. Intranasal	46.3%	53.7%	162
f. Other, please specify	3.1%	96.9%	162

Clinical experience	Yes	No	Total
a. Oral	80.2%	19.8%	162
b. Inhalation	86.4%	13.6%	162
c. Intramuscular	27.2%	72.8%	162
d. Intravenous	70.4%	29.6%	162
e. Intranasal	23.5%	76.5%	162
f. Other, please specify	2.5%	97.5%	162

f. Other, please specify - Text

Deep/Moderate sedation
General Anesthetic
Hypnosis
Monitoring anesthesia care
accidentally selected field
during OS and anesthesia rotations

Comments from AEGD/GPR Curriculum Section page 3

26. No software on hand to gather this answer, it is based on patients going into periodic exams. 27. Residents only stabilize patients in the ER until treatment can be made in the dental clinic.

27b. This number reflects emergency patients treated in the ER by dental residents only (not hospital-wide stat)

28d. Clinical experience during oral surgery rotation: observation of IV sedation administered by oral surgery residents.

344 Deep/Moderate Sedation procedures

Affiliated institution is when they take call at **REDACTED** dental clinic.

Again - it will take our program some time to get accurate numbers for these newer survey questions

Experience was done during hospital rotation in anesthesia

GPR Residents operate on patients receiving general anesthesia. GPR residents receive instruction on general anesthesia during their 3 week anesthesiology rotation.

Our residents do not take call after hours.

Please note, many emergencies from the hospital ED, during working hours, are immediately sent to the dental clinic.

Q#26: This number was calculated by taking the number of total comprehensive exams and subtracting the number of patients given to the following class for completion of care. This did not include periodic and limited oral exams. Q#27a: This number was calculated by the number of limited exam completed. All residents not on a rotation have one hour daily for triage of 'walk-in' emergencies and one resident per day has one hour to for treatment of 'walk-in' emergencies.

Regarding comprehensive care, I added up the total numbers of Code D0150, comp exam completed by residents. For dental emergencies, I added up the limited exams numbers seen by the residents. D0140 Code. For the in ED, I estimated the number to be 300, given residents report to ED almost every day, and had to provide care. The oral sedation clinic started last year, and residents have already been exposed to sedation lectures. They now have the opportunity to treat patients under IV sedation, with an attending faculty.

Residents learn about these techniques during their anesthesia rotation. We provide Nitrous Oxide techniques at the dental clinic.

These techniques are observed during the 2 week Anesthesia Rotation (70 hours)

We do not have an easy way to identify patients treated 'from treatment plan to completion' so number provided is number of comprehensive exams performed so is only a rough estimate. This will not capture patients 'inherited' from prior classes nor are we able to differentiate those patients who did not continue with care after initial exam. The numbers for emergencies treated in clinic are also an estimate-we currently do not have a specific code or designation to identify 'emergency' patients. We do not have a way to pull number of patients seen in the emergency room so this is also a rough estimate.

We use nitrous in the dental center. All GA are done in the OR, for our medically high-risk patients

approximate 2500 per resident

dental residents who go to the Operating room on our Hospital dentistry rotation get training in IM, IN IV sedation techniques for general anesthesia cases and with pediatric dentistry patients oral sedation is provided.

exposure to all types during anesthesia, oral surgery and ENT rotations

single dose anxiolysis and N20 only

29. Indicate the total number of each of the following procedures in Preventive Dentistry completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Prophylaxis (D1110, D1120, D4346, D4355)	0	15,340	681.9	162
b. Topical fluoride treatments (D1026 - D1028)	0	2,400	211.0	162
c. Sealants (D1351, D1353)	0	3,024	134.4	162

30. Indicate the total number of each of the following procedures in Restorative/Operative Dentistry completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Amalgam Restorations (D2140, D2150, D2160, D2161)	0	2,807	72.5	162
b. Anterior composites (D2330, D2331, D2332, D2335)	0	6,804	500.2	162
c. Posterior composites (D2391, D2392, D2393, D2394)	37	8,674	984.7	162
d. Single unit crowns (D2710, D2712, D2720-D2722, D2740, D2750-D2753, D2780-D2783, D2790-D2792, D2794)	2	3,222	180.1	162
e. Crown cores (cast or prefabricated) (D2952-D2954, D2957)	0	1,100	39.2	162
f. Crown core build-up, including pins (preparatory work before crown) (D2950)	0	1,000	77.5	162
g. Inlay/Onlay (D2510, D2520, D2530, D2542-D2544, D2610, D2620, D2630, D2642-D2644, D2650-D2652, D2662-D2664)	0	271	6.2	162

31. Indicate the total number of each of the following procedures in Endodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Single canals (anterior) (D3310, D3346)	0	901	58.2	162
b. Double canals (bicuspid) (D3320, D3347)	0	1,418	48.4	162
c. Molars (D3330, D3348)	0	1,974	55.6	162
d. Apicoectomies (D3410, D3421, D3425, D3426)	0	180	1.9	162

Comments from AEGD/GPR Curriculum Section page 4

29b - used codes D1206, D1208

3221 pulpal debridement 6 procedures; 3110 pulp caps direct 22 procedures; 3120 pulp caps indirect 104 procedures

Does not include production from one **REDACTED** rotation due to change in computer system (tech issues), and leadership (personnel issues).

During a portion of 2023/2024 academic year GPR general dentistry clinic did not have a Dental Hygienist. GPR residents were completing the prophylaxis treatment for the patients as needed. That explains the atypically high number of prophy procedures completed. That Dental Hygiene position has now been filled and GPR residents are not routinely completing prophylaxis treatment in clinic. Residents do complete full mouth debridement, and prophy in the Operating Room and our Hospital Clinic for special needs patients.

Each special needs patient taken to the OR for general dentistry has a prophylaxis and fluoride completed by the residents so the numbers for these procedures correlates to the number of special needs general dentistry OR cases plus those completed in the outpatient clinic.

I tried to enter and advance but the software would not allow me to advance. Maybe next time.

Numbers may be slightly skewed due to incorrect coding of procedures.

Question 29 C includes Application of Caries Medicament per tooth (D1354)

Section 29-31: not included in the statistics are procedures performed during the operating room adult and child rehabilitation cases.

Staff endodontist left in Q1. Replacement has been recruited and begins shortly

The residents does not get the credit for epicoectomies, but assist during the procedures while on rotation in Perio and Oral surgery

This data for us is an estimate and will be more accurate next year.

We do not bill fluoride treatment separate from the prophy

We don't use amalgam in our clinic.

We have 2 full time hygienists and our residents are doing fewer prophy's, fl. tx. and sealants.

residents also work with endodontist every Wednesday during dental rotation. partial completion, assisting and observation of many more endo cases during the year.

32. Indicate the total number of each of the following procedures in Periodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Scaling, root planing and curettage (D4341, D4342, D4346, D4910)	0	7,560	251.6	162
b. Gingivectomies (D4210-D4212)	0	74	5.7	162
c. Soft tissue grafts/gingival flap procedures (D4240, D4241, D4270, D4273, D4275, D4276)	0	50	5.0	162
d. Crown lengthening/Bone grafts/osseous surgery/guided tissue regeneration (D4249, D4260, D4261, D4266, D4267)	0	152	14.6	162
e. Apically repositioned flap (D4245)	0	64	1.8	162
f. Bone replacement graft – first site in quadrant (D4263)	0	242	13.3	162
g. Bone replacement graft – each additional site in quadrant (D4264)	0	100	2.4	162
h. Biologic materials to aid in soft tissue and osseous tissue regeneration (D4265, D4266)	0	6,162	52.9	162

33. Indicate the total number of each of the following procedures in Removable Prosthodontics completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Units/complete dentures (D5110-D5120)	2	3,443	116.9	162
b. Units/immediate dentures (D5130-D5140)	0	159	11.4	162
c. Units/overdentures (D5863-D5866)	0	195	5.0	162
d. Interim complete dentures (D5810, D5811)	0	200	8.8	162
e. Adjustment to dentures and partials (D5410-D5422)	0	852	80.8	162
f. Complete denture repairs (D5511, D5512, D5520)	0	756	17.2	162
g. Repairs to partials (D5611-D5671)	0	293	19.9	162
h. Acrylic partial dentures (D5211-D5212, D5221, D5222, D5225, D5226, D5820-D5821)	0	1,221	64.1	162
i. Conventional cast frame partial frame dentures (D5213-D5214, D5223-D5224)	0	4,298	81.2	162
j. Precision or semi-precision partial dentures attachments (D5862)	0	75	3.2	162

34. Indicate the total number of each of the following procedures in Implant Services completed by residents during the 2023-24 residency year.

Number of procedures	Minimum	Maximum	Mean	Count
a. Surgical placement of implant body (D6010, D6013)	0	241	37.4	162
b. Prefabricated abutment (including placement) (D6056)	0	80	7.8	162
c. Custom abutment (including placement) (D6057)	0	1,035	27.9	162

d. Implant retained Removable Prosthodontics (D6110-D6113)	0	100	4.6	162
e. Implant retained Fixed Prosthodontics (D6058-D6077, D6114-D6117)	0	1,369	42.8	162

Comments from AEGD/GPR Curriculum Section page 5

32h: The D4265 (biologic materials to aid in soft tissue regeneration) code was being used incorrectly to code for D7922 (intra-socket biologic dressing). This has been corrected. The realistic number of D4265 procedures would have been 0.
GPR residents routinely restore dental implants. Periodontal and OMFS residents place implants.
Implant course for 2023-2024 for placement of implants was rescheduled by the provider and residents will attend next course. Residents usually place 2 each during the course.
Numbers may be slightly skewed due to incorrect coding of procedures.
Question 33 G - Includes Prtl Dent Add Tooth (D5650)
Re: 32-C This facility does NOT code separately for these (they're included as other procedures)
Residents work with periodontist every Wednesday during dental rotation - perio surgeries were done under his supervision. residents also assisted and observed many perio procedures/surgeries during time spent with periodontist.
Section 33: Patients usually require at least one denture adjustment after a delivery of a complete or partial denture. We use a 'no charge' code for this to ensure no charge is incurred to the patient. Thus, the denture adjustments are not accurately tracked by the D5410-5422 statistics.
Sleep appliance - 6; D4355 added to 32a - 5; D7953 added to 32f - 55
The number of overdentures on implants, bone replacement grafts precision attachments and crown lengthening procedures and implant bridges should be reflected higher . possibly improper coding, this needs to be investigated.
These only reflect outpatient procedures, not procedures completed in the operating room setting.
This class of GPR Residents was possibly the best class we have had since I have been here. They were hard working, intentional, and eager to learn. They utilized all the resources we work so hard to provide for the care of our patients.
We have a Periodontist that comes in 4 hours a month but are planning to increase a few more hours per month to help residents with more training in Periodontics.
We just hired a board certified periodontist and we are starting to perform more periodontal procedures including clinical crown lengthening.

35. Indicate the total number of each of the following procedures in Fixed Prosthodontics completed by residents during the 2023-24 residency year.

Field	Minimum	Maximum	Mean	Count
Units/fixed bridgework (D6205-D6794)	0	774	57.3	162

36. Indicate the total number of each of the following procedures in Oral and Maxillofacial Surgery completed by residents during the 2023-24 residency year.

Field	Minimum	Maximum	Mean	Count
a. Uncomplicated extractions (D7111, D7140, D7210, D7250)	23	8,200	1377.7	162
b. Extractions of impacted teeth (D7220, D7230, D7240, D7241)	0	756	43.4	162
c. Oral Tissue biopsy (D7285, D7286)	0	120	8.9	162
d. Brush biopsy (D7288)	0	11	0.1	162
e. Surgical removal of lateral exostosis (maxilla or mandible) (D7471)	0	33	2.2	162
f. Surgical reduction of osseous tuberosity (D7485)	0	203	1.8	162
g. Surgical reduction of fibrous tuberosity (D7972)	0	19	0.4	162
h. Incision and drainage (D7510, D7511, D7520, D7521)	0	2,174	41.6	162
i. Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth (D7270)	0	152	9.4	162
j. Alveoplasties (D7310, D7311, D7320, D7321)	0	831	36.8	162
k. Removal of torus palatinus (D7472)	0	9	0.5	162
l. Removal of torus mandibularis (D7473)	0	197	5.0	162
m. Suture of recent small wounds up to 5 cm (D7910)	0	2,690	35.1	162
n. Complicated suture, up to 5 cm (D7911)	0	783	10.7	162
o. Complicated suture, greater than 5 cm (D7912)	0	75	1.5	162
p. Frenectomy (D7960)	0	20	1.3	162
q. Excision of hyperplastic tissue – per arch (D7970)	0	75	1.5	162
r. Excision of pericoronal gingiva (D7971)	0	57	2.7	162

Comments from AEGD/GPR Curriculum Section page 6

7922 Intra-socket biologicals 727 procedures; 7953 Bone graft 3 procedures

Again, these numbers only reflect procedures completed in the outpatient clinic, not sedation, OR settings, or emergency room settings.

Although many of the surgical procedures are not performed by the residents, they assist and receive training in the areas while on rotation in Oral Surgery

Incision and Drainage is largely performed in the Emergency Department when on-call. The number above are those performed in the clinic. The approximate number in the ED is >50.

Numbers may be slightly skewed due to incorrect coding of procedures.

Our residents complete most Oral Surgery procedures during their 3-week rotation at **REDACTED** and in the OR at **REDACTED** These numbers are not reflected, as these reports are solely based on the out-patient dental clinic.

RE 35. 10 per resident at **REDACTED**

Residents do numerous cases of facial and oral laceration repairs (complicated or non-complicated suture) and management of dental trauma (such as reimplantation of avulsed teeth and splinting) and also incision and drainage at ER every year. However, since they are performed at the hospital ER not at the clinic, they are not recorded under ADA codes. Thus, we have to put 0 for these procedures in this list.

Section 36: statistics do not include experiences during oral surgery rotation and experiences in the ED.

Some experiences with Surgical removal of lateral exostosis, torus palatinus and torus mandibularis where performed by the residents with the Oral Surgeon in the Minor Procedure Clinic.

Suturing of lacerations is done in the Emergency Room. Not recorded on our clinic report.

The figures for D7270, D7910, D7911, and D7912 are under-reported as we do not routinely track these procedures.

The residents spend 8 weeks in the Oral Surgery Department. No tally is kept of how many procedures were performed by the resident during their time there. However, the residents do go to the OR and do extractions as well as extractions in the out-patient clinic.

Where resident numbers are 0, such procedures are observed or residents act as an assistant during the OMFS rotation and service volumes are captured under the OMFS attending.

includes hospital procedures

37. How many times during the 2023-24 residency year were formal documented evaluations of resident performance conducted? (Standard 2-15)

Field	Minimum	Maximum	Mean	Count
	2	319	5.5	162

38. Please select the response below that best describes the intended outcomes of residents' education. (Standards 1-8, 1-9, 2-2, 2-3)

	Percentage
Goals and objectives	64.8%
Competencies and proficiencies	35.2%
Total	162

Comments from AEGD/GPR Curriculum Section page 7

Goals and objectives are used as well.
Question 37 - Formal evaluations are conducted 3 times per year for each resident.
The GPR residents are given quarterly feedback from there attendings regarding Competencies and Proficiencies
We primarily focus on the Goals and Objectives of the program but do utilize Competency and Proficiency measures as well to measure progress through the year.
We use both competencies and proficiencies as well as goals and objectives. they are both needed to achieve expected results.
While we have goals and objectives for each rotation, there are competencies that we give our residents in the GP clinic on stated procedures to establish that each resident is competent in the area that is deemed important in General Dentistry.
we used both, but the overarching outcomes are determined by g/o.

CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY RELATED TO THE OPTIONAL SECOND YEAR

Background: At its Summer 2023 meeting, the Review Committee on Postdoctoral General Dentistry Education (PGD RC) briefly discussed the optional second year that may be offered by advanced education in general dentistry (AEGD) and general practice residency (GPR) programs, and noted the primary requirement is that the written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training must be at a higher level than those of the first year of the program. Through discussion it was noted that some programs have designed the curriculum in the optional second year to focus on gaining additional experience in advanced general dentistry procedures beyond that gained through the first year of the program. The PGD RC also noted that some programs have designed the curriculum of the optional second year to focus on gaining training and experience in specific areas of dentistry, such as endodontics or oral and maxillofacial surgery as well as additional experiences in treating a select population of patients, such as patients with special needs or geriatric patients. However, these programs have minimal expectations that residents also gain additional experiences in other advanced general dentistry treatment. No matter the specific focus, the PGD RC believed the optional second year should include experience in all areas of advanced general dentistry and may additionally include more focused training and experience in specific areas of dentistry or in treating select populations. Therefore, the PGD RC believed the Accreditation Standards related to the optional second year should be reviewed for possible revision to clarify the intent and expectations of the optional second year.

At its Winter 2024 meeting, the Review Committee on Postdoctoral General Dentistry Education reviewed the Accreditation Standards related to the optional second year for Advanced Education in General Dentistry programs and General Practice Residency programs for possible revision. Following lengthy discussion, the PGD RC concluded that the Accreditation Standards related to the optional second year should be revised to clarify that the optional second year must include experience in all areas of advanced general dentistry and may additionally include more focused training in specific areas of dentistry or in treating select populations. The PGD RC discussed the most effective way to provide the clarification, including revision to GPR and AEGD Standard 2-2, which lists the areas of dentistry that must be included in the program's curriculum or revision to the Standards that specifically address the optional second year in the AEGD Standards (Standard 2-13) and GPR Standards (Standard 2-17).

The PGD RC concluded the revisions should be made to AEGD Standard 2-13 and GPR Standard 2-17**.** Additionally, the PGD RC believed circulation of the revisions to the communities of interest for a period of six (6) months is warranted and sufficient because the revisions were clarifying in nature rather than a substantial requirement change. Therefore, the PGD RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice

Residency be circulated to the communities of interest for review and comment for a period of six (6) months with a Hearing conducted in conjunction with the March 2024 American Dental Education Association (ADEA) Annual Session, with comments reviewed at the Commission's Summer 2024 meetings. The Commission concurred with the recommendation of the PGD RC and directed circulation of the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice Residency to the communities of interest for review and comment for a period of six (6) months.

At its Summer 2024 meeting, the Postdoctoral General Dentistry Education Review Committee considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice Residency. The Review Committee also considered all comments received by the Commission prior to the June 1, 2024 deadline**.**

The Review Committee noted that following circulation of the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry, the Commission received no (0) comments at the virtual hearing in conjunction with the 2024 ADEA meeting. The Commission office received three (3) written comments prior to the June 1, 2024 deadline. Further, following circulation of the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency, the Commission received one (1) comment at the virtual hearing in conjunction with the 2024 ADEA meeting. The Commission office received 30 written comments prior to the June 1, 2024 deadline.

The PGD RC reviewed all comments received and noted that many of the comments expressed concern that implementing the proposed revisions will create an unnecessary burden and hardship on the institutions and programs that offer a "focused" optional second year and that implementing the proposed revisions will limit educational opportunities for residents. Further, the PGD RC noted comments that indicated that residents may choose to apply for the optional second year seeking additional clinical experiences in specific areas of dentistry in which they do not feel ready to practice independently. Some comments also indicated that most of the graduates of the "focused" optional second year programs become practicing general dentists.

Through discussion, the PGD RC maintained that the intent of the optional second year is to provide opportunity for residents to gain additional and continued experience in advanced general dentistry procedures beyond that gained through the first year of the program. Further, the PGD RC believed that the curricula for programs that provide focused training and experience in specific areas of dentistry, or additional experiences in treating a select population of patients, should also include continued experiences in other areas of advanced general dentistry.

Following lengthy discussion, the PGD RC concluded that the proposed revisions warrant modification, based on the comments received, to allow flexibility, yet ensure that the optional second year includes continuing experiences in advanced general dentistry. To that end, the

PGD RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and Accreditation Standards for Advanced Dental Education Programs in General Practice Residency be circulated to the communities of interest for review and comment for a period of six (6) months with a Hearing conducted in conjunction with the October 2024 American Dental Association (ADA) Annual Session, with comments reviewed at the Commission's Winter 2025 meetings.

At its Summer 2024 meeting, the Commission concurred with the PGD RC and directed circulation of the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry (**Appendix 1)** and the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency **(Appendix 2)** to the communities of interest for review and comment for a period of six (6) months, with a Hearing conducted in conjunction with the October 2024 American Dental Association Annual Session, with comments reviewed at the Commission's Winter 2025 meetings.

Following circulation of the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry, the Commission received and no (0) comments at the virtual hearing in conjunction with the ADA meeting. The Commission office received six (6) written comments prior to the December 1, 2024 deadline **(Appendix 3)**. In addition, five (5) individuals initiated but did not complete or submit a comment.

Following circulation of the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency, the Commission received no (0) comments at the virtual hearing in conjunction with the ADA meeting. The Commission office received seven (7) written comments prior to the December 1, 2024 deadline **(Appendix 4)**. In addition, four (4) individuals initiated but did not complete or submit a comment.

Summary: At this meeting, the PGD RC and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry **(Appendix 1)** and General Practice Residency **(Appendix 2**) and all comments received prior to the December 1, 2024 deadline (**Appendices 3 and 4**)**.** If further revisions are warranted, the Commission may wish to circulate the modified revisions to the communities of interest for an additional comment period. Alternatively, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

Recommendation:

Prepared by: Ms. Peggy Soeldner

Commission on Dental Accreditation

At its Summer 2024 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2024, for review at the Winter 2025 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_8CuJce7nLbEhgod

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry

STANDARD 2 - EDUCATIONAL PROGRAM

2-11 Programs **must** be designed as either a one-year program, a one-year program with an optional second year or a mandatory two-year program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident training
Written curriculum plan
Schedules

2-12 Residents enrolled in the optional second year of training **must** have completed an accredited first year of Advanced Education in General Dentistry or General Practice Residency training at this or another institution.

Examples of evidence to demonstrate compliance may include:
Resident records or certificate

2-13 The program **must** have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program. The optional second year **must** include continuing experience in advanced general dentistry and may include more focused training and experience in other areas of dentistry or in treating select populations.

Intent: *The optional second year will have continuing experiences in the areas of advanced general dentistry.*

Commission on Dental Accreditation

At its Summer 2024 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in General Practice Residency be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2024, for review at the Winter 2025 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_0d2IXnuLZoCiPaJ

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in General Practice Residency

STANDARD 2 - EDUCATIONAL PROGRAM

2-15 Programs **must** be designed as either a one-year program, a one-year program with an optional second year or a mandatory two-year program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident training
Written curriculum plan
Schedules

2-16 Residents enrolled in the optional second year of training **must** have completed an accredited first year of a General Practice Residency or Advanced Education in General Dentistry training at this or another institution.

Examples of evidence to demonstrate compliance may include:
Resident records or certificate

2-17 The program **must** have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program. The optional second year **must** include continuing experience in advanced general dentistry and may include more focused training and experience in other areas of dentistry or in treating select populations.

Intent: *The optional second year will have continuing experiences in the areas of advanced general dentistry.*

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Wednesday, November 13, 2024 4:52:17 PM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

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Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for Advanced Education in General Dentistry programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	David
Last Name	MacPherson
Email	[redacted]
Title	AEGD Program Director

Q3. Please select one of the following options that best describes you or your organization:

- College/University

Q4. Is this an official comment from your organization?

- No. This is a personal comment.

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

AEGD Standard 2-13

Q6. Do you agree with the proposed revision?

- Agree

Q7. Enter your comment. Type or copy and paste in the text box below.

The revision is ideal for Optional 2nd Year Programs, and formalizes the ability to include a focus within the 2nd Year, such as Treating Patients with Special Needs, or added training and experience in Oral Surgery.

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Wednesday, November 13, 2024 6:13:45 PM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

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Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for Advanced Education in General Dentistry programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Annette
Last Name	Puzan
Email	[redacted]
Title	Manager, Dental Education and Licensure

Q3. Please select one of the following options that best describes you or your organization:

- Other (Please specify):
  Council on Dental Education and Licensure (CDEL)

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  Council on Dental Education and Licensure (CDEL)

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry, Standard 2-13

Q6. Do you agree with the proposed revision?

- Agree

Q7. Enter your comment. Type or copy and paste in the text box below.

The following comment is being submitted on behalf of the ADA Council on Dental Education and Licensure by Dr. Jason A. Tanguay, chair:

A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, via a November electronic ballot, the Council considered and supported the proposed change to Standard 2-13 of the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry. The Council appreciates the opportunity to submit comment on this important document.

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Friday, November 22, 2024 6:05:51 PM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

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Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for Advanced Education in General Dentistry programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Kent
Last Name	Weitzel
Email	[redacted]
Title	General Dentist

Q3. Please select one of the following options that best describes you or your organization:

- Dental/Healthcare Professional

Q4. Is this an official comment from your organization?

- No. This is a personal comment.

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Standard 2-11, page 2, line 3: Standard 2-13, page 2, lines 21 and 22

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

Standard 2-11, page 2, line 3 after "one-year program" add which must include assessing, diagnosing, and treating special healthcare needs patients"
Standard 2-13, page 2, line 21 strike the word "may" and change to "must"
Standard 2-13, page 2 , line 22 strike the word "or" and change to "must"
Standard 2-13, page 2, line 22 after the word populations add "including patients with special healthcare needs"

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Thursday, November 28, 2024 11:41:46 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

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Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for Advanced Education in General Dentistry programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Suzanne
Last Name	Weitzel
Email	[redacted]
Title	Physical Therapist/ Dental Administrator

Q3. Please select one of the following options that best describes you or your organization:

- Dental/Healthcare Professional

Q4. Is this an official comment from your organization?

- No. This is a personal comment.

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Standard 2-11, page 2, line 3; Standard 2-13, page 2, lines 21 and 22

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

Standard 2-11, page 2, line 3 after “one-year program” add “which must include assessing, diagnosing, and treating special healthcare needs patients”
Standard 2-13, page 2, line 21 strike the word “may” and change to “must”
Standard 2-13, page 2, line 22 strike the word “or” and change to “must”
Standard 2-13, page 2, line 22 after the word “populations” add “including patients with special healthcare needs”

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Thursday, November 28, 2024 9:47:34 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

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URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Geraldine
Last Name	Edrei
Email	[redacted]
Title	Dentist

Q3. Please select one of the following options that best describes you or your organization:

- Other (Please specify)

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  Edrei Global Services

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc_ Standard Page 37
Standard 2-11 line 7

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

Include adults including those with Intellectual Developmental Disabilities,
and geriatric patients.

Q8. Do you have additional comment?

- YES, I have additional comment.

Q9. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc_Standard
Page 38
Standard 2-12 – line 13 (#9)
Page 38- #d
Line 41 – #2.
Line 43

Q10. Do you agree with the proposed revision?

- Disagree

Q11. Enter your comment. Type or copy and paste in the text box below.

Page 38
Standard 2-12 – line 13 (#9) including referrals after clinical assessment when indicated.
Page 38- #d (Practice and Profession)
Line 41 – #2. Recognition, management, and clinical assessment of patients with IDD.
Line 43 - referral after clinical assessment.

Q12. Do you have additional comment?

- YES, I have additional comment.

Q13. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc Standard.
Page 39 – Line 21 (#9).
Page 39- Line 43 #d
Line 45 #2
Page 40 –
Page 40 Standard 2-14 #a Line 29

Q14. Do you agree with the proposed revision?

- Disagree

Q15. Enter your comment. Type or copy and paste in the text box below.

Page 39 – Line 21 (#9). referral after clinical assessment
Page 39- Line 43 #d (Practice and Profession)
Line 45 #2 Recognition, management, and clinical assessment of patients with IDD.
Page 40 – Line 1 (#2) referral after clinical assessment
Page 40 Standard 2-14 #a Line 29 referral after clinical assessment

Q16. Do you have additional comment?

- YES, I have additional comment.

Q17. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc Standard
Page 41 Line 3 #d
Line 5 #2

Q18. Do you agree with the proposed revision?

- Disagree

Q19. Enter your comment. Type or copy and paste in the text box below.

Page 41 Line 3 #d (Practice and Profession)
Line 5 #2 Recognition, management, and clinical assessment of patients with IDD.

Q20. Do you have additional comment?

- YES, I have additional comment.

Q21. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 21
Page 2: 2-13 Line 22

Q22. Do you agree with the proposed revision?

- Disagree

Q23. Enter your comment. Type or copy and paste in the text box below.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 21 change may to “must”
Page 2: 2-13 Line 22 and treating select populations including patients with intellectual
developmental disabilities.

Q24. Do you have additional comment?

- YES, I have additional comment.

Q25. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 3: GPR Standards
Page 2: 2-17 Line 21
Page 2: 2-17 Line 22

Q26. Do you agree with the proposed revision?

- Disagree

Q27. Enter your comment. Type or copy and paste in the text box below.

Appendix 3: GPR Standards
Page 2: 2-17 Line 21 change may to “must”
Page 2: 2-17 Line 22 and treating select populations including patients with intellectual
developmental disabilities.

Q28. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Thursday, November 28, 2024 9:51:10 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

Download as PDF

URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Jennifer
Last Name	Campbell
Email	[redacted]
Title	Co-Founder

Q3. Please select one of the following options that best describes you or your organization:

- Certifying Board/Organization

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  IDD United

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 37
Standard 2-11 -line 7 include adults including those with Intellectual Developmental Disabilities,
and geriatric patients.

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

include adults including those with Intellectual Developmental Disabilities,
and geriatric patients.

Q8. Do you have additional comment?

- YES, I have additional comment.

Q9. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 38
Standard 2-12 – line 13 (#9)

Q10. Do you agree with the proposed revision?

- Disagree

Q11. Enter your comment. Type or copy and paste in the text box below.

including referrals after clinical assessment when indicated.

Q12. Do you have additional comment?

- YES, I have additional comment.

Q13. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 38- #d (Practice and Profession)
Line 41 – #2.

Q14. Do you agree with the proposed revision?

- Disagree

Q15. Enter your comment. Type or copy and paste in the text box below.

Recognition, management, and clinical assessment of patients with IDD.

Q16. Do you have additional comment?

- YES, I have additional comment.

Q17. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 38
Standard 2-12 –
Line 43 -

Q18. Do you agree with the proposed revision?

- Disagree

Q19. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment.

Q20. Do you have additional comment?

- YES, I have additional comment.

Q21. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 39 – Line 21 (#9).

Q22. Do you agree with the proposed revision?

- Disagree

Q23. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment

Q24. Do you have additional comment?

- YES, I have additional comment.

Q25. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 39- Line 43 #d (Practice and Profession)
Line 45 #2

Q26. Do you agree with the proposed revision?

- Disagree

Q27. Enter your comment. Type or copy and paste in the text box below.

Recognition, management, and clinical assessment of patients with IDD.

Q28. Do you have additional comment?

- YES, I have additional comment.

Q29. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Standard 2-12 Page 40 – Line 1 (#2)

Q30. Do you agree with the proposed revision?

- Disagree

Q31. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment

Q32. Do you have additional comment?

- YES, I have additional comment.

Q33. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 40 Standard 2-14 #a Line 29

Q34. Do you agree with the proposed revision?

- Disagree

Q35. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment

Q36. Do you have additional comment?

- YES, I have additional comment.

Q37. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 41 Line 3 #d (Practice and Profession)
Line 5 #2

Q38. Do you agree with the proposed revision?

- Disagree

Q39. Enter your comment. Type or copy and paste in the text box below.

Recognition, management, and clinical assessment of patients with IDD.

Q40. Do you have additional comment?

- YES, I have additional comment.

Q41. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 21

Q42. Do you agree with the proposed revision?

- Disagree

Q43. Enter your comment. Type or copy and paste in the text box

below.

change may to “must”

Q44. Do you have additional comment?

- YES, I have additional comment.

Q45. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 22

Q46. Do you agree with the proposed revision?

- Disagree

Q47. Enter your comment. Type or copy and paste in the text box below.

and treating select populations including patients with intellectual developmental disabilities.

Q48. Do you have additional comment?

- YES, I have additional comment.

Q49. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 3: GPR Standards
Page 2: 2-17 Line 21

Q50. Do you agree with the proposed revision?

- Disagree

Q51. Enter your comment. Type or copy and paste in the text box below.

change may to “must”

Q52. Do you have additional comment?

- YES, I have additional comment.

Q53. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 3: GPR Standards

Page 2: 2-17 Line 22

Q54. Do you agree with the proposed revision?

- Disagree

Q55. Enter your comment. Type or copy and paste in the text box below.

and treating select populations including patients with intellectual developmental disabilities.

Q56. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Wednesday, November 13, 2024 6:16:59 PM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

Download as PDF

URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Annette
Last Name	Puzan
Email	[redacted]
Title	Manager, Dental Education and Licensure

Q3. Please select one of the following options that best describes you or your organization:

- Other (Please specify):
  Council on Dental Education and Licensure (CDEL)

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  Council on Dental Education and Licensure (CDEL)

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Accreditation Standards for Advanced Dental Education Programs in General Practice Residency, Standard 2-17

Q6. Do you agree with the proposed revision?

- Agree

Q7. Enter your comment. Type or copy and paste in the text box below.

The following comment is being submitted on behalf of the ADA Council on Dental Education and Licensure by Dr. Jason A. Tanguay, chair:

A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, via a November electronic ballot, the Council considered and supported the proposed change to Standard 2-17 of the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency.

The Council appreciates the opportunity to submit comment on this important document.

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Tuesday, November 19, 2024 9:51:25 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

Download as PDF

URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

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Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Nasser
Last Name	Said-Al-Naief
Email	[redacted]
Title	Professor, OMFP

Q3. Please select one of the following options that best describes you or your organization:

- College/University

Q4. Is this an official comment from your organization?

- No. This is a personal comment.

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 15, Collaboration with other Health Care Professionals

Q6. Do you agree with the proposed revision?

- Agree

Q7. Enter your comment. Type or copy and paste in the text box below.

There is nothing mentioned about educating the dental student physician, which is beneficial to add in this area. this, I believe an integral part for dentist-MD communication and mutual collaboration on patient care, initiating proper referrals when needed, and other.

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Friday, November 22, 2024 7:08:41 PM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

Download as PDF

URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Kent
Last Name	Weitzel
Email	[redacted]
Title	General Dentist

Q3. Please select one of the following options that best describes you or your organization:

- Dental/Healthcare Professional

Q4. Is this an official comment from your organization?

- No. This is a personal comment.

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Standard 2-15, page 2, line 3: Standard 2-17, page 2, lines 21 and 22

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

Standard 2-15, page 2, line 3 after the words " one-year program" add "which must include assessing, diagnosing, and treating special healthcare needs patients"
Standard 2-17, page 2, line 21 change the word "may" to "must"
Standard 2-17, page 2, line 22 change the word "or" to "and"
Standard 2-17, page 2, line 22 after the word "populations" add " including patients with special healthcare needs" in a typical clinical office setting and in an ambulatory or operating room setting"

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Thursday, November 28, 2024 11:56:44 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

Download as PDF

URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Suzanne
Last Name	Weitzel
Email	[redacted]
Title	Physical Therapist/Dental Administrator

Q3. Please select one of the following options that best describes you or your organization:

- Dental/Healthcare Professional

Q4. Is this an official comment from your organization?

- No. This is a personal comment.

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Standard 2-15, page 2, line 3; Standard 2-17, page 2, line 21 and 22

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

Standard 2-15, page 2, line 3 after the words “one-year program” add “which must include assessing, diagnosing, and treating special healthcare needs patients”
Standard 2-17, page 2, line 21 change the word “may’ to “must”
Standard 2-17, page 2, line 22 change the word “or” to “and”
Standard 2-17, page 2, line 22 after the word “populations” add “including patients with special healthcare needs in a typical clinical office setting and in an ambulatory or operating room setting”

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Thursday, November 28, 2024 9:47:34 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

Download as PDF

URL to view Results	[Click Here]

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

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Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Geraldine
Last Name	Edrei
Email	[redacted]
Title	Dentist

Q3. Please select one of the following options that best describes you or your organization:

- Other (Please specify)

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  Edrei Global Services

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc_ Standard Page 37
Standard 2-11 line 7

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

Include adults including those with Intellectual Developmental Disabilities,
and geriatric patients.

Q8. Do you have additional comment?

- YES, I have additional comment.

Q9. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc_Standard
Page 38
Standard 2-12 – line 13 (#9)
Page 38- #d
Line 41 – #2.
Line 43

Q10. Do you agree with the proposed revision?

- Disagree

Q11. Enter your comment. Type or copy and paste in the text box below.

Page 38
Standard 2-12 – line 13 (#9) including referrals after clinical assessment when indicated.
Page 38- #d (Practice and Profession)
Line 41 – #2. Recognition, management, and clinical assessment of patients with IDD.
Line 43 - referral after clinical assessment.

Q12. Do you have additional comment?

- YES, I have additional comment.

Q13. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc Standard.
Page 39 – Line 21 (#9).
Page 39- Line 43 #d
Line 45 #2
Page 40 –
Page 40 Standard 2-14 #a Line 29

Q14. Do you agree with the proposed revision?

- Disagree

Q15. Enter your comment. Type or copy and paste in the text box below.

Page 39 – Line 21 (#9). referral after clinical assessment
Page 39- Line 43 #d (Practice and Profession)
Line 45 #2 Recognition, management, and clinical assessment of patients with IDD.
Page 40 – Line 1 (#2) referral after clinical assessment
Page 40 Standard 2-14 #a Line 29 referral after clinical assessment

Q16. Do you have additional comment?

- YES, I have additional comment.

Q17. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix_1_ Predoc Standard
Page 41 Line 3 #d
Line 5 #2

Q18. Do you agree with the proposed revision?

- Disagree

Q19. Enter your comment. Type or copy and paste in the text box below.

Page 41 Line 3 #d (Practice and Profession)
Line 5 #2 Recognition, management, and clinical assessment of patients with IDD.

Q20. Do you have additional comment?

- YES, I have additional comment.

Q21. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 21
Page 2: 2-13 Line 22

Q22. Do you agree with the proposed revision?

- Disagree

Q23. Enter your comment. Type or copy and paste in the text box below.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 21 change may to “must”
Page 2: 2-13 Line 22 and treating select populations including patients with intellectual
developmental disabilities.

Q24. Do you have additional comment?

- YES, I have additional comment.

Q25. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 3: GPR Standards
Page 2: 2-17 Line 21
Page 2: 2-17 Line 22

Q26. Do you agree with the proposed revision?

- Disagree

Q27. Enter your comment. Type or copy and paste in the text box below.

Appendix 3: GPR Standards
Page 2: 2-17 Line 21 change may to “must”
Page 2: 2-17 Line 22 and treating select populations including patients with intellectual developmental disabilities.

Q28. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

From: CODA
To: [redacted]
Cc: Soeldner, Peggy
Subject: CODA Comment Submission Confirmation
Date: Thursday, November 28, 2024 9:51:10 AM

Thank you for your interest in the Commission on Dental Accreditation (CODA). Your comment has been successfully submitted. Below, please find a copy of your comment as recorded.

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URL to view Results	[Click Here]

Response Summary:

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Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Jennifer
Last Name	Campbell
Email	[redacted]
Title	Co-Founder

Q3. Please select one of the following options that best describes you or your organization:

- Certifying Board/Organization

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  IDD United

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 37
Standard 2-11 -line 7 include adults including those with Intellectual Developmental Disabilities,
and geriatric patients.

Q6. Do you agree with the proposed revision?

- Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

include adults including those with Intellectual Developmental Disabilities,
and geriatric patients.

Q8. Do you have additional comment?

- YES, I have additional comment.

Q9. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 38
Standard 2-12 – line 13 (#9)

Q10. Do you agree with the proposed revision?

- Disagree

Q11. Enter your comment. Type or copy and paste in the text box below.

including referrals after clinical assessment when indicated.

Q12. Do you have additional comment?

- YES, I have additional comment.

Q13. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 38- #d (Practice and Profession)
Line 41 – #2.

Q14. Do you agree with the proposed revision?

- Disagree

Q15. Enter your comment. Type or copy and paste in the text box below.

Recognition, management, and clinical assessment of patients with IDD.

Q16. Do you have additional comment?

- YES, I have additional comment.

Q17. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 38
Standard 2-12 –
Line 43 -

Q18. Do you agree with the proposed revision?

- Disagree

Q19. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment.

Q20. Do you have additional comment?

- YES, I have additional comment.

Q21. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 39 – Line 21 (#9).

Q22. Do you agree with the proposed revision?

- Disagree

Q23. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment

Q24. Do you have additional comment?

- YES, I have additional comment.

Q25. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 39- Line 43 #d (Practice and Profession)
Line 45 #2

Q26. Do you agree with the proposed revision?

- Disagree

Q27. Enter your comment. Type or copy and paste in the text box below.

Recognition, management, and clinical assessment of patients with IDD.

Q28. Do you have additional comment?

- YES, I have additional comment.

Q29. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Standard 2-12 Page 40 – Line 1 (#2)

Q30. Do you agree with the proposed revision?

- Disagree

Q31. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment

Q32. Do you have additional comment?

- YES, I have additional comment.

Q33. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 40 Standard 2-14 #a Line 29

Q34. Do you agree with the proposed revision?

- Disagree

Q35. Enter your comment. Type or copy and paste in the text box below.

referral after clinical assessment

Q36. Do you have additional comment?

- YES, I have additional comment.

Q37. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Page 41 Line 3 #d (Practice and Profession)
Line 5 #2

Q38. Do you agree with the proposed revision?

- Disagree

Q39. Enter your comment. Type or copy and paste in the text box below.

Recognition, management, and clinical assessment of patients with IDD.

Q40. Do you have additional comment?

- YES, I have additional comment.

Q41. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 21

Q42. Do you agree with the proposed revision?

- Disagree

Q43. Enter your comment. Type or copy and paste in the text box

below.

change may to “must”

Q44. Do you have additional comment?

- YES, I have additional comment.

Q45. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 2: AEGD Standards
Page 2: 2-13 Line 22

Q46. Do you agree with the proposed revision?

- Disagree

Q47. Enter your comment. Type or copy and paste in the text box below.

and treating select populations including patients with intellectual developmental disabilities.

Q48. Do you have additional comment?

- YES, I have additional comment.

Q49. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 3: GPR Standards
Page 2: 2-17 Line 21

Q50. Do you agree with the proposed revision?

- Disagree

Q51. Enter your comment. Type or copy and paste in the text box below.

change may to “must”

Q52. Do you have additional comment?

- YES, I have additional comment.

Q53. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Appendix 3: GPR Standards

Page 2: 2-17 Line 22

Q54. Do you agree with the proposed revision?

- Disagree

Q55. Enter your comment. Type or copy and paste in the text box below.

and treating select populations including patients with intellectual developmental disabilities.

Q56. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

Q1. The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for General Practice Residency Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

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Click next to submit a comment.

Q2. Please complete the requested information.

First Name	x
Last Name	x
Email	[redacted]
Title	x

Q3. Please select one of the following options that best describes you or your organization:

- ○ College/University
- ○ Dental or Dental-Related Education Program
- ○ Federal Agency
- ○ Dental Organization/Dental Association
- ○ Dental/Healthcare Professional
- ○ State Licensing Board
- ○ Certifying Board/Organization
- ○ Student (dental, allied dental or advanced dental)
- ○ Member of the Public
- ◉ Other (Please specify) x

Q4. Is this an official comment from your organization?

- ◉ Yes. Please enter the name of your organization below. x
- ○ No. This is a personal comment.

Q5. **Enter the Standard number(s), page(s) and line(s) to which you would like to comment.**

134

Q6. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q7. Enter your comment. Type or copy and paste in the text box below.

123

Q8. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q9. **Enter the Standard number(s), page(s) and line(s) to which you would like to comment.**

2

Q10. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q11. Enter your comment. Type or copy and paste in the text box below.

Q12. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q13. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

1

Q14. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q15. Enter your comment. Type or copy and paste in the text box below.

1

Q16. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q17. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

1

Q18. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q19. Enter your comment. Type or copy and paste in the text box below.

1

Q20. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q21. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

1

Q22. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q23. Enter your comment. Type or copy and paste in the text box below.

1

Q24. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q25. **Enter the Standard number(s), page(s) and line(s) to which you would like to comment.**

1

Q26. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q27. Enter your comment. Type or copy and paste in the text box below.

1

Q28. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q29. **Enter the Standard number(s), page(s) and line(s) to which you would like to comment.**

1

Q30. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q31. Enter your comment. Type or copy and paste in the text box below.

1

Q32. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q33. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

1

Q34. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q35. Enter your comment. Type or copy and paste in the text box below.

1

Q36. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q37. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

1

Q38. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q39. Enter your comment. Type or copy and paste in the text box below.

1

Q40. Do you have additional comment?

- (●) YES, I have additional comment.
- ( ) I have NO additional comment and ready to submit.

Q41. **Enter the Standard number(s), page(s) and line(s) to which you would like to comment.**

1

Q42. Do you agree with the proposed revision?

- (●) Agree
- ( ) Disagree

Q43. Enter your comment. Type or copy and paste in the text box below.

1

Q44. Do you have additional comment?

- ○ YES, I have additional comment.
- ◉ I have NO additional comment and ready to submit.

Q45. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

This question was not displayed to the respondent.

Q46. Do you agree with the proposed revision?

This question was not displayed to the respondent.

Q47. Enter your comment. Type or copy and paste in the text box below.

This question was not displayed to the respondent.

Q48. Do you have additional comment?

This question was not displayed to the respondent.

Q49. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

This question was not displayed to the respondent.

Q50. Do you agree with the proposed revision?

This question was not displayed to the respondent.

Q51. Enter your comment. Type or copy and paste in the text box below.

This question was not displayed to the respondent.

Q52. Do you have additional comment?

This question was not displayed to the respondent.

Q53. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

This question was not displayed to the respondent.

Q54. Do you agree with the proposed revision?

This question was not displayed to the respondent.

Q55. Enter your comment. Type or copy and paste in the text box below.

This question was not displayed to the respondent.

Q56. Do you have additional comment?

This question was not displayed to the respondent.

Q57. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

This question was not displayed to the respondent.

Q58. Do you agree with the proposed revision?

This question was not displayed to the respondent.

Q59. Enter your comment. Type or copy and paste in the text box below.

This question was not displayed to the respondent.

Q60. Do you have additional comment?

This question was not displayed to the respondent.

Q61. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

This question was not displayed to the respondent.

Q62. Do you agree with the proposed revision?

This question was not displayed to the respondent.

Q63. Enter your comment. Type or copy and paste in the text box below.

This question was not displayed to the respondent.

Q64. Do you have additional comment?

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Q65. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

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Q82. Do you agree with the proposed revision?

This question was not displayed to the respondent.

Q83. Enter your comment. Type or copy and paste in the text box below.

This question was not displayed to the respondent.

Q84. If you have additional comments, **please submit these comments first** and begin a new submission form using the same link. Thank you.

This question was not displayed to the respondent.

Scoring Results	
Score	
Mean Score:	0.00
Weighted Mean of Items:	0.00
Weighted Standard Deviation of Items:	0.00
Items:	0.00

Location Data

CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Background: On October 11, 2024, the Commission on Dental Accreditation (CODA) received a request from Dr. Todd Thierer, Associate Dental Director, HealthPartners Dental Group and Director, Regions Hospital Advanced Education in General Dentistry Program, to consider a proposed revision to Standards for Advanced Dental Education Programs Related to Sponsoring Institution and Authority to Operate (**Appendix 1**).

Dr. Thierer believes revisions to the Standard to provide clarification are warranted and proposed the revision found in **Appendix 2**, which Dr. Thierer believes meets the intent of the Commission and provides such clarification.

In addition, Commission staff recently learned that the list of accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) included in the Examples of Evidence of the Accreditation Standards found in **Appendix 3** has changed. CODA staff noted changes include the addition of one (1) organization, deletion of organizations, and changes in the acronyms listed for some organizations. It was noted that institutional accreditation by some organizations included in the CMS may warrant further consideration to determine whether accreditation by these organizations should be an option for dental education programs.

Summary: The Review Committee on Postdoctoral General Dentistry Education and the Commission on Dental Accreditation are requested to consider the proposed revisions from Dr. Todd Thierer **(Appendix 2)**. In addition, the Review Committee on Postdoctoral General Dentistry Education and the Commission on Dental Accreditation are requested to consider whether revisions to the Examples of Evidence **(Appendix 3)** are warranted. If revisions to the Accreditation Standards are proposed, the Commission may wish to circulate the proposed revisions to all advanced dental education program Review Committees for further consideration. Additionally, the Commission may wish to circulate the proposed revisions to the communities of interest for review and comment.

Recommendation:

Prepared by: Ms. Peggy Soeldner

From: [redacted]
To: Soeldner, Peggy
Cc: Tooks, Sherin
Subject: Re: AEGD Program Director Announcement following CODA Summer 2024 meeting
Date: Friday, October 11, 2024 11:32:45 AM
Attachments: [redacted]

Peggy and Sherin,

Thank you again for taking the time to meet with me today. It is much appreciated. I am attaching a copy of my suggested revisions based on our conversation today. It is a Word document with the review functions turned on. Here is a "clean" version of my proposed changes:

Advanced dental educational programs must operate in accordance with all applicable state and federal educational and operational regulations and requirements.

Intent: Where additional state operational and/or educational regulations and/or requirements exist, for example requirement for institutions to have a state business license, the program demonstrates that they meet those regulations and/or requirements.

Examples of evidence to demonstrate compliance may include:

- Documentation of a state business license as evidence to operate
- If required by the state, the program demonstrates authority through an appropriate state agency when issuing a certificate of completion
- If conferring a degree, the program demonstrates authorization from its institutional accrediting agency.

I believe that this meets the intent of the Commission but may be clearer (at least to me).

I am planning on sharing this with ADEA COAEP as well.

Have a great weekend!

Best,

Todd

Your partner for good
Todd Thierer DDS, MPH (he/him)
Associate Dental Director
HealthPartners Dental Group
Director, Regions Hospital Advanced Education in General Dentistry Program
Tel. 952-883-5159 | Fax 952-883-5160

CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

1-1 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) or receive regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV) process.

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).

Evidence of successful achievement of regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV) process.

~~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.~~

Advanced dental educational programs **must** operate in accordance with all applicable state and federal educational and operational regulations and requirements.

~~***Intent:** The educational program demonstrates either: a) documentation of receipt of*~~

~~*federal aid as evidence to operate, or b) documentation of a state business license as evidence to operate. Additionally, as required by the state, the program demonstrates authority through an appropriate state agency when issuing a certificate of completion. If conferring a degree, the program demonstrates authorization from its institutional accrediting agency.*~~

Intent: *Where additional state operational and/or educational regulations and/or requirements exist, for example requirement for institutions to have a state business license, the program demonstrates that they meet those regulations and/or requirements.*

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.~~

Documentation of a state business license as evidence to operate

If required by the state, the program demonstrates authority through an appropriate state agency when issuing a certificate of completion

If conferring a degree, the program demonstrates authorization from its institutional accrediting agency.

CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

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~~QuadA); ~~American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP);~~Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation ~~Program~~ Partner (CHAP); DNV ~~GL~~ Healthcare (DNV~~GL~~); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (TJC), National Association of Boards of Pharmacy (NABP), Utilization Review Accreditation Commission (URAC).
- Evidence of successful achievement of receive regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV) process.

CONSIDERATION OF ACCREDITATION STANDARDS FOR ADVANCED DENAL EDUCATION PROGRAMS IN ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY RELATED TO ADMINISTRATIVE OVERSIGHT AT MAJOR SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

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

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

Summer 2024: The Ad Hoc Committee, which was comprised of all current CODA Commissioners, met on August 7, 2024 at the ADA Headquarters, in association with the Commission's Summer 2024 meeting. The Ad Hoc Committee reviewed the background materials, which included the Commission's action leading to the Ad Hoc Committee, and the Standards for each discipline related to program director **(Appendix 1)**. The Ad Hoc Committee noted that the Advanced Education in General Dentistry, General Practice Residency Standards, and Pediatric Dentistry Standards include a requirement for a site director/site administrator at all off-campus clinical locations. The Committee discussed the changing environment in dental and dental hygiene education, noting increased establishment of off-campus sites where students spend a majority or all their time, much like a satellite campus. It was noted that while all CODA Standards have a requirement for clinical supervision at all educational activity sites, it was noted that most Standards do not address overall administrative oversight of the program, by the program director or a designee, at all sites where a student spends a majority or all their time. The Committee discussed whether virtual oversight or assignment of a responsible individual would be appropriate at all educational sites. The Committee believed there must be consistency in the educational program at all program sites.

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

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

Recommendation:

Prepared by: Dr. Sherin Tooks

COMMISSION ON DENTAL ACCREDITATION
STANDARDS RELATED TO PROGRAM DIRECTOR REQUIREMENTS

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

Discipline	Standard Number	Requirement of the Standard
Predoctoral Dental		
	N/A	
Dental Assisting		
	Standard 2-25	**The dental assisting faculty must plan, approve, supervise, and evaluate the student's clinical experience, and the following conditions must be met:** **a. A formal agreement exists between the educational institution and the facility providing the experience** **b. The program administrator retains authority and responsibility for the student** **c. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the dental assisting program.** **d. The facility accommodates the scheduling needs of the program** **e. Notification for termination of the agreement ensures that instruction will not be interrupted for currently assigned students** **f. Expectations and orientation are provided to all parties prior to student assignment**
	Standard 3-1	**The program must be a recognized entity within the institution's administrative structure which supports the attainment of program goals.** **Intent:** *The position of the program in the institutions administrative structure should permit direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program The administration of the program should include formal provisions for program planning, staffing, management, coordination and evaluation.*
	Standard 3-2	**The program administrator must have a full-time commitment to the institution and an appointment which provides time for program operation, evaluation and revision.**

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

		An objective evaluation system including student, administration and peer evaluation can identify strengths and weaknesses for each faculty member (to include those at distance sites) including the program administrator. The results of evaluations should be communicated to faculty members on a regular basis to ensure continued improvement.
	Standard 4-10	**It is preferable and, therefore recommended, that the educational institution provide physical facilities and equipment which are adequate to permit achievement of the program's objectives. If the institution finds it necessary to contract for use of an existing facility for laboratory, preclinical and/or clinical education, then the following conditions must be met in addition to all existing standards.** **a. There is a formal agreement between the educational institution and agency or institution providing the facility.** **b. The program administrator retains authority and responsibility for instruction.** **c. All students receive instruction and practice experience in the facility.** **d. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the educational program.** **e. Availability of the facility accommodates the scheduling needs of the program.** **f. Notification for termination of the contract ensures that instruction will not be interrupted for currently enrolled students.** **g. Instruction is provided and evaluated by calibrated dental assisting program faculty.** **Intent:** *This standard applies to sites off-campus used for laboratory, preclinical and/or clinical education. All students assigned to a particular facility are expected to receive instruction in that facility. This standard is not applicable to dental offices/clinic sites used for clinical/externship practice experience.*
Dental Hygiene		
	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.** **Intent:** *To allow sufficient time to fulfill administrative responsibilities, program administrative hours should represent the majority of hours, and teaching contact hours should be limited.*

	Standard 3-4	**The program administrator must have the authority and responsibility necessary to fulfill program goals including:** **a) curriculum development, evaluation and revision;** **b) faculty recruitment, assignments and supervision;** **c) input into faculty evaluation;** **d) initiation of program or department in-service and faculty development;** **e) assessing, planning and operating program facilities;** **f) input into budget preparation and fiscal administration;** **g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.**
Dental Laboratory Technology		
	Standard 3-3	**A program administrator who is employed full-time (as defined by the institution) and who is responsible for the day-to-day implementation of the program and must have the authority, responsibility and privileges necessary to manage the program.**
	Standard 3-4	**The program administrator must:** **a) have the educational background and occupational experience necessary to understand and fulfill the program goals** **b) have attained a higher level of education than that presented in the program or be enrolled in a program progressing toward that degree** **c) current background in educational theory and methodology** **d) have practical experience as a dental technician** **e) be certified by the National Board for Certification in Dental Laboratory Technology**
	Standard 3-5	**Duties: The program administrator must have authority and responsibility necessary to fulfill program goals.**
Dental Therapy		
	Standard 3-1	The program director **must** have a full-time administrative appointment as defined by the institution and have primary responsibility for operation, supervision, evaluation and revision of the Dental Therapy educational program. **Intent:** *To allow sufficient time to fulfill administrative responsibilities, teaching contact hours should be limited for the program director and should not take precedent over administrative responsibilities.*

	Standard 3-2	The program director **must** be a licensed dentist (DDS/DMD) or a licensed dental therapist possessing a master's or higher degree. The director **must** be a graduate of a program accredited by the Commission on Dental Accreditation and who has background in education and the professional experience necessary to understand and fulfill the program's mission and goals. **Intent:** *The program director's background should include administrative experience, instructional experience, and professional experience in general dentistry. The term of interim/acting program director should not exceed a two year period.*
	Standard 3-3	The program director **must** have the authority and responsibility necessary to fulfill program goals including: a) curriculum development, evaluation and revision; b) faculty recruitment, assignments and supervision; c) input into faculty evaluation; d) initiation of program or department in-service and faculty development; e) assessing, planning and operating program facilities; f) input into budget preparation and fiscal administration; g) coordination, evaluation and participation in determining admission criteria and h) procedures as well as student promotion and retention criteria.
Advanced Education in General Dentistry		
	Standard 2-15	The program's resident evaluation system **must** assure that, through the director and faculty, each program: a) periodically, but at least three times annually, evaluates and documents the resident's progress towards achieving the program's written goals and objectives or competencies for resident training using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions **must** be taken; and c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits. ***Intent:*** *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident*

		training described in response to Standard 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.
	Standard 3-1	The program **must** be administered by a director who has authority and responsibility for all aspects of the program. ***Intent:*** *The program director's responsibilities include:* *a) program administration;* *b) development and implementation of the curriculum plan;* *c) ongoing evaluation of program content, faculty teaching and resident performance;* *d) evaluation of resident training and supervision in affiliated institutions and off-services rotations;* *e) maintenance of records related to the educational program; and* *f) resident selection.* *It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:*
	Standard 3-2	Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, **must** have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.
	Standard 3-3	For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
General Practice Residency		
	Standard 2-5	Residents **must** be assigned to an anesthesia rotation with supervised practical experience in the following: a) preoperative evaluation; b) assessment of the effects of behavioral and pharmacologic techniques; c) venipuncture technique; d) patient monitoring; e) airway management; f) understanding of the use of pharmacologic agents; g) recognition and treatment of anesthetic emergencies; and

		h) assessment of patient recovery from anesthesia. ***Intent:*** *Program directors should interact with the anesthesia department to determine the rotation length and methods necessary to meet the requirements of the standard. Generally a minimum of 70 hours is considered to provide the appropriate practical experience.*
	Standard 2-15	The program's resident evaluation system **must** assure that, through the director and faculty, each program: a) periodically, but at least three times annually, evaluates and documents the resident's progress towards achieving the program's written goals and objectives or competencies for resident training using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions **must** be taken; and c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits. ***Intent:*** *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.*
	Standard 3-1	The program **must** be administered by a director who has authority and responsibility for all aspects of the program. ***Intent:*** *The program director's responsibilities include:* *a) program administration;* *b) development and implementation of the curriculum plan;* *c) ongoing evaluation of program content, faculty teaching and resident performance;* *d) evaluation of resident training and supervision in affiliated institutions and off-services rotations;* *e) maintenance of records related to the educational program; and* *f) resident selection.* *It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected*

		that the program will develop a formal plan for such assignments that includes: *1) what duties are assigned,* *2) to whom they are assigned, and* *3) what systems of communication are in place between the program director and individuals who have been assigned responsibilities.* *In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.*
	Standard 3-2	Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, **must** have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.
	Standard 3-3	For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
Dental Anesthesiology		
	Standard 2-10	Residents **must** participate in at least four (4) months of clinical rotations from the following list. If more than one rotation is selected, each **must** be at least one month in length. a) Cardiology, b) Emergency medicine, c) General/internal medicine, d) Intensive care, e) Pain medicine, f) Pediatrics, g) Pre-anesthetic assessment clinic (max. one [1] month), and h) Pulmonary medicine. ***Intent:*** *The dental anesthesia resident should have a strong foundation in clinical medicine that can be achieved through rotations in the above-mentioned areas. When the resident entering the program has minimal clinical medicine experience, the program director should attempt to increase the time in these rotations beyond the minimum number of months required. The goal is to give the resident experience in medical evaluation and long-term management of patients. Therefore, only one month of the four months of this requirement may be met in the pre-anesthetic assessment clinic, although longer periods of time may be arranged as desired.*
	Standard 2-19	The program's resident evaluation system **must** assure that, through the director and faculty, each program:

		a) Periodically, but at least twice annually, evaluates and documents the resident's progress towards achieving the program's written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures; b) Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and c) Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits. ***Intent:*** *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific competency and anesthesia case requirements described in response to Standards 2-1, 2-2, and 2-6.*
	Standard 3-1	The program **must** be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. ***Intent:*** *The program director's responsibilities include:* *1. program administration;* *2. development and implementation of the curriculum plan;* *3. ongoing evaluation of program content, faculty teaching and resident performance;* *4. evaluation of resident training and supervision in affiliated institutions and off-services rotations;* *5. maintenance of records related to the educational program; and* *6. Resident selection.* *It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:* *1. what duties are assigned;* *2. to whom they are assigned; and* *3. what systems of communication are in place between the program director and individuals who have been assigned responsibilities.* In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

	Standard 3-2	The program director **must** be board certified in dental anesthesiology. Program directors appointed after January 1, 2020, who have not previously served as program directors, **must** be board certified in dental anesthesiology. The program director **must** have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable. ***Intent:*** *The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology.*
Dental Public Health		
	Standard 1	The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director **must** have the authority, responsibility, and privileges necessary to manage the program.
	Standard 1-3	For each site where educational activity occurs, there **must** be an appropriate on-site supervisor who is qualified by education in the curriculum areas for which he/she is responsible.
	Standard 2	The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.) ***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.*
	Standard 2	The program **must** be administered by one director who is board certified in dental public health. ~~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.*~~
	Standard 2	The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.
	Standard 2	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 2-1	The program **must** be directed by a single individual who has at least a 40% appointment to the sponsoring institution. ***Intent:*** *Other activities do not dilute a program director's ability to discharge his/her primary obligations to the educational program.*
	Standard 2-1	The program **must** be directed by a single individual who has at least a 40% appointment to the sponsoring institution and a commitment to teaching and supervision that is uncompromised by additional responsibilities.
	Standard 4	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.
	Standard 4-4	Directors of one-year programs **must** review each student's/resident's previous public health training and supplement it, where necessary, to ensure that instruction identified in Standard 4-2 is covered.

	Standard 4-7	The program **must** include a supervised field experience at a location determined by the program director which requires the students/residents to gain an understanding of one or more of the competencies listed in Standard 4-5. ***Intent:*** *Supervised field experiences are multi-week or multi-day mentored experiences such as practicums or internships that allow students/residents to enhance their practical understanding in one or more of the competencies listed in Standard 4-5. Supervised field experiences are not meant to include attendance at meetings, conferences, fieldtrips or other didactic sessions.*
	Standard 4-8	The program **must** include a supervised research experience for each student/resident, approved by the program director, that demonstrates application of dental public health principles and sound research methodology and is consistent with the competencies listed is Standard 4-5. (Also see Standard 6)
	Standard 4-8	The program **must** include a supervised field experience at a location determined by the program director which requires the students/residents to gain an understanding of one or more of the competencies listed in Standard Standard 4-~~5~~6. The program **must** document, with a log of activities, the specific dental public health competency(ies) addressed during each field experience. ***Intent:*** *Supervised multi-day field experiences ~~are multi-week or multi-day mentored experiences such as practicums or internships that~~ allow students/residents to enhance their practical understanding in one or more of the competencies listed in Standard 4-~~5~~6. Supervised field experiences are not meant to include attendance at meetings, conferences, fieldtrips or other didactic sessions.*
	Standard 4-9	The program must include a supervised experience at a location determined by the program director which offers an opportunity for the students/residents to gain knowledge regarding the administration of oral healthcare services (management and delivery of care) of a dental program that provides clinical care to underserved and/or vulnerable population(s). a) Students'/Residents' with no prior postdoctoral experience in a public health dental care setting must document evidence of a minimum of 80 hours of supervised participation and documentation of the experience and understanding the challenges to delivering oral health services to the population(s) served. b) Students/Residents entering the program with equivalent postdoctoral experience in a public health dental care settings serving vulnerable and underserved populations

		could be exempt from the 80-hour required rotation based on the residency director's evaluation of their experience. The student/resident must fulfill this requirement with submission of a written, guided personal reflection on the challenges delivering oral health care services to underserved and vulnerable populations. ***Intent:*** *To facilitate the development of Dental Public Health students'/residents' knowledge in the delivery of oral healthcare services to populations, students/residents should deepen their understanding of the provision of clinical care in settings that focus on underserved and/or vulnerable population(s). Experiences are multi-day mentored activities such as practicums or internships or personally providing clinical care, that offer the opportunity for students/residents to enhance their understanding and appreciation of dental care for underserved and/or vulnerable population(s) populations. Personally providing clinical care is not a requirement of this Standard. Clinical facilities may include but are not limited to Community Health Centers, hospitals, schools, clinics that care for vulnerable populations, such as low-income children, persons living with HIV, the homeless, and those with intellectual and/or developmental disabilities. Completion of Standard 4-9 does not fulfill the requirement for Standard 4-8 (Supervised Field Experience).*
	Standard 4-10	The program **must** include a supervised research experience for each student/resident, approved by the program director, that demonstrates application of dental public health principles and sound dental public health research methodology, biostatistics and epidemiology, and is consistent with the competencies listed in Standard 4-~~5~~6. (Also see Standard 6)
	Standard 5 - Evaluation	A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program: a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods; b. Provides to students/residents an assessment of their performance, at least semiannually; c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.

	Standard 5	Specific written criteria, policies and procedures **must** be followed when admitting students/residents. ***Intent:*** *Written non-discriminatory policies are to be followed in selecting students/residents. These policies should make clear the methods and criteria used in recruiting and selecting students/residents and how applicants are informed of their status throughout the selection process. Program directors are encouraged to refer applicants to the Dental Public Health program to the American Board of Dental Public Health for eligibility requirements to obtain Diplomate status.*
	Standard 5-2	Applicants for one-year dental public health programs **must** possess an MPH or comparable degree. ***Intent:*** *For those students/residents admitted with a graduate degree comparable to the MPH, it is expected that the program director document the satisfactory completion of the educational requirements of Standard 4-3. Where deficiencies exist, the student's/resident's program director will create a supplemental curriculum plan to meet those requirements.*
Endodontics		
	Standard 1-3	For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, **must** be board certified.) **The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.** **Documentation of all program activities must be ensured by the program director and available for review.**
	Standard 2-1	**The sponsoring institution must appoint a program director who: a) is a full-time faculty member and b) whose time commitment is no less than twenty-four hours per week to the advanced dental education program in endodontics.**
	Standard 2-1	**The sponsoring institution must appoint a program director whose time commitment is no less than twenty-four hours per week to the advanced dental education program in endodontics.**
	Standard 2-2	**Responsibilities of the program director must include:** **a. Development of mission, goals, and objectives for the program;**

		b. Development and implementation of a curriculum plan; **c. Planning for and operation of the facilities used in the endodontic program;** **d. Student/resident selection unless the program is sponsored by a federal service utilizing a centralized student/resident selection process;** **e. Ensuring ongoing evaluation of student/resident performance and faculty teaching performance;** **f. Evaluation of teaching program and faculty supervision in affiliated institutions;** **g. Maintenance of records related to the educational program, including written instructional objectives and course outlines;** **h. Overall continuity and quality of patient care as it relates to program;** **i. Ongoing planning, evaluation and improvement of the quality of the program;** **j. Preparation of graduates for certification by the American Board of Endodontics; and** **k. Ensuring formal (written) evaluation of faculty members at least annually to assess their performance in the educational program.**
	Standard 2-5	**Program directors and full time faculty must be provided time and resources to engage in scholarly pursuits, which may include:** **a. Participation in continuing education in endodontics;** **b. Participation in regional or national endodontic societies;** **c. Participation in research; and** **d. Presentation and publication of scientific/clinical studies.**
Oral and Maxillofacial Pathology		
	Standard 1	The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the

		institution and the program director **must** have the authority, responsibility, and privileges necessary to manage the program.
	Standard 1	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 recognized certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.*
	Standard 1-4	For each site where educational activity occurs, there **must** be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.
	Standard 2	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 2-1	The program **must** be directed by a single individual who has a full-time appointment to the sponsoring institution.
	Standard 2-1.1	The program director and faculty of an advanced oral and maxillofacial pathology program **must** demonstrate a commitment to teaching and supervision that is uncompromised by additional responsibilities.
	Standard 4	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

	Examples of Evidence Standard 4-1	Examples of evidence to demonstrate compliance may include: • Formal courses taken for University credit; and • Courses, seminars, conferences, reading assignments, hospital rounds and assignment in the laboratories which are carefully organized; the objectives and content should be carefully planned or reviewed by the program director to avoid deficiencies and unnecessary repetition.
	Intent Standard 4-2.2	Training must include attendance at tumor boards, clinical assessment of patients, selection of appropriate laboratory studies and their interpretation, evaluation of medical and drug status, administration of systemic and local medications, and participation in multi-disciplinary treatment planning. ***Intent:*** *Students/Residents should have the opportunity to manage patients with interesting and unusual diseases. Students/residents should be urged to maintain a log, either photographic and/or written, for cases in which they have had some responsibility. Program directors should periodically evaluate the extent of the students'/residents' clinical experience. Regular conferences and seminars should be scheduled to broaden clinical experience and fill in deficiencies with past clinical teaching cases. A wide variety of clinical situations should also be discussed in regularly scheduled literature reviews or journal clubs.*
	Standard 5	A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program: a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods; b. Provides to students/residents an assessment of their performance, at least semiannually; c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.
Oral and Maxillofacial Radiology		
	Standard 1	The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director **must** have the authority responsibility, and privileges necessary to manage the program.
	Standard 1-2	The program director and faculty **must** actively assess the

		outcomes of the oral and m axillofacial radiology program in terms of whether it is achieving its educational objectives.
	Standard 1-4	For each site where educational activity occurs, there **must** be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.) ***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.*
	Standard 2	The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.
	Standard 2	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 2-1	The oral and maxillofacial radiology program **must** be directed by one individual who has a full-time appointment to the sponsoring institution.
	Standard 2-2	The program director and faculty of an advanced oral and maxillofacial radiology program **must** demonstrate a commitment to teaching and supervision.
	Standard 2-3	The program director and full-time faculty **must** have adequate time to develop and foster their own professional development.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

	Standard 5	A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program: a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods; b. Provide to students/residents an assessment of their performance, at least semiannually; c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.
Oral and Maxillofacial Surgery (Residency)		
	Standard 2	The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, **must** be board certified.) The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals. Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 2-1	**Program Director: The program must be directed by a single responsible individual who is a full time faculty member as defined by the institution.**
		The responsibilities of the program director must include:
	Standard 2-1.1	**Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.**
	Standard 2-1.2	**Ensuring the provision of adequate physical facilities for the educational process.**
	Standard 2-1.3	**Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff. This must include documentation of evaluation of the members of the teaching staff by the residents at least annually.**

	Standard 2-1.4	**Responsibility for adequate educational resource materials for education of the residents, including access to an adequate health science library and electronic reference sources.**
	Standard 2-1.5	**Responsibility for selection of residents and ensuring that all appointed residents meet the minimum eligibility requirements, unless the program is sponsored by a federal service utilizing a centralized resident selection process.**
	Standard 2-1.6	**Maintenance of appropriate records of the program, including resident and patient statistics, institutional agreements, and resident records.**
	Standard 2-1.8	**The program director and teaching staff must lead by example in all aspects of professionalism.**
Oral and Maxillofacial Surgery (Fellowship)		
	Standard 2	The program **must** be administered by a director who is board certified.
	Standard 2-1	Program Director: The program **must** be directed by a single individual. The responsibilities of the program director **must** include:
	Standard 2-1.1	Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.
	Standard 2-1.2	Ensuring the provision of adequate physical facilities for the educational process.
	Standard 2-1.3	Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.
	Standard 2-1.4	Responsibility for adequate educational resource materials for education of the fellows, including access to adequate learning resources.
	Standard 2-1.5	Responsibility for selection of fellows and ensuring that all appointed fellows meet the minimum eligibility requirements.
	Standard 2-1.6	Maintenance of appropriate records of the program, including fellow and patient statistics, institutional agreements, and fellow records.
Oral Medicine		
	Standard 2-6	Part-time residents **must** start and complete the program within a single institution, except when the program is discontinued or relocated. ***Intent:*** *The director of an accredited program may enroll residents on a part-time basis providing that (1) residents are also enrolled on a full-time basis, (2) the educational experiences, including the clinical experiences and responsibilities, are equivalent to those acquired by full-time residents and (3) there are an equivalent number of months spent in the program.*

	Standard 3-1	The program **must** be administered by an appointed director who is full-time faculty and who is board certified in oral medicine.
	Standard 3-2	The program director **must** have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program. ***Intent:*** *The program director's responsibilities include:* *a) selecting residents;* *b) developing and implementing the curriculum;* *c) utilizing faculty to offer a diverse educational experience in biomedical, behavioral and clinical sciences;* *d) facilitating the cooperation between oral medicine, general dentistry, related dental specialties, medicine and other health care disciplines;* *e) evaluating and documenting resident training, including training in affiliated institutions;* *f) documenting educational and patient care records as well as records of resident attendance and participation in didactic and clinical programs,* *g) ensuring quality and continuity of patient care;* *h) ensuring research opportunities for the residents;* *i) planning for and operation of facilities used in the program;* *j) training of support staff at an appropriate level; and* *k) preparing and encouraging graduates to seek certification by the American Board of Oral Medicine.*
	Standard 3-8	The program director and staff **must** actively participate in the assessment of the outcomes of the educational program.
	Standard 5-5	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 or competencies for resident training using appropriate written criteria and procedures; b) provides residents with an assessment of their performance after each evaluation; and c) maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits. ***Intent:*** *The program should employ evaluation methods that measure a resident's skills or behavior at a given time. It is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standards 2-10, 2-12 and 2-14. Where deficiencies are noted, corrective actions are taken. The*

		final resident evaluation or final measurement of educational outcomes may count as one of the two annual evaluations.
Orofacial Pain		
	Standard 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.*
	Standard 3-1	The program **must** be administered by a director who is board certified or educationally qualified in orofacial pain and has a full-time appointment in the sponsoring institution with a primary commitment to the orofacial pain program.
	Standard 3-2	The program director **must** have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program. ***Intent:*** *The program director's responsibilities include:* *a. program administration;* *b. development and implementation of the curriculum plan;* *c. ongoing evaluation of program content, faculty teaching, and resident performance;* *d. evaluation of resident training and supervision in affiliated institutions and off-service rotations;* *e. maintenance of records related to the educational program; and* *f. resident selection; and* *g. preparing graduates to seek certification by the American Board of Orofacial Pain.*

		In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.
Orthodontics and Dentofacial Orthopedics (Residency)		
	Standard 1-4	For each site where educational activity occurs, there **must** be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.
	Standard 2	The program **must** be administered by **one** director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, **must** be board certified.) The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals. Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 2-1	**The program must be directed by one individual.**
	Standard 2-2	**The program director position must be full-time as defined by the institution.**
	Standard 2-3	**There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.**
	Standard 2-5	**Besides maintaining clinical skills, the director must have teaching experience in orthodontics and dentofacial orthopedics. For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.**
	Standard 2-14	**The program director and faculty must prepare students/residents to pursue certification by the American Board of Orthodontics.**
	Standard 2-14.a	**The program director must document the number of graduates who become certified by the American Board of Orthodontics.**
Orthodontics and Dentofacial Orthopedics (Fellowship)		

	Standard 1-5	For each site where educational activity occurs, there **must** be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.
	Standard 2	The program **must** be administered by a director who has documented expertise in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics. Additionally, the program director **must** either be board certified in orthodontics or have previously served as a director in a craniofacial orthodontic fellowship program prior to January 1, 2008.
	Standard 2-1	Program Director: The program **must** be directed by one individual. The responsibilities of the program director **must** include:
	Standard 2-1.1	Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.
	Standard 2-1.2	Ensuring the provision of adequate physical facilities for the educational process.
	Standard 2-1.3	Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.
	Standard 2-1.4	Responsibility for adequate educational resource materials for education of the students/fellows, including access to adequate learning resources.
	Standard 2-1.5	Responsibility for selection of students/fellows and ensuring that all appointed students/fellows meet the minimum eligibility requirements.
	Standard 2-1.6	Maintenance of appropriate records of the program, including student/fellow and patient statistics, institutional agreements, and student/fellow records.
Pediatric Dentistry		
	Standard 1	The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director **mus**t have the authority, responsibility, and privileges necessary to manage the program.
	Standard 1-3	For each site where educational activity occurs, there **must** be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.
	Standard 2	The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

		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.*
	Standard 2	The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.
	Standard 2-1	The program director **must** be evaluated annually.
	Standard 2-2 (and sub-parts)	Administrative Responsibilities: The program director **must** have sufficient authority and time to fulfill administrative program assessment and teaching responsibilities in order to achieve the educational goals of the program including: ***Intent:*** *Program directors with remote programs have resources to visit these programs.* 2-2.1 Student/Resident selection, unless the program is sponsored by federal services utilizing a centralized student/resident selection process. 2-2.2 Curriculum development and implementation. 2-2.3 Ongoing evaluation of program goals, objectives and content and outcomes assessment. ***Intent:*** *The program uses a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement that relate directly to the stated program goals and objectives.* 2-2.4 Annual evaluations of faculty performance by the program director or department chair; including a discussion of the evaluation with each faculty member. 2-2.5 Evaluation of student/resident performance. 2-2.6 Participation with institutional leadership in planning for and operation of facilities used in the educational program. 2-2.7 Evaluation of student's/resident's training and supervision in affiliated institutions. 2-2.8 Maintenance of records related to the educational program, including written instructional objectives,

		course outlines and student/resident clinical logs (RCLs) documenting the completion of specified procedures and/or patient complexity, including: a) nitrous oxide analgesia patient encounters as primary operator b) patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used c) operating room cases d) clinical procedures (e.g. emergency, trauma, restorative, preventative, orthodontic, multi-disciplinary, etc.) e) patient diversity/complexity (e.g. well-patient, medically complex, special needs, hospital based, etc.) ***Intent:*** *These records are to be available for on-site review: overall program objectives, objectives of student/resident rotations, specific student/resident schedules by semester or year, completed student/resident evaluation forms for current students/residents and recent alumni, self-assessment process, curricula vitae of faculty responsible for instruction. The RCL provides programs with data required for program improvement and gives students/residents and official record of clinical procedures required by regulatory boards and hospitals. The RCL may be comprised of a HIPAA-compliant patient and procedure log and/or a printout of procedure codes, for example, and may be compiled by the program, student/resident, and/or staff.* 2-2.9 Responsibility for overall continuity and quality of patient care. 2-2.10 Oversight responsibility for student/resident research. 2-2.11 Responsibility for determining the roles and responsibilities of associate program director(s) and their regular evaluation.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

	Standard 5	A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program: a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods; b. Provides to students/residents an assessment of their performance, at least semiannually; c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.
Periodontics		
	Standard 2	**The program must be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)** **The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.** **Documentation of all program activities must be ensured by the program director and available for review.**
	Standard 2-1	**The program director must have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following:** **a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences;** **b. Promote cooperation between periodontics, general dentistry, related dental specialties and other health sciences;** **c. Select students/residents qualified to undertake training in periodontics unless the program is sponsored by a federal service utilizing a**

		centralized student/resident selection process; **d. Develop and implement the curriculum plan;** **e. Evaluate and document student/resident and faculty performance;** **f. Document educational and patient care records as well as records of student/resident attendance and participation in didactic and clinical programs; and** **g. Responsibility for the quality and continuity of patient care.**
	Standard 2-2	**The program director must prepare graduates to seek certification by the American Board of Periodontology.** **a. The program director must track Board Certification of program graduates.**
	Standard 2-9	**The program director and faculty must actively participate in the assessment of the outcomes of the educational program.**
Prosthodontics		
	Standard 1	The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director **must** have the authority responsibility, and privileges necessary to manage the program.
	Standard 1-2	For each site, including those at major and minor educational activity sites, there **must** be an on-site clinical supervisor who is an educationally qualified specialist in the curriculum areas for which he/she is responsible.
	Standard 2	The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.) ***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.*
	Standard 2	The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.

	Standard 2	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 2-1.1	The program director **must** have primary responsibility for the organization and execution of the educational and administrative components to the program.
		The program director must devote sufficient time to: *a. Participate in the student/resident selection process, unless the program is sponsored by federal services utilizing a centralized student/resident selection process;* *b. Develop and implement the curriculum plan to provide a diverse educational experience in biomedical and clinical sciences;* *c. Maintain a current copy of the curriculum's goals, objectives, and content outlines;* d. Maintain a record of the number and variety of clinical experiences accomplished by each student/resident; e. Ensure that the majority of faculty assigned to the program are educationally qualified prosthodontists; f. Provide written faculty evaluations at least annually to determine the effectiveness of the faculty in the educational program; g. Conduct periodic staff meetings for the proper administration of the educational program; and h. Maintain adequate records of clinical supervision.
	Standard 2-2	The program director **must** encourage students/residents to seek certification by the American Board of Prosthodontics.
	Standard 4	Documentation of all program activities **must** be ensured by the program director and available for review.
	Standard 4	If an institution and/or program enrolls part-time students/residents, the institution/program **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.
	Intent Standard 4-4	Students/Residents **must** have the didactic/clinical background that supports successful completion of the prosthodontic specialty board examination and fosters life-long learning. ***Intent****: Program directors promote prosthodontic board certification. It is expected that students/residents continue their life-long professional development by employing the didactic and clinical knowledge acquired during the program.*

	Intent Standard 4-32	Students/Residents **must** have the didactic/clinical background that supports successful completion of the prosthodontic specialty board examination and fosters life-long learning. ***Intent**: Program directors should promote prosthodontic board certification to attain the appropriate hospital appointment for the clinical practice of maxillofacial prosthetics. It is expected that students/residents continue their life-long professional development by employing the didactic and clinical knowledge acquired during the maxillofacial program.*
	Standard 5	A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program: a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods; b. Provides to students/residents an assessment of their performance, at least semiannually; c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.

CONSIDERATION OF ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY RELATED TO DIVERSITY AND HUMANISTIC CULTURE AND LEARNING ENVIRONMENT

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

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

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

The short-term suggestions from TNCDHE included:

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

The long-term suggestions from TNCDHE included:

1. Achieving a humanistic environment, addressing discrimination in policies and practice.

Suggested revisions to the Accreditation Standards for Predoctoral Dental Education Programs were provided.

2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.
3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

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

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

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

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

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

Recommendation:

Prepared by: Dr. Sherin Tooks

The National Coalition of DENTISTS for HEALTH EQUITY

December 1, 2023

Dr. Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
tookss@ada.org

Dear Dr. Tooks,

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

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

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

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

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

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

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

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

SHORT-TERM SUGGESTIONS

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

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

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

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

LONG-TERM SUGGESTIONS

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

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

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

2) Student Admissions

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

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

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

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

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

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

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

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

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

3) Inclusive Environments in Dental Education

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

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

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

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

4) Access to Care among Diverse Populations

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

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

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

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

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

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

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

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

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

National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board
Diverse Dental Society – Dr. Tamana Begay, President
American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director
Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager
Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director;
American Dental Association – Dr. Ray Cohlmia, Executive Director; Dr. Jane Grover, Council on Advocacy for Access, and Prevention; Dr. Linda J. Edgar, President
American Dental Hygienists' Association – Jennifer Hill, Interim CEO; JoAnn Gurenlian, RDH, MS, PhD, AAFAAOM, FADHA Director, Education, Research & Advocacy
Community Catalyst – Tera Bianchi, Director of Partner Engagement; Parrish Ravelli, Associate Director, Dental Access Project
National Indian Health Board – Brett Webber, Environmental Health Programs Director; Dawn Landon, Public Health Policy and Programs Project Coordinator
American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Annaliese Cothron, Executive Director

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COMMISSION ON DENTAL ACCREDITATION
STANDARDS RELATED TO DIVERSITY AND LEARNING ENVIRONMENT

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

Discipline	Standard Number	Requirement of the Standard
Predoctoral Dental		
	Standard 1-3	The dental education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated. **Intent:** *The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.* **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 1-4	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. **Intent:** *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.
	Standard 2-17	Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment. **Intent:** *Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:* • *basic principles of culturally competent health care;* • *basic principles of health literacy and effective communication for all patient populations* • *recognition of health care disparities and the development of solutions;* • *the importance of meeting the health care needs of dentally underserved populations, and;* • *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi- dimensionally diverse society.*
	Standard 2-26	Dental education programs **must** make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences. **Intent:** *Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.*
	Standard 4-4	Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population. **Intent 4-1 to 4-4:** *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.
	Proposed Educational Environment	Among the factors that may influence predoctoral curricula are expectations of the parent institution, standing or emerging scientific evidence, new research foci, interfaces with specialty or other dental-related education programs, approaches to clinical education, and pedagogical philosophies and practices. In addition, the demographics of our society are changing, and the educational environment must reflect those changes. People are living longer with more complex health issues, and the dental profession will routinely be expected to provide care for these individuals. Each dental school must also have policies and practices to achieve an appropriate level of diversity among its students, faculty, and staff. While ~~diversity~~ variability of curricula is a strength of dental education, the core principles below promote an environment conducive to change, innovation, and continuous improvement in educational programs. Application of these principles throughout the dental education program is essential to achieving quality.
	Proposed ~~Humanistic~~ Learning Environment	Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A ~~humanistic pedagogy~~ safe learning environment inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising, and small group interaction. A dental school environment characterized by: • physical and psychological safety, free of intimidation, abuse, and retaliation; • respectful and collegial professional relationships between and among faculty, staff, and students; and • ~~establishes~~ a context for the development of interpersonal skills necessary for learning, ~~for~~ and patient care., ~~and for making meaningful contributions to the profession.~~
	Proposed Diversity and Inclusion	Diversity and inclusion in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, national origin, gender identity, age, physical abilities/qualities, sexual orientation, religions, and ideologic backgrounds; come from ~~cities~~ urban, rural areas, and from various geographic regions; and have a wide variety of interests,

		~~talents~~ abilities, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogeneous environment. Programs ~~must~~ strive to create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural, religious, and socioeconomic lines.
	Proposed Definition of Terms	**Cultural competence**: Having the ability to provide care to patients with diverse backgrounds, values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers' understanding the relationship between diversity of culture, values, beliefs, behavior, and language and the needs of patients. ~~**Dimensions of Diversity**: The dimensions of diversity include: structural, curriculum and institutional climate.~~ **Diversity - Structural:** Structural diversity, also referred to as compositional diversity, focuses on ~~the numerical distribution of~~ students, faculty, and staff from diverse backgrounds in a program or institution. ~~**Curriculum:** Curriculum diversity, also referred to as classroom diversity, covers both the diversity-related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.~~ **Diversity - Institutional Climate:** Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.
	Proposed Standard 1-2	The dental education program **must** ~~have a stated~~ demonstrate a commitment to a ~~humanistic culture and~~ learning environment that includes: ~~is regularly evaluated.~~ a. a stated commitment and activities to promote a safe learning environment; b. regular evaluation of the learning environment, with input from faculty, staff, and students;

		c. actions aimed at enhancing the learning environment based on the results of regular evaluation. ~~**Intent:**~~ ~~*The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.*~~ **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Development of a Code of Conduct • Training to recognize and mitigate microaggressions, implicit and explicit bias, racism, gender identity and sexual orientation, hate speech, or other derogatory or harmful behaviors • Student, faculty, and ~~patient~~ staff groups involved in ~~promoting diversity,~~ professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, ~~patient, and alumni~~ and staff perceptions of the ~~cultural~~ learning environment
	Proposed Standard 1-3	The dental school **must** have policies and practices related to diversity and inclusion consistent with University policies and state law to: ~~a. achieve appropriate levels of diversity among its students, faculty and staff;~~ ~~b.~~ a. engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; ~~and~~ ~~c.~~ b. systematically evaluate ~~comprehensive~~ strategies to improve the ~~institutional climate for~~ dental school's diversity and inclusion.; and ~~d.~~ c. engage in actions aimed at enhancing the program's diversity and inclusion based on results of regular evaluation. **Intent:** ~~*The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate.*~~ *The dental school ~~should~~ articulate*s *its expectations regarding diversity, equity, inclusion, and belonging ~~across its academic community in the context of local and national responsibilities~~, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity and inclusion in their planning that include, but are not limited to,*

		gender, ethnicity, race, cultural, and socioeconomic factors. ~~*gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.*~~
	Proposed Standard 2-9	Instruction in social and behavioral sciences **must** be at an in-depth level and include: a. patient management, including cultural diversity and interpersonal communications skills; b. intra-professional collaboration, including communicating with other members of the oral health care team; c. inter-professional collaboration, including communicating with other members of the health care team; d. professional conduct, including ethical decision making; e. legal and regulatory concepts related to patient care; f. basic principles of practice management, including models of oral health care delivery, and how to function successfully as the leader of the oral health care team; and g. oral epidemiology, dental public health, and social determinants of health.
	Proposed Standard 2-10	Following patient experiences, graduates **must** demonstrate competence in social and behavioral sciences including: a. patient management, including cultural diversity and interpersonal communications skills; b. demonstration of intra-professional collaboration, including communicating with other members of the oral health care team; c. demonstration of inter-professional collaboration, including communicating with other members of the health care team d. adherence to professional conduct, including ethical decision making; and e. compliance with legal and regulatory concepts related to patient care.
	Proposed Standard 2-15	~~Dental education programs~~ The dental education program **must** make available community-based patient experience opportunities and encourage students to ~~engage in service learning experiences and/or community based learning experiences~~ interact with and treat patients in varied clinical environments. **Intent:** ~~*Service learning experiences and/or c*~~*Community-based learning experiences are* ~~*essential*~~ *valuable to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the* ~~*value of*~~ *community* ~~*service*~~*.*

	Proposed Standard 4-1	~~Specific w~~Written criteria, policies and procedures, including policies and procedures designed to recruit and admit a diverse student population, **must** be followed when admitting predoctoral students. **Intent 4-1 to ~~4-3~~ 4-4:** *The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures ~~should~~ ensure~~s~~ 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.*
Dental Assisting		
	Standard 1-7	**There must be an active advisory committee to serve as a liaison between the program, local dental and allied dental professionals and the community. Dentists and dental assistants must be equally represented.** **Intent:** *The purpose of the advisory committee is to provide a mutual exchange of information for program enhancement, meeting program and community needs, standards of patient care, and scope of practice. Membership should include representation from a variety of practice settings. The program administrator, faculty, students, and appropriate institutional personnel are non-voting participants.* **Examples of evidence to demonstrate compliance may include:** •Membership responsibilities are defined and terms staggered to provide both new input and continuity •Diverse membership with consideration given to student representation, recent graduate(s), public representation, and a profile of the local dental community. •Responsibilities of program representatives on the committee are defined in writing. •Meeting minutes are maintained and distributed to committee members.
	Standard 2-14	**The dental science aspect of the curriculum must include content at the familiarity level in:** **a. Oral pathology** **b. General anatomy and physiology** **c. Microbiology** **d. Nutrition** **e. Pharmacology to include:** **i. Drug requirements, agencies, and regulations** **ii. Drug prescriptions**

		iii. Drug actions, side effects, indications and contraindications **iv. Common drugs used in dentistry** **v. Properties of anesthetics** **vi. Drugs and agents used to treat dental-related infection** **vii. Drug addiction including opioids and other substances** **f. Patients with special needs including patients whose medical, physical, psychological, or social conditions make it necessary to modify normal dental routines.**
	Standard 2-20	**The program must demonstrate effectiveness in creating an academic environment that supports ethical and professional responsibility to include:** **a. Psychology of patient management and interpersonal communication** **b. Legal and ethical aspects of dentistry** **Intent:** *Faculty, staff and students should know how to draw on a range of resources such as professional codes, regulatory law and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive or of public concern.* **Examples of evidence may include:** • Faculty, student, staff membership and participation in dental professional organizations, e.g., American Dental Assistants Association, American Dental Education Association, American Dental Association • Professional Code of Conduct • State Dental Practice Act • Student Handbook • Professional and ethical expectations
	Standard 2-21	**The dental assisting program must provide opportunities and encourage students to engage in service and/or community-based learning experiences.** **Intent:** *Community-based experiences are essential to develop dental assistants who are responsive to the needs of a culturally diverse population.* **Examples of evidence may include:** •Service hours •Volunteer activities
Dental Hygiene		
	Standard 1-2	**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, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship. **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 2-12	Graduates must be competent in providing dental hygiene care for all patient populations including: 1) child 2) adolescent 3) adult 4) geriatric 5) special needs Intent: An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, developmental, intellectual or social conditions may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student. Clinical instruction and experiences should include the dental hygiene process of care compatible with each of these patient populations.
	Standard 2-15	Graduates must be competent in interprofessional communication, collaboration and interaction with other members of the health care team to support comprehensive patient care. Intent: Students should understand the roles of members of the health-care team and have interprofessional educational experiences that involve working with other health-care professional students and practitioners. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental Hygienists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).
	Standard 2-19	Graduates must be competent in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management. Intent: Dental hygienists should understand and practice ethical behavior consistent with the professional code of ethics throughout their educational experiences.

Dental Laboratory Technology		
	Standard 1-7	**There must be an active liaison mechanism between the program and dental professionals in the community.** **Intent:** *The purpose of the active liaison mechanism is to provide a mutual exchange of information for improving the program and meeting employment needs of the community.* *Meetings, either in-person or virtual, should be held at least once per year.*
	Standard 2-1	**Admission of students must be based on specific written criteria, procedures and policies. Minimum admissions requirements must include high school diploma or its equivalent. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability, and employment opportunities for dental laboratory technicians.** **Intent:** *Because the curriculum is science and technology-oriented and enrollment is limited by facility capacity, special program admissions criteria and procedures may be necessary. The program administrator and faculty, in cooperation with appropriate institutional personnel establish admissions procedures which are non-discriminatory, contribute to the quality of the program, and allow selection of students with potential for successfully completing the program.*
	Standard 2-7	**The basic curriculum must include content in the subject areas: general studies; physical sciences; dental sciences; legal, ethical and historical aspects of dentistry and dental laboratory technology; infectious disease and hazard control management; and, basic laboratory techniques.** **Intent:** *To ensure that foundational knowledge is established early in the program and that subsequent information is provided which is comprehensive and prepares the student to achieve competence in all components of dental laboratory practice. Content identified in each subject need not constitute a separate course, but the subject areas are included within the curriculum.*
	Standard 2-11	**The curriculum must include content in the legal, ethical and historical aspects of dentistry and dental laboratory technology to include:**

		a) Organizations that advance certification and continuing education for dental technicians and certification of laboratories. **b) Work authorization/prescription of the dentist in accordance with the state dental practice act, consistent with current procedures in dental laboratory technology in the geographic area served by the program.** **c) Federal and state laws and regulations related to operating a dental laboratory and/or working as a dental laboratory technician.** **d) HIPAA laws related to health care professionals** **e) Ethics for health care professionals** **Intent:** *The dental laboratory technology curriculum prepares students to assume a professional and ethical standard to understand the basic foundation in which the fundamentals of dental laboratory technology were established.*
Dental Therapy		
	Standard 1-3	The dental therapy education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated. **Intent:** *The dental therapy education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.* **Examples of evidence to demonstrate compliance may include:** • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available • Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities • Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment
	Standard 1-4	The program **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.

		Intent: *The program should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The program should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Programs could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Programs should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.*
	Standard 2-14	Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment. **Intent:** *Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:* • *basic principles of culturally competent health care;* • *basic principles of health literacy and effective communication for all patient populations;* • *recognition of health care disparities and the development of solutions;* • *the importance of meeting the health care needs of dentally underserved populations, and;* • *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.* *Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).* **Examples of evidence to demonstrate compliance may include:** • student projects demonstrating the ability to communicate effectively with a variety of individuals and groups.

		• examples of individual and community-based oral health projects implemented by students during the previous academic year • evaluation mechanisms designed to monitor knowledge and performance
	Standard 2-24	Dental therapy education programs **must** have students engage in service learning experiences and/or community-based learning experiences. **Intent:** *Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.*
	Standard 4-2	Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population. **Intent:** *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*.
Advanced Education in General Dentistry		
	Goals 2, 6, 7	2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs. 6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 7. Understand the oral health needs of communities and engage in community service.
	Standard 1-10	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to*

		guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
	Standard 2-1	The program **must** provide didactic and clinical training to ensure upon completion of training, the resident is able to: a) Act as a primary oral health care provider to include: 1) providing emergency and multidisciplinary comprehensive oral health care; 2) obtaining informed consent; 3) functioning effectively within interdisciplinary health care teams, including consultation and referral; 4) providing patient-focused care that is coordinated by the general practitioner; and 5) directing health promotion and disease prevention activities. b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs. c) Manage the delivery of patient-focused oral health care. ***Intent:*** *"Patients with special needs" is defined in the Definition of Terms on page 10 of this document.* *Patient-focused care should include concepts related to the patient's social, cultural, behavioral, economic, medical and physical status.*
General Practice Residency		
	Goals 2, 7, 8	2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs. 7. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 8. Understand the oral health needs of communities and engage in community service
	Standard 1-10	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

		Intent: *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-1	The program **must** provide didactic and clinical training to ensure upon completion of training, the resident is able to: a) Act as a primary oral health care provider to include: 1) providing emergency and multidisciplinary comprehensive oral health care; 2) obtaining informed consent; 3) functioning effectively within interdisciplinary health care teams, including consultation and referral; 4) providing patient-focused care that is coordinated by the general practitioner; and 5) directing health promotion and disease prevention activities. b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs. c) Manage the delivery of patient-focused oral health care. ***Intent:*** *"Patients with special needs" is defined in the Definition of Terms on page 10 of this document.* *Patient-focused care should include concepts related to the patient's social, cultural, behavioral, economic, medical and physical status.*
Dental Anesthesiology		
	Standard 1-10	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*

	Goals 2, 7	2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs. 7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.
	Standard 2-1	The program **must** list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.
	Standard 2-6	The following list represents the minimum clinical experiences that **must** be obtained by each resident in the program at the completion of training: a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty five (25) advanced airway technique requirements can be blind nasal intubations. (2) One hundred and twenty five (125) children age seven (7) and under, and (3) Seventy five (75) patients with special needs, and b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation.
Dental Public Health		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments,

		complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-2	Graduates **must** receive instruction in and be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, practice management, and programs to promote the oral health of individuals and communities. ***Intent:*** *Graduates are expected to know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern. Graduates are expected to respect the culture, diversity, beliefs and values in the community.*
Endodontics		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of

		Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 1-1	Graduates **must** receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *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.*
Oral and Maxillofacial Pathology		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-8.1	**Graduates must have an understanding of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.**

		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*
Oral and Maxillofacial Radiology		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-3	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.*
Oral and Maxillofacial Surgery (Residency)		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care

		without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-16	Graduates must receive instruction in the application of the principle of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *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.*
	Standard 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 2-1.7	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
	Standard 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*
	Standard 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.
	Standard 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.
	Standard 4-21 (4-21.1 – 4-21.4)	Residents must be educated in wellness, impairment, burnout, depression, suicide, and substance abuse as well as on the importance of adequate rest to avoid fatigue in order to balance their professional lives and deliver high quality care. ***Intent:*** *It is understood that many competing interests exist both within and outside of their commitment to residency obligations. Residents need to understand the value of wellness and fatigue and have the ability to openly address individual and programmatic concerns. Programs need to be responsive to concerns raised regarding out of balance or inappropriate burdens placed on residents that undermine the primary purposes of their training.*

		Programs also need to look for resident duties that could be reasonably offloaded to non-residents in order to optimize resident education, promote wellness, and avoid fatigue. Examples of evidence to demonstrate compliance may include: • ROAAOMS Wellness Webinar Series • Resident Evaluations of the program • SCORE and/or institutional modules on wellness 4.21.1 The program must have policies in place that promote faculty and residents looking out for the wellness of one another and fitness for patient care with mechanisms for reporting at-risk behaviors without the fear of retaliation. 4-21.2 Programs must blend supervised patient care, teaching responsibilities of residents, didactic commitments, and scholarly activity of residents such that it is accomplished without the excessive reliance on residents to fulfill other service needs and without compromising wellness and fatigue. 4-21.3 Resident work hours must be monitored and reviewed. *Intent:* It is required that programs have a system in place for ongoing monitoring of weekly work hours including total number of hours worked, time off between shifts, and days off per week. This data can then be reviewed in appropriate settings such as faculty and resident meetings, annual reviews, and morbidity and mortality conferences. The tracking of hours creates data for shared decision making and assists programs in addressing outlying individuals or situations that could be avoided with more effective training and programmatic structure. 4-21.4 The program must have policies and procedures which allow residents leaves of absence from work in order to address issues not limited to fatigue, illness, family emergencies, and parental leave.
Oral and Maxillofacial Surgery (Fellowship)		
	None	
Oral Medicine		
	Goals 6, 7	6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice. 7. Understand the oral health needs of communities and engage in community service.

	Standard 1-12	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-12	The educational program **must** provide training to the level of competency for the resident to: a) perform a comprehensive physical evaluation and medical risk assessment on patients who have medically complex conditions and make recommendations for dental treatment plans and modifications;
Orofacial Pain		
	Goals 2, 10	2. Plan and provide interdisciplinary/multidisciplinary health care for a wide variety of patients with orofacial pain. 10. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
	Standard 1-11	The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. ***Intent:*** *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*
	Standard 2-10	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.*
Orthodontics and Dentofacial Orthopedics (Residency)		

	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 1-1	Graduates **must** receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *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.*
	Standard 4-3.2	**An advanced dental education program in orthodontics and dentofacial orthopedics requires extensive and comprehensive clinical experience, which must be representative of the character of orthodontic problems encountered in private practice.** ***Intent****: The intent is to ensure there is diversity in the patient population so that the students/residents will learn to treat a variety of orthodontic problems from the primary to adult dentition.*
Orthodontics and Dentofacial Orthopedics (Fellowship)		
	None	

Pediatric Dentistry		Note: The nature of the discipline requires treating infant, child, adolescent and patients with special healthcare needs.
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, national origin, age, disability, sexual orientation, status with respect to public assistance or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 4-6	Didactic Instruction: Didactic instruction in behavior guidance **must** be at the in-depth level and include: a. Physical, psychological and social development. This includes the basic principles and theories of child development and the age-appropriate behavior responses in the dental setting; b. Child behavior guidance in the dental setting and the objectives of various guidance methods; c. Principles of communication, listening techniques, and communication with parents and caregivers; d. Principles of informed consent relative to behavior guidance and treatment options; e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the REFERENCE MANUAL; and f. Recognition, treatment and management of adverse events related to sedation and general anesthesia, including airway problems. ***Intent:*** *The term "treatment" refers to direct care provided by the residents/student for that condition or clinical problem. The term*

		"management" refers to provision of appropriate care and /or referral for a condition consistent with contemporary practice and in the best interest of the patient.
	4-7	Clinical Experiences: Clinical experiences in behavior guidance **must** enable students/residents to achieve competency in patient management using behavior guidance: a. Experiences **must** include infants, children and adolescents including individuals with special health care needs, using: 1. Non-pharmacological techniques; 2. Sedation; and 3. Inhalation analgesia. b. Students/Residents **must** perform adequate patient encounters to achieve competency: 1. Students/Residents **must** complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and 2. Students/Residents **must** complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.
	Standard 4-7	Clinical Experiences: Clinical experiences in behavior guidance **must** enable students/residents to achieve competency in patient management using behavior guidance: a. Experiences **must** include infants, children and adolescents including individuals with special health care needs, using: 1. Non-pharmacological techniques; 2. Minimal ~~S~~sedation; and 3. Moderate sedation ~~Inhalation analgesia~~. b. Students/Residents **must** perform adequate patient encounters to achieve competency: 1. ~~Students/Residents **must** complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and~~ 2. 1. Students/Residents **must** complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used to sedate pediatric patients or patients with special health care needs. The

		agents may be administered by any route.
	Standard 4-20	Didactic Instruction: Didactic instruction **must** be at the understanding level and include: a. The design, implementation and management of a contemporary practice of pediatric dentistry, emphasizing business skills for proper and efficient practice; b. Jurisprudence and risk management specific to the practice of Pediatric Dentistry; c. Use of technology in didactic, clinical and research endeavors, as well as in practice management and telehealth systems; d. Principles of biomedical ethical reasoning, ethical decision making and professionalism as they pertain to the academic environment, research, patient care and practice management; and e. Working cooperatively with consultants and clinicians in other dental specialties and health fields, including interprofessional education activities. Didactic instruction **must** be at the in-depth level for the following: f. The development and monitoring of systems for prevention and management of adverse events and medical emergencies in the dental setting; g. Exposure to the principles of quality management systems and the role of continuous process improvement in achieving overall quality in the dental practice setting; h. Exposure to the principles of ethics and professionalism in dental practice is an integral component of all aspects of this process improvement experience; and i. Employing principles of quality improvement, infection control, and safety, including an understanding of the mechanisms to ensure a safe practice environment. ***Intent:*** *(d) Graduates should draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern, (e) The student/resident learns to prevent, recognize and manage common medical emergencies for infants and children through adolescence and when to refer to other health care professionals and (g) Graduates should experience the elements of process improvement and the manner in which to involve the entire team*
	Standard 4-22	Didactic Instruction: Didactic instruction **must** be at the in-depth level and include: a. Formulation of treatment plans for individuals with special health care needs. b. Medical conditions and the alternatives in

		the delivery of dental care that those conditions might require. c. Management of the oral health of individuals with special health care needs, i.e.: 1. Medically compromised; 2. Physically compromised or disabled; and diagnosed to have developmental disabilities, psychiatric disorders or psychological disorders. 3. Transition to adult practices ***Intent:*** *(a) The student/resident learns how and when to modify dental care options as required by a patient's medical condition; and (c) Individuals with special health care needs include those with* *medical, physical, psychological or social circumstances that require modification in normal dental routines to provide dental treatment.*
	Standard 4-23	Clinical Experiences: Clinical experiences **must** enable students/residents to achieve competency in: a. Examination, treatment and management of infants, children, adolescents and individuals with special health care needs; and b. Participation in interprofessional experiences and collaborative care, including craniofacial teams. ***Intent:*** *Pediatric dentists often remain providers of oral health care for individuals with special health care needs into adulthood and should be able to render basic dental services to adults with special health care needs. These individuals include (but are not limited to) individuals with developmental disabilities, craniofacial anomalies, complex medical problems and significant physical limitations. Management should be understood to include consideration of social, educational, vocational and other aspects of special health care needs.*
	Standard 4-28	Didactic Instruction: Didactic instruction **must** be at the understanding level and include: a. The fundamental domains of child advocacy including knowledge about the disparities in the delivery of dental care, issues pertaining to access to dental care and possible solutions; b. The social determinants of health and the impact on general and oral health; c. Services available through healthcare and oral healthcare programs for at-risk populations, such as U.S. governmental programs (e.g., Medicaid and SCHIP); and

		d. Principles of learning and teaching to diverse audiences. ***Intent:*** *Pediatric dentists serve as the primary advocates for the oral health of children. The intent of the competency standards is to ensure that the resident is adequately trained to assume this role. Such training includes enhancing knowledge about oral health disparities and available services within the state and federal programs directed at meeting those needs. It also includes knowledge about their role as advisors to policy makers and organized dentistry.*
	Standard 4-29	Experiences: Experiences **must** provide exposure of the student/resident to: a. Communicating, teaching, and collaborating with groups and individuals on children's oral health issues; and/or b. Advocating and advising public health policy legislation and regulations to protect and promote the oral health of children; and/or c. Participating at the local, state and/or national level in organized dentistry and child advocacy groups/organizations to represent the oral health needs of children, particularly the underserved.
Periodontics		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

		The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.
	Standard 1-1	Graduates **must** receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management. *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.*
	Standard 2-1.a	The program director **must** have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following: a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences;
Prosthodontics		
	Preface	As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery. The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.

	Standard 4-21	Students/Residents **must** be competent regarding principles of ethical decision making pertaining to academic, research, patient care and practice environments. ***Intent****: Students/Residents should be able to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive or of public concern.*