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

Committee Chair: Dr. Cataldo Leone. Committee Members: Dr. Sillas Duarte (virtual Tuesday), Dr. Kevin Haubrick, Ms. Danae Kotula (virtual), Ms. Wilhemina Leeuw, Dr. Thomas McConnell, Dr. Scott Phillips, Dr. Daniel Shin, and Dr. Deborah Weisfuse (virtual). Commissioner Trainees: Dr. Richard Callan, Dr. Russel Chin, Dr. Theresa Gonzalez, and Dr. Patrick Lloyd observed the meeting virtually as Commissioner trainees. Staff Members: Ms. Kelly Stapleton, manager, Predoctoral Dental Education and Ms. Attiyya Muhammad, senior project assistant, CODA. Dr. Sherin Tooks, senior director, CODA, attended a portion of the meeting. The meeting of the Review Committee on Predoctoral Dental Education (PREDOC RC) was held on July 7 – 8, 2025 at the ADA Headquarters, Chicago, Illinois and via a virtual meeting and on July 28, 2025 via a virtual meeting.

CONSIDERATION OF MATTERS RELATED TO PREDOCTORAL DENTAL EDUCATION AND DENTAL THERAPY EDUACTION

Informational Report on Frequency of Citings of Accreditation Standards for Dental Education Programs (p. 100): The Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the annual report on the frequency of citings for dental education programs (**Policy Report p. 100**). The PREDOC RC discussed that the highest number of citings overall are found within Standard 2 on Educational Program, with 214 citings. The Commission noted Standard 2-9, which requires availability of adequate patient experiences received 21 citings. Standard 2-19, which requires graduates to be competent in practice management received 15 citings. Standard 2-5 which requires methods of student evaluation to measure defined competencies received 14 citings. The highest number of citings for a single area of compliance (with 27 citings) was Standard 2-24 h, regarding competency in the replacement of teeth including fixed, removable and dental implant prosthodontic therapies. Overall, Standard 2-24 a-o totaled 100 citings and is the most frequently cited Standard within dental education.

Standard 5 on Patient Care Services was the second most frequently cited area with 71 citings total. The second most frequently cited Standard (with 49 citings total) was Standard 5-3 a-e, which requires programs to conduct a formal system of continuous quality improvement for patient care. There were 28 citings for Standard 1 - Institutional Effectiveness, 12 citings for Standard 3 - Faculty and Staff, 14 citings for Standard 4 - Educational Support Services, and six (6) citings for Standard 6 - Research Program. Of the 130 site visits conducted since the adoption of the current Accreditation Standards, 61 programs were in compliance with all requirements at the time of the site visit.

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

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

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

Report of the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs (p. 102): In accordance with the prior directives of the Commission on Dental Accreditation (CODA), the Ad Hoc Committee continued its work to review the comments received following the six (6) month circulation of the proposed revisions to the Accreditation Standards for Dental Education Programs. The previous work of the Ad Hoc Committee and directives of the Commission are found in **Policy Report p. 102**.

The Ad Hoc Committee initiated its meetings in December 2024 following receipt of all comments, including both written comments and comments received during the Commission Hearing in October 2024 (**Appendix 3 and 4, Policy Report p. 102**). The Committee discussed first impressions of the comments noting the variety, volume, and common themes. The Committee decided to move forward by organizing all comments by Standard and to proceed in the following meetings to review each comment Standard by Standard. The Committee started with reviewing comments related to the Introduction, Goals, Educational Environment, and Definition of Terms. The Committee then proceeded with reviewing comments related to Standard 1, Standard 3, Standard 4, Standard 5, and Standard 6, respectively. The Committee reviewed Standard 2 comments last to ensure the focus remained on the educational aspects of the Standards. In consideration of comments received and as directed by CODA in Winter 2025, the Ad Hoc Committee also discussed the topic of administrative oversight at major sites where educational activity occurs, and the topic of diversity and the humanistic culture and learning environment. Finally, the Committee reviewed the entire document for consistency among language and for any conflicts or discrepancies between Standards.

At its Summer 2025 meeting, the Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the Report of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs (**Policy Report p. 102**), including the background and history of the Ad Hoc Committee composition, and the Committee's recommendations for revision of the dental education Standards. The PREDOC RC noted the first circulation of the proposed revisions **(Appendix 5, Policy Report p. 102)** of the dental education Standards received an abundance of comments in various areas and noted that the Ad Hoc Committee held considerable discussions (i.e., 11 meetings) about comments making further improvements to the proposed revisions. The PREDOC RC discussed the most recent revisions **(Appendix 1)** to the Accreditation Standards, which was submitted by the Ad Hoc Committee following

consideration of all comments received. It was noted that a summary is provided on the first pages of the second proposed revisions document to further explain changes made since the previous circulation. The summary also retains background on the revisions circulated following the Summer 2024 Commission meeting to ensure that the community of interest is able to understand the progression of the proposed changes. The PREDOC RC noted that the Commission makes proposed revisions to the current Standards, not prior circulations of proposed Standards, to ensure there is no confusion as to what Standards are currently in place or presented as revised. Following consideration, the PREDOC RC believed that the proposed revisions found in **Appendix 1,** including the explanation of proposed revisions cover page, should be circulated to the communities of interest for a period of six (6) months to gather additional feedback, including a Hearing in conjunction with the October 2025 American Dental Association Annual Meeting, with comments to be reviewed at future meetings of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs. The PREDOC RC believed an additional six (6) month circulation was sufficient since this is the second call for comments, following an initial six (6) month circulation in Fall 2024.

The PREDOC RC also discussed the need for CODA's revision of supporting documents to the Standards, including the self-study, applications, and the site visit schedule. To continue the work of the Ad Hoc Committee while revisions are circulated this fall, the PREDOC RC believed that the Ad Hoc Committee's charge should be revised to direct that the Ad Hoc Committee begin reviewing the Self-Study Guide for Dental Education Programs to align with the proposed revisions to the Accreditation Standards. The PREDOC RC noted that many programs will be preparing for site visits in the coming years and believes that documents such as the self-study guide should be prepared and ready to share with programs when the Accreditation Standards are adopted in the future. The PREDOC RC also believed that the current membership and composition of the Ad Hoc Committee should be retained to ensure continuity in the review process of the revised Standards and Self-Study Guide.

> **Recommendation:** It is recommended that the Commission on Dental Accreditation direct that proposed revisions to the Accreditation Standards for Dental Education Programs (**Appendix 1**) be circulated for six (6) months to the communities of interest to obtain feedback on the proposed revisions, including a Hearing in conjunction with the October 2025 American Dental Association Annual Meeting, with comments to be reviewed at future meetings of the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs, the Review Committee and the Commission.
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> It is further recommended that the Commission on Dental Accreditation direct the Ad Hoc Committee to Review the Accreditation Standards for Dental Education Programs to review and revise the Self-Study Guide for Dental Education Programs to align with the proposed revisions of the Accreditation Standards for Dental Education Programs, with a future report to the Review Committee and the Commission.
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> It is further recommended that the Commission on Dental Accreditation direct that the current membership and composition of the Ad Hoc Committee to Review the

Accreditation Standards for Dental Education Programs be retained through completion of the Ad Hoc Committee's charge to review the Accreditation Standards for Dental Education Programs and related documents.

Report on the 2025 Validity and Reliability Study of the Accreditation Standards for Dental Therapy Education Programs (p. 103): The Accreditation Standards for Dental Therapy Education Programs **(Appendix 1, Policy Report p. 103)** were adopted by the Commission on Dental Accreditation at its February 6, 2015 meeting for implementation August 7, 2015. According to the Commission's "Policy on Assessing the Validity and Reliability of the Accreditation Standards", the validity and reliability of Accreditation Standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the Standards for a one (1) year program will be assessed after four (4) years, while Standards applying to program two (2) years in length will be assessed five (5) years after implementation. In accordance with this policy, the Validity and Reliability Study for Accreditation Standards for Dental Therapy Programs was initiated in Spring 2025 with the results to be reviewed at the Summer 2025 meeting of the Commission.

A total of 293 individuals were invited by e-mail to complete the online survey on May 7, 2025. In order to increase the response rate, follow-up mailings were administered to all non-respondents on May 14, 2025 and May 22, 2025. Data collection ended on May 27, 2025, yielding 77 respondents, for an overall adjusted response rate of 24.1% (excluding those whose e-mail addresses were invalid).

At its Summer 2025 meeting and following consideration of the report, the PREDOC RC believed that an Ad Hoc Committee should be formed to further review the results of the Validity and Reliability Study for consideration of revisions to the Accreditation Standards for Dental Therapy Education Programs. The PREDOC RC also recalled previous charges from the Commission at its Winter 2022 and Winter 2025 meetings to review the Accreditation Standards for Dental Therapy Education Programs related to the usage of the word "should", expectations related to educational activity sites, standards related to patients with special needs, standards related to on-site supervision by program directors at educational activity sites, and standards related to review of diversity, humanistic culture, and learning environment. The PREDOC RC believes that the Ad Hoc Committee should review these topics with the comments received on the Validity and Reliability Study. The PREDOC RC believed the membership of the Ad Hoc Committee should be comprised of select members from the PREDOC RC, one (1) dental therapy educator, and one (1) dental therapy site visitor who will be appointed by the Commission. Once appointed, the Ad Hoc Committee could begin its work with a future report to the Review Committee on Predoctoral Dental Education and Commission.

Recommendation: It is recommended that the Commission on Dental Accreditation direct the formation of an Ad Hoc Committee of select members of the Predoctoral Dental Education Review Committee, one (1) dental therapy educator, and one (1) dental therapy site visitor to further study the data and comments collected through the Validity

and Reliability Study and previous charges to consider potential revisions to the Accreditation Standards for Dental Therapy Education Programs, with a future report to Review Committee and the Commission.

Consideration of Proposed Revision to the Accreditation Standards for Dental Therapy Education Programs Related to Faculty to Student Ratios (p. 104): On January 28, 2025, the Commission on Dental Accreditation (CODA) received a letter from Dr. Jason A. Tanguay, chair, American Dental Association Council on Dental Education and Licensure (ADA-CDEL) requesting that the Commission consider Resolution 401H-2024 Increasing Allied Personnel in the Workforce, adopted by the 2024 ADA House of Delegates (**Appendix 1, Policy Report p. 104**).

As noted in the ADA-CDEL letter:

> *Resolution 401H-2024 Increasing Allied Personnel in the Workforce urges the Commission on Dental Accreditation to review its Accreditation Standard for all allied dental education programs regarding faculty-to-student ratios to align with the Accreditation Standard for Predoctoral Dental Education Program. Further, this resolution urges CODA to adopt the following language currently in the Accreditation Standards for Predoctoral Dental Education for the Accreditation Standards for each of the allied dental education programs: The number, distribution, and qualifications of faculty and staff must be sufficient to meet the dental program's stated purpose/mission, goals, and objectives, at all sites where required educational activity occurs.*

In consideration of this matter, the ADA-CDEL noted testimony emphasizing the importance of consistency across Accreditation Standards for all allied and predoctoral dental education programs. The ADA-CDEL expressed a position that, while workforce-related concerns fall outside CODA's direct purview, ensuring consistency in faculty-to-student ratio Standards across all allied dental education programs aligns with CODA's mission of supporting and improving program quality and enhances program flexibility while maintaining educational quality and standards. The ADA-CDEL believes these revisions will promote consistency and program autonomy, thereby supporting the educational quality of allied dental education programs.

At its Summer 2025 meeting, the Review Committee on Predoctoral Dental Education (PREDOC RC) noted that the proposed revision for allied dental education programs removes any required faculty-to-student ratios and broadens the expectations for the number of faculty to be sufficient to meet the expectations of the program's goals and objectives at all sites where required educational activity occurs. The proposed revisions align with the current Dental Standard 3-1 language in the Accreditation Standards for Dental Education Programs. The PREDOC RC also noted comments on faculty-to-student ratios in response to the Validity and Reliability Study for Dental Therapy Education Programs. Following consideration, the PREDOC RC believed that an Ad Hoc Committee should consider this topic in review of the Accreditation Standards for Dental Therapy Education Programs.

Recommendation: It is recommended that the Commission on Dental Accreditation direct the Ad Hoc Committee to Review Accreditation Standards for Dental Therapy Education Programs to consider the proposed revisions to faculty-to-student ratios submitted by the American Dental Association Council on Dental Education and Licensure (**Appendix 1, Policy Report p. 104**), with a future report to the Review Committee and Commission.

Informational Report of the Standing Committee on International Accreditation (p. 105): The Review Committee on Predoctoral Dental Education (PREDOC RC) reviewed the report of the Standing Committee on International Accreditation. The Standing Committee considered reports from Kuwait University, Kuwait and Yonsei University, Korea at its April 4, 2025 meeting. Informational updates were also provided to the Standing Committee related to Saveetha Institute of Medical and Technical Sciences, India, Tecnologico de Estudios Superiores Monterrey, Mexico, and University of Otago, New Zealand. Additionally, the Standing Committee considered information from Kuwait University, Kuwait at its June 16, 2025 meeting. The Standing Committee on International Accreditation directed that a formal letter be sent to the programs reviewed, as applicable, in accordance with the actions taken by the Committee at each meeting.

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

NEW BUSINESS

American College of Prosthodontics Letter on Dental Standard 2-24h: The Commission on Dental Accreditation received a letter on June 27, 2025 related to Dental Standard 2-24h (clinical competency for the replacement of missing teeth) from the American College of Prosthodontics (ACP) (**Appendix 2**). The letter raises concerns from the ACP and its membership on the interpretation of Dental Standard 2-24 h (clinical competency for the replacement of missing teeth) for prosthodontic education for tooth replacement. The purpose of the letter was to voice ACP membership concerns and request that CODA clarify policy or similar outcomes to assure consistency and assurance of appropriate assessment alternatives in the review of predoctoral dental education programs.

The ACP letter indicates that representatives from institutions with recent site visits have reported inconsistent outcomes where the use of a non-patient assessments were accepted in the review of some programs, while unacceptable for others. The letter acknowledges the replacement of missing teeth is an essential component of predoctoral dental education to ensure that new graduates are well-prepared to meet diverse patient needs. The ACP believes that a combination of clinical simulation exercises, Objective Structured Clinical Examinations (OSCEs), and rigorous preclinical evaluations among other assessment tools provide effective mechanisms in evaluation to determine clinical competency regarding fixed partial dentures. The letter describes changing patient preferences and the shift towards the use of dental implants as a method of tooth replacement. The ACP notes that the results of patient preferences for

alternative treatments in the replacement of missing teeth presents challenges to assure adequate patient experiences for all graduates. The ACP believes that robust simulation experiences serve as a reliable substitution for direct patient experiences. The ACP requests that the Commission ensure consistency for non-patient competency assessment for Dental Standard 2-24h (clinical competency for the replacement of missing teeth) in addition to traditional patient-based assessments.

At its Summer 2025 meeting, the Review Committee on Dental Accreditation (PREDOC RC) reviewed the letter from ACP. The PREDOC RC noted that the Accreditation Standards for Dental Education Programs, including Dental Standard 2-24 (clinical competencies), has always allowed for competency assessments to be performed through various methods including, but not limited to, simulation, OSCEs, case-based scenarios, written examinations, and patient-based examinations. Programs may choose the appropriate competency assessment and evaluation methods to ensure graduates are competent for entry into the profession. While on-site for a regular program review, Commission site visit teams review the effectiveness of the assessment tool and data in the review of the program's compliance with Accreditation Standards related to graduate competency.

The PREDOC RC noted confusion in the letter between Dental Standard 2-24 (clinical competencies) and Dental Standard 2-9 (adequate patient experiences). While assessment of clinical competencies may occur through a variety of methods, Dental Standard 2-9 (adequate patient experiences) requires that programs must ensure patient experiences for all students to achieve competencies. The Commission does not require patient experiences to be the assessment method, although a program may choose direct patient experiences as a method of evaluation; however, Dental Standard 2-9 (adequate patient experiences) does require that patient experiences must occur in instruction and/or formative practice to achieve competency.

The PREDOC RC noted that the ACP letter describes the changes in patient preferences, but the letter requests that the Commission ensure consistency in the interpretation of assessment methods for Dental Standard 2-24 h (clinical competency in the replacement of missing teeth). It was unclear to the PREDOC RC if the ACP believes that a change or revision is necessary to patient experiences in fixed prosthodontics in accordance with Dental Standard 2-9 (adequate patient experiences) or student assessment of competency with Dental Standard 2-24h (clinical competency in the replacement of missing teeth).

The PREDOC RC noted many ways the Commission provides calibration to its site visit teams on this topic and all CODA Standards. The Commission conducts yearly site visitor training for all new site visitors and all current site visitors are invited to attend. The Commission also provides site visitor update sessions for current site visitors, and a mandatory annual assessment for training. The Commission held three (3) sessions in the past year for predoctoral site visitor chair training to provide calibration to many Standards, including Dental Standard 2-24 (clinical competencies) and Dental Standard 2-9 (adequate patient experiences). Additionally, without further information and context, the PREDOC RC is unable to determine how representatives, as stated in the ACP letter, believe there is a misinterpretation of the Accreditation Standards. The

Commission's policy regarding response to the preliminary draft site visit report provides a mechanism by which programs who believe there has been a misinterpretation of Commission Policy or Accreditation Standards by a site visit team can address these concerns within the site visit response process for further review by the Commission. Finally, the PREDOC RC noted that the proposed revisions to the Accreditation Standards for Dental Education Programs adequately addresses these concerns and were circulated for a period of public comment in Fall 2024 (see elsewhere in this report). The proposed revisions describe the objective for assessments of competency. As continued review of the proposed revisions continues, the PREDOC RC believed that the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs should review the letter sent by ACP during its discussions.

> **Recommendation:** It is recommended that the Commission on Dental Accreditation direct that the Ad Hoc Committee to Review Accreditation Standards for Dental Education Programs consider the letter from the American College of Prosthodontics (ACP) (**Appendix 2**), with a future report to the Review Committee and Commission.

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

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

Respectfully submitted,

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

Commission on Dental Accreditation

At its Summer 2024 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Dental Education Programs be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2024, for review at future meetings of the Ad Hoc Committee to Review the Accreditations Standards for Dental Education Programs.

This document represents the proposed new revisions submitted for Commission review in Summer 2025, based upon review of comments received from communities of interest from August 9, 2024 to December 1, 2024, and following consideration by the Review Committee at its Summer 2025 meeting.

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards For Dental Education Programs

Explanation of Proposed Revisions

The explanation below provides a summary of the proposed revisions circulated for review following the Summer 2025 Commission meeting. This Explanation of Proposed Revisions page is intended to provide background information and will be removed from the final Standards that is approved by the Commission on Dental Accreditation.

Highlights of Proposed Revisions from Summer 2025:

Goals, Educational Environment, and Definition of Terms:
Based on the comments received, the Ad Hoc Committee reviewed and updated the definition of a learning environment to include humanistic as a term to describe a setting that is safe, respectful, and allows for growth of interpersonal skills. The Ad Hoc Committee noted that the proposed revisions for Standard 1-2 ensure that dental schools provide a commitment to, regular evaluation of, and applicable actions to ensure a humanistic learning environment for all students, staff, and faculty. Additionally, the Ad Hoc Committee removed specific examples of technology (i.e., artificial intelligence) and types of assessments (i.e., Entrustable Professional Activities) from its definitions. As technology and assessment techniques evolve, the Committee noted that definitions should remain broad and open to innovation as programs utilize various tools and frameworks. The Committee also included a new definition for "manage" and updated definitions, such as "competency", to provide clarification for Standards that utilize these terms.

Standard 1 – Institutional Effectiveness:
In review of Standard 1, the Ad Hoc Committee revised Standard 1-3 to ensure that dental schools have policies and practices to prevent discrimination in its efforts to attract and retain students, faculty, and staff. The Ad Hoc Committee reviewed many comments related to a commitment to diversity, however it also noted that programs must follow local, state, and federal regulations. As it pertains to recruitment of students, staff, and faculty, the Ad Hoc Committee believes that non-discriminatory practices are essential to maintain integrity and the proposed revisions to Standard 1-3 would allow all programs to demonstrate compliance.

Standard 2 – Educational Program:
In review of Standard 2, the Ad Hoc Committee carefully reviewed comments related to the educational program, specifically related to instruction, experiences, and competency in basic sciences and clinical sciences. Several proposed revisions streamlined requirements for consistency. The proposed revisions related to Standard 2-13 (instruction), 2-14 (direct patient experiences), and 2-15 (competency assessment) have been revised to consolidate topics. For example, many concepts previously listed under "b. Prevention and Wellness" are now included within "a. Diagnosis and Treatment Planning". Additionally, the Ad Hoc Committee discussed the comments in relation to clarifying the stages of life for proposed Standard 2-11, and determined that four (4) stages for children, adolescents, adults, and geriatric patients, at a minimum, are necessary.

The Committee reviewed several comments related to the replacement of teeth and held extensive discussions over several meetings. The Committee noted concerns from the commentors related to the availability of patients and the ethical responsibility to ensure that patients are provided with the appropriate care. The Ad Hoc Committee reiterates that students may graduate and practice in communities where the replacement of teeth in fixed partial dentures could be an appropriate treatment. In these cases, it is the obligation of dental schools to prepare students to enter practice as a general dentist and that experiences in these dental techniques are imperative. The proposed revisions confirm the requirements for patient experiences in fixed prosthodontics, removable prosthodontics, and implant dentistry in proposed Standard 2-14 (direct patient experiences). The Ad Hoc Committee further expanded the Intent Statement of Standard 2-14 to illustrate that patient experiences may be obtained through rotations to educational activity sites and other methods such as co-treatment of patients by students, as appropriate. The Ad Hoc Committee also noted that programs have flexibility in proposed Standard 2-15 (competency assessment) to determine which competency assessments are to be completed through direct patient assessments within the requirement of at least fifty percent (50%) in each category (a-d). The Ad Hoc Committee recognizes the validity and importance of various assessment methods, including direct patient, case study, and simulation experiences.

The Ad Hoc Committee also noted the comments related to patients with special health care needs. The proposed revisions previously circulated included experiences and competency for patients with special health care needs under the appropriate standards for Practice and Profession to include didactic, patient care experience, and competency assessment. After careful consideration of the comments received, the Ad Hoc Committee decided to emphasize graduate competency in the management of patients with special health care needs as a standalone standard in proposed new Standard 2-12. The addition of an intent statement also provides further clarification to the requirements for patients considered to have special health care needs and the management of these patients.

Standard 3 – Faculty and Staff:
Based on the comments received, the proposed revisions in Standard 3-6 clarify the requirement for objective measurement of faculty performance for all faculty relative to teaching, patient care, scholarship, and research relative to their area(s) of contribution to the program. It is expected that faculty evaluations would be appropriate to their roles, responsibilities, and assignments of duties.

Standard 4 – Educational Support Services:
In review of Standard 4, the Ad Hoc Committee considered programs that have external educational activity sites that may be located at a substantial distance from the dental school and have students rotating to these sites for a significant period of time. To ensure that students have access to appropriate services while participating at distant educational activity sites, the proposed revisions for Standard 4-13 clarify the expectation for students to have access to health care services in all aspects of the educational program.

Standard 5 – Patient Care Services:

Based on the comments received, the proposed revisions include a reorganized Standard 5 with significant updates related to the operations of patient care at the dental school clinic and clinics where students spend a significant amount of time for program requirements. The proposed revisions now clarify in Standards 5-4, 5-5, and 5-6 that the requirements in these Standards pertain to the dental school clinic and any sites owned and/or operated by the institution. The Ad Hoc Committee believes it is imperative that dental school patients at any site(s) owned by the institution have access to quality care, which includes continuous quality improvement, access to professional services for management of dental emergencies, and students, faculty, and staff who are trained to manage medical emergencies.

The proposed revisions also include the addition of Standard 5-10 which refers to sites that are not owned and/or operated by the dental school but are used for credited patient experiences and/or competency assessments. The Ad Hoc Committee believed that it is important that sites used for credited patient experiences and/or where competency is assessed for students, the program must ensure that the sites provide quality patient care, including: continuous quality improvement; access to professional services for management of dental emergencies; students, faculty, and staff who are trained to manage medical emergencies; written policies and procedures for safe ionizing radiation; and written protocols to ensure adequate asepsis, infection, and biohazard control.

Standard 6 – Research Program:
Additional revisions in Standard 6 were proposed to further clarify that research is to be conducted by dental school faculty. It is important for sustained research in the field of dentistry that faculty with dental school appointments engage in opportunities for scholarly activity.

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The explanation below provides a summary of the proposed revisions following the first circulation directed by the Commission at its Summer 2024 Commission meeting. This Explanation of Proposed Revisions page is intended to provide background information and will be removed from the final Standards that is approved by the Commission on Dental Accreditation. As noted above, changes to the proposed revisions may have occurred based on feedback.

Highlights of Proposed Revisions from Summer 2024:

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

Pertaining to the Educational Environment, the Committee proposed revisions to the humanistic culture definition to expand broadly the concept of a safe learning environment that includes

physical and psychological safety, free of intimidation, abuse, and retaliation. The Committee also modified Student Assessment to encourage adoption of innovations in assessment methods. The Ad Hoc Committee noted language throughout the Standards, which encourages innovative educational methods. The Committee also expanded the educational environment definitions to include "inclusion" as an important component of diversity and proposed additional changes elsewhere in the document.

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

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

Standard 2 – Educational Program: Again, within Standard 2, the Ad Hoc Committee attempted to streamline and clarify the Standards which could be subject to differing interpretations. Related to the program length, the Ad Hoc Committee believed an intent statement could further clarify that a program could have policies for students' time away from the program (e.g., vacation or excused absence), while ensuring that students meet all program academic expectations and competencies for graduation within the formal program and in conformance with institutional policies on student attendance.

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

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

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

Standard 3 – Faculty and Staff: The Ad Hoc Committee believed that current Standard 3-1 should be divided into a standard related to the number and distribution of faculty, and a separate standard related to the qualifications of those faculty. Additionally, the Ad Hoc Committee moved the requirement from current Standard 2-6 (i.e., comparable instruction through calibration of faculty) to proposed Standard 3-3, which will ensure that faculty are calibrated consistent with instruction and assessment of students at all sites. The Ad Hoc Committee believed that institutions must provide ongoing faculty development (proposed Standard 3-4), and that faculty regularly involved in the program (i.e., at least a weekly commitment) must be evaluated through a defined performance review process related to their contributions in the program.

Standard 4 – Educational Support Services: The Ad Hoc Committee incorporated the components of admission of a diverse student population within its proposed revision to Standard 4-1 and proposed that Standard 4-4 be stricken. The Committee also believed that students must be advised of mandatory health and technical standards and proposed a new Standard 4-4 to address this requirement. The Ad Hoc Committee spent considerable time reviewing the Student Services section and concluded that several revisions were warranted, including creation of, and

revision to, sections of the Standards for student support services, student due process, and student financial aid. Recognizing that the use of educational activity sites is increasing within dental education, the Ad Hoc Committee proposed a revision to proposed Standard 4-13 to require arrangement for access to health care for students at all sites where educational activity occurs. Additionally, influenza and COVID-19 were added to proposed revised Standard 4-14 as additional immunizations for which students should be encouraged.

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

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

Accreditation Standards for Dental Education Programs

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Document Revision History

Date	Item	Action
~~August 6, 2010~~	~~Accreditation Standards for Dental Education Programs~~	~~Approved~~
~~February 1, 2012~~	~~Revised Compliance with Commission Policies section (Complaint~~	~~Approved~~
~~February 3, 2012~~	~~Revision to Standard 2-23-e and 3-2~~	~~Approved Implemented~~
~~August 10, 2012~~	~~Revised Mission Statement~~	~~Approved Implemented~~
~~July 1, 2013~~	~~Accreditation Standards for Dental Education Programs~~	~~Implemented~~
~~July 1, 2013~~	~~Revision to Standard 2-23-e and 3-2~~	~~Implemented~~
~~August 9, 2013~~	~~Revised Policy on Accreditation of Off-Campus Sites~~	~~Approved Implemented~~
~~January 29, 2014~~	~~Revised Policy on Accreditation of Off-Campus Sites~~	~~Approved Implemented~~
~~January 30, 2014~~	~~Revision to Policy on Complaints (Anonymous)~~	~~Approved Implemented~~
~~February 2015~~	~~Revision to Standard 4-3 and5-8~~	~~Approved Implemented~~
~~August 2015~~	~~Revision to Standard 4-6~~	~~Approved~~
~~February 5, 2016~~	~~Revised Accreditation Status Definitions~~	~~Approved Implemented~~
~~July 1, 2016~~	~~Revision to Standard 4-6~~	~~Implemented~~
~~August 5, 2016~~	~~Revised Mission Statement~~	~~Adopted~~

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

TABLE OF CONTENTS

Mission Statement of the Commission on Dental Accreditation

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

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

Accreditation Status Definitions

1. Programs Which Are Fully Operational

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

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

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

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

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

2. Programs Which Are Not Fully Operational

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

of "initial accreditation."

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

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

Introduction

Accreditation

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

The Commission on Dental Accreditation

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

Standards

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

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

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

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

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

Format of the Standards

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

Goals

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

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

Specific objectives of the current version of the Standards include:

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

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

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

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

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

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

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

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

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

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

Educational Environment

Among the factors that may influence predoctoral curricula are expectations of the parent institution, standing or emerging scientific evidence, new research foci, interfaces with specialty or other dental-related education programs, approaches to clinical education, and pedagogical philosophies and practices. In addition, the demographics of our society are changing, and the educational environment must reflect those changes. People are living longer with more complex health issues, and the dental profession will routinely be expected to provide care for these individuals. Each dental school must also have policies and practices to achieve an appropriate level of diversity among its students, faculty, and staff. While ~~diversity~~ variability of curricula is a strength of dental education, the core principles below promote an environment conducive to change, innovation, and continuous improvement in educational programs. Application of these principles throughout the dental education program is essential to achieving quality.

Comprehensive, Patient-Centered Care

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

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

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

Critical Thinking

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

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

Self-Directed Learning and Assessment

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

Humanistic Learning Environment

Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic ~~pedagogy~~ 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.~~

Scientific Discovery and the Integration of Knowledge

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

Evidence-based Care

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

Student Assessment

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

[1] ~~American Dental Association, http://www.ada.org/prof/resources/positions/statements/evidencebased.asp. Accessed Oct 25, 2006.~~

Application of Technology

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

~~Faculty~~ Professional Development

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

Collaboration with other Health Care Professionals

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

Diversity and Inclusion

Diversity and inclusion in education ~~is~~ are essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of ~~different~~ various races, ethnicities, national origin, gender identity, age, physical abilities/qualities, sexual orientation, religions, and ideologic backgrounds; come from ~~cities~~ urban areas, 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.

Summary

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

Definition of Terms Used in Accreditation Standards for Dental Education Programs

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

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

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

Competence: The attainment of knowledge, skills and values required by the new graduates to begin independent, unsupervised dental practice.

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

Competency Assessments: Assessment of competency includes mechanisms used to evaluate a student's attainment of knowledge, skills and values required to begin independent, unsupervised dental practice. Competency assessment strategies across the curriculum include a process of formative and summative evaluations. Each competency statement is evaluated through a process consistent for all students, which measures the defined expectations, and includes demonstration of student independence without critical errors.

~~**Competent:** The levels of knowledge, skills and values required by the new graduates to begin independent, unsupervised dental practice.~~

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.

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

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

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

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

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

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

Manage: A coordinated process of assessment, planning, organization, directing and/or providing patient-centered care including appropriate referral, based upon clinical reasoning and ethical responsibility.

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

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

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

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

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

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

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

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

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

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

Accreditation Standards for Dental Education Programs

STANDARD 1-INSTITUTIONAL EFFECTIVENESS

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

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

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

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

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

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

Intent:
To improve curricula, assessment involves a dialogue between and among faculty,

students, and administrators that is grounded in the scholarship of teaching and learning. Data from program outcomes, assessment of student learning, and feedback from students and faculty can be used in a process that actively engages both students and faculty. Moreover, programs are encouraged to adopt innovations in assessment methods as they become available.

~~1-3~~ **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 free of intimidation, abuse, and retaliation;
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, hate speech, or other derogatory or harmful behaviors
- Training to avoid discrimination or bias regarding gender identity and sexual orientation
- 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

1-3 The dental school **must** have policies and practices to prevent discrimination related to its efforts to attract and retain students, faculty, and staff.

~~1-4~~ ~~The dental school **must** have policies and practices to:~~
~~achieve appropriate levels of diversity among its students, faculty and staff;~~
~~engage in ongoing systematic and focused efforts to attract and retain students, faculty, and staff from diverse backgrounds; and~~
~~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.*~~

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

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

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

~~**Examples of evidence to demonstrate compliance may include:**~~
- ~~Written agreement(s)~~
- ~~Contracts between the institution/ program and sponsor(s) (For example: contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)~~

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

Examples of evidence to demonstrate compliance may include:

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

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

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

STANDARD 2-EDUCATIONAL PROGRAM

Instruction

2-1 In advance of each course or other unit of instruction, students **must** be provided written information about the goals, ~~and~~ requirements, and applicable competencies of each course, ~~the nature of~~ the course content, the method(s) of evaluation to be used, ~~and~~ how course grades ~~and competency~~ are determined.

~~**2-2** If students do not meet the didactic, behavioral and/or clinical criteria as published and distributed, individual evaluations **must** be performed that lead to an appropriate decision in accordance with institutional due process policies.~~

Curriculum Management

~~2-3~~ **2-2** The curriculum **must** include at least four academic years of instruction or its equivalent.

Intent: *The school's academic year is defined by and compliant with the definition of the sponsoring institution and institutional accrediting agency, as applicable. The school has a policy for students' time away from the program that ensures all students meet the program's academic expectations and competencies needed for graduation are completed within the formal program and conforms to institutional policies on student attendance.*

~~2-4 The stated goals of the dental education program **must** be focused on educational outcomes and define the competencies needed for graduation, including the preparation of graduates who possess the knowledge, skills and values to begin the practice of general dentistry.~~

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

a. establish competency statements that, at a minimum, are consistent with the Commission on Dental Accreditation Standards, and

b. employ student ~~evaluation~~ assessment methods that measure ~~its defined~~ the competencies defined for graduation and readiness for independent dental practice.

Intent:

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

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

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

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

~~**Examples of Evidence to demonstrate compliance may include**:~~

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

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

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

a. an ongoing curriculum review and evaluation process ~~which~~ that includes input from faculty, ~~students,~~ administration and ~~other appropriate sources~~ students, including student evaluation of instruction;

b. evaluation of all courses with respect to the defined ~~competencies of the school to include student evaluation of instruction~~ competency statements;

c. elimination of unwarranted repetition~~,~~ and outdated material~~, and unnecessary material~~;

d. ongoing evaluation of sequencing of curriculum content;

e. integration of biomedical, behavioral, and clinical science instruction; and

f. incorporation of emerging information and technologies. ~~and achievement of appropriate sequencing;~~

~~g. incorporation of emerging didactic and clinical technologies to support the dental education program curriculum.~~

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

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

Critical Thinking

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

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

Examples of evidence to demonstrate compliance may include:

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

thinking

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

Self-Assessment

~~2-11~~ **2-6** ~~Graduates~~Students **must** demonstrate the ability to self-assess.~~, including the development of professional competencies and the demonstration of professional values and capacities associated with self-directed, lifelong learning.~~

~~**Intent:**~~

~~*Educational program should prepare students to assume responsibility for their own learning. The education program should teach students how to learn and apply evolving and new knowledge over a complete career as a health care professional. Lifelong learning skills include student assessment of learning needs.*~~

Examples of evidence to demonstrate compliance may include:

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

Biomedical Sciences

~~2-12~~ 2-7 Biomedical science instruction ~~in dental education~~ **must** ensure ~~an~~ in-depth

~~Understanding~~ foundation knowledge of basic biological principles, ~~consisting of a core of information on the fundamental~~ including:

a. structures, functions and interrelationships of the body systems, with emphasis on the oro-facial complex, and
b. abnormal biological conditions, including systemic, oral, and craniofacial disorders.

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

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

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

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

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

Social and Behavioral Sciences

2-9 Instruction in social and behavioral sciences **must** be at an in-depth level and include:

a. patient management, including considerations of cultural norms 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.

2-10 During patient experiences, graduates **must** demonstrate competence in social and behavioral sciences including:
a. patient management, including considerations of cultural norms 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.

Intent:
Patient care experiences are critical in the development of competence in social and behavioral sciences. Competence in social and behavioral sciences are to be demonstrated through patient care and/or standardized patient experiences.

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

~~2-17 Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.~~

~~**Intent:**~~
~~*Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:*~~
- ~~*basic principles of culturally competent health care;*~~
- ~~*basic principles of health literacy and effective communication for all patient populations*~~
- ~~*recognition of health care disparities and the development of solutions;*~~

- ~~*the importance of meeting the health care needs of dentally underserved populations, and;*~~
- ~~*the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.*~~

~~Practice Management and Health Care Systems~~

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

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

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

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

~~Ethics and Professionalism~~

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

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

Clinical Sciences

2-22 ~~Graduates **must** be competent to access, critically appraise, apply, and~~

~~communicate scientific and lay literature as it relates to providing evidence-based patient care.~~

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

~~2-23~~ 2-11 Graduates **must** be competent in providing oral health care for a broad spectrum of patients to include ~~within the scope of general dentistry to patients in all stages of life~~ children, adolescents, adults, and geriatric patients, as defined by the school.

2-12 Graduates **must** be competent in the management of patients with special health care needs, including dental/medical/behavioral complexities requiring modification of treatment or referral.

Intent:
Patients considered to have special health care needs are those whose medical, physical, psychological, cognitive, or social situations make it necessary to consider a wide range of assessment and care options, including necessary appropriate referral, in order to provide dental treatment. These individuals include people with one or more of the following characteristics: intellectual and developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Patients with special health care needs may require a modification or accommodation to patient care.

~~2-24 At a minimum, graduates **must** be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:~~
~~a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;~~
~~b. screening and risk assessment for head and neck cancer;~~
~~c. recognizing the complexity of patient treatment and identifying when referral is indicated;~~
~~d. health promotion and disease prevention, including caries management;~~
~~e. local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;~~
~~f. restoration of teeth;~~
~~g. communicating and managing dental laboratory procedures in support of patient care;~~
~~h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;~~
~~i. periodontal therapy;~~

~~j. pulpal therapy;~~
~~k. oral mucosal, temporomandibular, and osseous disorders;~~
~~l. hard and soft tissue surgery;~~
~~m. dental emergencies;~~
~~n. malocclusion and space management; and~~
~~o. evaluation of the outcomes of treatment, recall strategies, and prognosis~~

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

2-13 Instruction in clinical sciences **must** be at an in-depth level and include:

a. Diagnosis and Treatment Planning
   1. history taking, including medical status;
   2. clinical examination, including radiographic examination;
   3. risk assessment, including assessment of caries, periodontal, oral cancer, and obstructive sleep apnea;
   4. diagnosis;
   5. treatment plan, including prognosis; and
   6. referrals when indicated.

b. Oral Health Care
   1. *Health Promotion and Disease Prevention*, to include dental prophylaxis, oral hygiene instruction, caries management, space maintenance, tobacco cessation, and nutrition counseling;
   2. *Operative Dentistry*, to include direct and indirect restorations;
   3. *Fixed Prosthodontics,* to include fixed partial dentures;
   4. *Removable Prosthodontics,* to include partial and complete dentures;
   5. *Implant Dentistry,* to include treatment planning, placement, restoration, and maintenance of dental implants;
   6. *Endodontics,* to include pulpal therapy, non-surgical and surgical root canal therapy, and endodontic retreatment;
   7. *Periodontics,* to include non-surgical and surgical periodontal therapy, and periodontal maintenance;
   8. *Oral & Maxillofacial Surgery*, to include exodontia, alveoloplasty, and surgical management of mucosal and osseous disorders;
   9. *Orthodontics,* to include diagnosis and treatment of malocclusion and

interceptive therapy;
10. *Management of Pain*, including a) appropriate use of local anesthesia and analgesia, and b) recognition of orofacial pain/temporomandibular joint disorders; and
11. *Management of Anxiety*, including pharmacologic and non-pharmacologic approaches.

c. Practice and Profession
1. obtaining informed consent;
2. communicating with dental laboratories/laboratory technicians and evaluating the resultant restorations and appliances;
3. digital dentistry;
4. emerging technologies;
5. management of dental and medical emergencies;
6. prescribing practices, including screening for substance use disorders;
7. use of clinical guidelines and accepted parameters of care;
8. infection prevention and control practices;
9. assessment of treatment outcomes; and
10. recall strategies.

2-14 Patient-based instruction and experiences in clinical sciences **must** include direct care provided by the student, for the following:

a. Diagnosis and Treatment Planning
1. history taking, including medical status;
2. clinical examination, including radiographic examination;
3. risk assessment, including assessment of caries, periodontal, oral cancer
4. diagnosis;
5. treatment plan, including prognosis; and
6. referrals when indicated.

b. Oral Health Care
1. *Health Promotion and Disease Prevention*, to include dental prophylaxis, oral hygiene instruction, caries management, space maintenance, and nutrition counseling;
2. *Operative Dentistry*, to include direct and indirect restorations;
3. *Fixed Prosthodontics,* to include fixed partial dentures;
4. *Removable Prosthodontics,* to include partial and complete dentures;
5. *Implant Dentistry,* to include treatment planning, restoration, and maintenance of dental implants;
6. *Endodontics,* to include pulpal therapy and non-surgical root canal therapy;
7. *Periodontics,* to include non-surgical periodontal therapy and periodontal maintenance;
8. *Oral & Maxillofacial Surgery*, to include exodontia;
9. *Orthodontics,* to include diagnosis of malocclusion and interceptive therapy;
10. *Management of Pain*, to include a) appropriate use of local anesthesia and

analgesia, and b) recognition of orofacial pain/temporomandibular joint disorders; and

11. *Management of Anxiety*, to include pharmacologic and non-pharmacologic approaches.

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

Intent:
Patient experiences are critical to the educational preparation of students to enter practice as a general dentist. Programs may achieve sufficient patient experiences in a number of ways, including rotations to sites where educational activity occurs related to the clinical program, and other methods such as co-treatment of patients by students, as appropriate.

2-15 Graduates **must** demonstrate competence in the following areas within the scope of general dentistry, and for each category (a-d) at least fifty percent (50%) of competencies in that category are completed through direct patient assessments.

a. Diagnosis and Treatment Planning
   1. history taking, including medical status;
   2. clinical examination, including radiographic examination;
   3. risk assessment, including assessment of caries, periodontal, oral cancer
   4. diagnosis;
   5. treatment plan, including prognosis; and
   6. referrals when indicated.

b. Oral Health Care
   1. *Health Promotion and Disease Prevention*, to include dental prophylaxis, oral hygiene instruction, and caries management;
   2. *Operative Dentistry*, to include direct and indirect restorations;
   3. *Fixed Prosthodontics,* to include fixed partial dentures;
   4. *Removable Prosthodontics,* to include partial and complete dentures;
   5. *Implant Dentistry,* to include restoration of dental implants;
   6. *Endodontics,* to include pulpal therapy and non-surgical root canal therapy;
   7. *Periodontics,* to include non-surgical periodontal therapy;
   8. *Oral & Maxillofacial Surgery*, to include exodontia;
   9. *Orthodontics,* to include diagnosis of malocclusion;

10. *Management of Pain*, to include a) appropriate use of local anesthesia and analgesia, and b) recognition of orofacial pain/temporomandibular joint disorders; and
11. *Management of Anxiety*, to include pharmacologic and non-pharmacologic approaches.

c. Practice and Profession
   1. obtaining informed consent;
   2. communicating with dental laboratories/laboratory technicians and evaluating the resultant restorations and appliances;
   3. management of medical and dental emergencies;
   4. prescribing practices, including screening for substance use disorder;
   5. infection prevention and control practices; and
   6. assessment of treatment outcomes and recall strategies.

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

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

~~2-25~~ 2-16 ~~Dental education programs~~ The dental education program **must** make ~~available~~ community-based patient experience opportunities available 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~~.*

STANDARD 3- FACULTY AND STAFF

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

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

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

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

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

Examples of Evidence to demonstrate compliance may include:

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

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

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

Examples of evidence to demonstrate compliance may include:

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

- Mentored experiences for new faculty
- ~~Scholarly productivity~~
- ~~Maintenance of existing and development of new and/or emerging clinical skills~~
- ~~Documented understanding of relevant aspects of teaching methodology~~
- ~~Curriculum design and development~~
- ~~Curriculum evaluation~~
- ~~Student/Resident assessment~~
- ~~Cultural Competency~~
- ~~Ability to work with students of varying ages and backgrounds~~
- ~~Use of technology in didactic and clinical components of the curriculum~~
- ~~Records of Calibration of Faculty~~

~~3-3~~ 3-5 Faculty **must** be ensured a form of governance that allows participation in the school's decision-making processes.

~~3-4~~ 3-6 A defined evaluation process **must** exist that ensures objective measurement of the performance of ~~each~~ faculty members ~~in teaching, patient care, scholarship and service~~ relative to their area(s) of contribution to the program.

Intent:
All faculty in the program are to be evaluated at least annually relative to teaching, patient care, scholarship and service with the evaluation process and procedures appropriate for their roles, responsibilities, and assignment of duties.

~~3-5~~ 3-7 The dental school **must** have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.

STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Admissions

4-1 Specific written criteria, policies and procedures **must** be followed when admitting predoctoral students.

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

Intent 4-1 to 4-3 ~~4-4~~:
The dental education curriculum is a scientifically oriented program ~~which~~ that is rigorous and intensive. Admissions criteria and procedures ~~should~~ ensures the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, ~~should~~ establish admissions procedures that are non-

discriminatory and ensure the quality of the program.

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

Facilities and Resources

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

Written Agreements

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

Student**s** ~~Services~~

4-7 Student support services **must** include counseling in the following:

a. ~~P~~personal wellness~~, academic and career counseling of students;~~
b. academics,
c. career pathways, and
d. financial aid

~~b. assuring student participation on appropriate committees;~~
~~c. providing appropriate information about the availability of financial aid and health services;~~
~~d. developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;~~
~~e. student advocacy;~~
~~f. maintenance of the integrity of student performance and evaluation records; and~~
~~g. Instruction on personal debt management and financial planning.~~

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

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

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

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

Student Due Process

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

a. academic due process;
b. disciplinary due process; and
c. guidance on navigating due process.

Intent:
Due process includes individual student review of performance and/or behavior that leads to an appropriate decision and provides avenues for appeal.

Student Financial Aid

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

Intent:
*Financial information ~~should~~ include*s *estimates of living expenses and educational fees, an analysis of financial need, and the availability of financial aid.*

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

Health Services

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

~~**4-11** There **must** be a mechanism for ready access to health care for students while they are enrolled in dental school.~~

4-13 The program **must** ensure that students have access to health care services while participating in all aspects of the educational program.

Intent:
Students have access to health care services, including behavioral and emergency services, while enrolled in the program. Medical insurance alone does not assure access to health care services.

Examples of Evidence:

- Written agreement with nearby health care facility
- List of nearby health care facilities for each site where educational activity occurs
- Protocols for exposures to potentially infectious materials
- Procedures for emergencies

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

STANDARD 5 - PATIENT CARE SERVICES

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

~~**Intent:**~~

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

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

5-2 The dental school **must** demonstrate a commitment to patient-centered care that is not compromised by student advancement and graduation**.**

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

Intent:

*The dental school ~~should~~ use*s *evidence to evaluate new treatments, technology, and products and to guide diagnosis and treatment decisions.*

Examples of Evidence to Demonstrate Compliance May Include:

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

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

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

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

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

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

5-6 ~~All students, faculty and support staff involved in the direct provision of patient care **must** be continuously certified in basic life support (B.L.S.), including cardiopulmonary resuscitation, and be able to manage common medical emergencies.~~ At sites it owns and/or operates, the dental education program **must**:

a. have a written and distributed plan to manage medical emergencies;
b. ensure all students, faculty, and support staff involved in the direct provision of patient care are continuously certified in basic life support (B.L.S.) or advanced cardiac life support (A.C.L.S.); and
c. ensure faculty involved in the direct provision of patient care are able to manage common medical emergencies.

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

5-8 The dental school **must** establish and ~~enforce~~ follow a ~~mechanism~~ written protocol to ensure adequate preclinical/clinical/laboratory asepsis, infection and

biohazard control, and disposal of hazardous waste, ~~consistent with accepted dental practice~~ in accordance with local, state, and/or federal guidelines.

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

5-10 For external sites not owned and/or operated by the dental school and where patient experiences are credited for graduation and/or where competency is assessed, the dental school must ensure that the sites:

a. have a formal system of continuous quality improvement for the patient care program that includes the components of Standard 5-4;
b. provide access to professional services at all times for the management of dental emergencies;
c. have a written and distributed plan to manage medical emergencies;
d. ensure that faculty involved in the direct provision of patient care are able to manage common medical emergencies;
e. ensure that all students, faculty, and support staff involved in the direct provision of patient care are continuously certified in basic life support (B.L.S.) or advanced cardiac life support (A.C.L.S.);
f. have written policies and procedures in place to ensure the safe use of ionizing radiation, which include criteria for patient selection, frequency of exposing radiographs on patients, and retaking radiographs consistent with current, accepted dental practice;
g. have a written protocol to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste, in accordance with local, state, and/or federal guidelines.

STANDARD 6 - RESEARCH PROGRAM

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

Intent:

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

Examples of evidence to demonstrate compliance may include:

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

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

Intent:

~~Schools should establish focused, significant, and sustained programs to recruit and retain faculty suitable to the institution's research themes, and or scholarly activity~~. While not all faculty are expected to engage in research, the ~~program should~~ dental school employs ~~an adequate number of full-time~~ dental faculty with time ~~dedicated~~ allocated to the research mission of the ~~institution~~ the dental school. Dental faculty are encouraged to establish inter-disciplinary collaborations consistent with the dental school's research mission. Financial resources ~~should~~ ensure that the ~~program~~ dental school will be in a position to recruit and retain qualified research faculty.

Examples of evidence to demonstrate compliance may include:

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

- Extramural funding of dental faculty
- Documentation of research dental faculty recruitment efforts
- Dental faculty research mentorship programs
- Peer reviewed ~~scholarly~~ publications (manuscripts, abstracts, books, etc.) based on original research
- Presentation at scientific meetings and symposia
- Other evidence of the impact of the research program and research productivity

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

Intent:

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

Examples of evidence to demonstrate compliance may include:

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

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June 27, 2025

Sherin Tooks, Ed.D., M.S.
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From: The American College of Prosthodontists

To: Sharon Tooks, Commission on Dental Accreditation

RE: CODA Standard 2-24h: Replacement of Teeth Including Fixed, Removable and Dental Implant Prosthodontic Therapies

The American College of Prosthodontists (ACP) membership from the educational community has raised concerns which we would like to share with the Commission in regard to consistent interpretation of Standard 2-24h for prosthodontic education for tooth replacement.

> 2-24 At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:
> h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;

The intent of this communication regards use of objective structured clinical examinations (OSCEs), simulations, and similar educational assessments in place of clinical assessments when an institution demonstrates evidence of insufficient patient volumes or adverse impacts on treatment selection for clinical competencies or entrustable professional activities (EPAs).

Representatives of multiple institutions with recent site visits have reported inconsistent outcomes where the use of non-patient assessments were acceptable in some sites visits while unacceptable for others. The ACP is responding to our membership concerns by sending this inquiry in hopes of a clarifying policy or similar outcome to assure consistency and assurance of appropriate assessment alternatives in the regular review of predoctoral educational programs.

The American College of Prosthodontists (ACP) adheres to evidence-based clinical decision making in the treatment planning process concerning tooth replacement options. The ACP acknowledges an ongoing shift in patient preferences in conjunction with evolving dental laboratory technology in the field of

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prosthodontics impacting educational clinical experiences for fixed and removable partial dentures as well as complete denture therapies. As outlined in CODA Standard 2-24h, the replacement of missing teeth is an essential aspect of predoctoral dental education, aiming to ensure that new graduates are well-prepared to meet diverse patient needs effectively.

Shift Toward Dental Implants and Changing Patient Preferences

In recent years, there has been a substantial shift toward the use of dental implants as the preferred method for tooth replacement. Market data shows that more patients are choosing implant treatment options over fixed and removable prosthetics due to the stability, longevity, and esthetic advantages of implants; in addition, an implant treatment option can avoid unnecessary tooth preparation adjacent to an edentulous area. Over 5 million implants are placed annually in the United States, with an anticipated growth trajectory driven by patient demand for more permanent and reliable solutions. (Dental Implants Market Size, Share & Growth Report. 2030. https://www.grandviewresearch.com/industryanalysis/dental-implants-market)

Additionally, the global dental implant market is expected to reach $13 billion by 2023. Explosive growth is anticipated in the coming decade because of a change in demographics, increased consumer awareness, technological advances in both diagnosis and treatment, and other restorative and surgical innovations. (https://connect.aaid-implant.org/blog/trends-in-dentalimplants-2022)

Education Implications on Prosthetic Treatments

While the shift toward implant therapy is undeniable, fixed partial dentures (FPDs) and removable partial dentures (RPDs) remain a viable, well-documented treatment option in clinical practice as well as complete dentures. Competency-based education related to tooth replacement options, including both implant, tooth-supported, and tissue-supported procedures, is important when considering comprehensive, patient-centered care. Adequate patient experiences for partial and complete prosthetic assessments cannot be assured for all learners and is additionally impacted by regional, economic, and other factors affecting patient care.

Nonetheless, dental schools must retain a balanced curriculum that reflects the full spectrum of prosthodontic treatment options. CODA Standard 2-24h supports this balance by setting expectations that graduates must be competent in diverse methods for restoring missing teeth. The importance of teaching different treatment modalities ensures students can meet the needs of all patient demographics as highlighted by the Commission on Dental Accreditation (https://coda.ada.org › files › predoc_standards), and the American College of Prosthodontists, ("Posterior Single Tooth Replacement" https://www.prosthodontics.org/about-acp/position-statement-posterior-single-tooth-replacement/). By

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understanding the strengths, limitations, and suitability of each option, students can make treatment decisions tailored to each individual person, considering factors like oral health, social determinants of health, patient preferences, and predictable, long-term outcomes for optimal patient care.

Conclusion

The ACP is committed to advancing the science and education in the treatment of patients requiring tooth replacement therapies, ensuring that all patients have access to optimal oral health solutions. However, we remain concerned that if site visitors have expectations of clinical assessment, treatment decision-making could be biased to meet educational needs rather than treatments in the best interest of patients. The ACP asserts that a combination of clinical simulation exercises, Objective Structured Clinical Examinations (OSCEs), and rigorous preclinical evaluations among other assessment tools, provide effective mechanisms in evaluation to determine clinical competency regarding fixed partial dentures. These methodologies offer a structured, safe, and controlled environment that mirrors real patient interactions, thereby enabling students to develop essential didactic knowledge, clinical skills, critical thinking, and decision-making capabilities. When implemented in alignment with CODA Standard 2-24h, these approaches collectively ensure that learners are thoroughly prepared for the practice of general dentistry and real-world patient encounters. Thus, these simulated experiences serve as a robust, reliable proxy for direct patient experience, meeting the educational standards and safeguarding patient welfare. The ACP requests the Commission to assure consistency for non-patient competency assessment for 2-24h in addition to traditional patient-based assessment.

Thank you for the consideration,

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