REPORT OF THE AD HOC COMMITTEE TO REVIEW ACCREDITATION STANDARDS FOR DENTAL AND DENTAL THERAPY EDUCATION PROGRAMS

At its Summer 2021 meeting, the Commission on Dental Accreditation appoint the Ad Hoc Committee to Review Accreditation Standards for Dental and Dental Therapy Education Programs. Below is background information related to the Commission’s directive for the Ad Hoc Committee.

**Background:**

Validity and Reliability Study of the Accreditation Standards for Dental Education Programs: At their Summer 2021 meetings, the Review Committee on Predoctoral Dental Education (PREDOC RC) and the Commission on Dental Accreditation (CODA) considered the Accreditation Standards for Dental Education Programs (Appendix 1) and the results of the Validity and Reliability study (Appendix 2) that was conducted in Spring 2021. The validity study had been delayed from 2020 to 2021 as directed by CODA due to the COVID-19 pandemic.

Through discussion of the findings, the PREDOC RC noted that among all “must” statements, between 69.0% and 96.6% of the dental deans who responded indicated the standards were “Sufficiently demanding;” and between 70.4% and 95.8% of the predoctoral dental education site visitors indicated the standards were “Sufficiently demanding.” In addition, the five (5) standards identified as “Too demanding,” by dental deans were Standard 2-6, Standard 2-19, Standard 1-4, Standard 2-24 and Standard 4-3. The standards most cited as “Too demanding” (14.1%) by predoctoral dental education site visitors were Standard 1-4, Standard 2-19 and Standard 2-25. The PREDOC RC also noted the standards that were identified as “Not demanding” by the highest percentage (10%) of the dental deans who completed the survey were part of Standard 2-25 related to assessing and managing the treatment of patients with special needs, and Standard 2-26 related to service learning experiences and/or community-based learning experiences.

As a result of initial analysis and discussion of the validity and reliability survey data and written comments, the PREDOC RC concluded that further study of the survey data and review of the Accreditation Standards was warranted. The PREDOC RC believed that the Standards and related statements of intent should be further considered to ensure programs and site visitors clearly understand the Commission’s expectations. The PREDOC RC recommended that an Ad Hoc committee of its members be appointed by the Commission to further study the data and identify Accreditation Standards, if any, which warrant revision, with a report to the PREDOC RC and Commission at its Winter 2022 meetings. The Commission, at its Summer 2021 meeting, concurred with the PREDOC RC and directed the formation of the Ad Hoc Committee to review the accreditation standards for dental education programs.
Use of the Term “Should” Within the Accreditation Standards for Dental Education Programs and the Accreditation Standards for Dental Therapy Education Programs: In a separate action, the Commission also directed review of the usage of “Should” within the Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental Therapy Education Programs (Appendix 3) by the Ad Hoc Committee, with a report to the Commission in Winter 2022.

Prior to taking this action at its Summer 2021 meeting, the Commission directed the immediate revision of the predoctoral dental and dental therapy Accreditation Standards to reflect the current definition of should, which is: “Should: Indicates a method to achieve the standard; highly desirable, but not mandatory.” The revised definition of “Should” was adopted by the Commission in Summer 2019, with a directive that all Review Committees consider the new definition within the context of the discipline-specific Accreditation Standards. The PREDOC RC previously noted there are approximately 49 “should” statements in the dental education standards and 89 “should” statements in the dental therapy education standards. Due to similarities in language within the Standards for both disciplines, it was believed that a concurrent review of this topic was warranted.

Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental Therapy Education Programs Related to Institutional Accreditation: At its Winter 2021 meeting, the Commission considered the report of the Standing Committee on Documentation and Policy Review and learned that the language used by the United States Department of Education (USDE) related to a parent institution’s accreditation changed from “regional” accreditation to “institutional” accreditation, as noted in regulation §602.3 (Definitions). In addition, the Commission learned the USDE’s sole reference to “institutional accreditation” could create confusion when identifying the institutional accreditors that have USDE recognition authority to oversee institutions at the post-secondary, doctoral, and post-doctoral levels. The concern is that the change in USDE language could result in questions regarding the level of degree-granting authority that the institution has and its institutional accreditor’s USDE recognition authority. Therefore, the Commission directed all Review Committees to review and revise their Accreditation Standards, as applicable, to align with USDE terminology related to “institutional accreditation” and to ensure the Accreditation Standards clearly document the appropriate type of accreditor for the discipline, with a report to the Commission’s Summer 2021 meeting.

In Summer 2021, the PREDOC RC noted that the Dental Education Standards refer to “regional” accrediting agencies, while the Dental Therapy Education Standards refer to “institutional accrediting agency…regional or appropriate national accrediting agency.” The Review Committee noted that the term “institutional accreditor” alone could create confusion regarding the level of degree-granting authority that the institution has and its institutional accreditor’s USDE recognition authority. Recognizing that “regional” classification for accrediting agencies is no longer in use, the PREDOC RC believed that the Commission’s Standing Committee on
Documentation and Policy Review should consider this matter and may wish to develop a general standard for disciplines that reference regional or national accrediting agencies.

At the Summer 2021 meetings, the PREDOC RC recommended, and the Commission concurred, that the Standing Committee on Documentation and Policy Review be directed to consider the concept of “institutional accreditor” and develop standardized language for use in the Accreditation Standards of disciplines that currently cite national or regional accreditation.

Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental Therapy Education Programs Related to Educational Activity Sites: In Winter 2021, the Commission directed all Review Committees to consider the discipline-specific Accreditation Standards under their purview for potential revision to address expectations related to use of U.S.-based educational activity sites including, but not limited to: 1) consideration of time away from the program, which removes the student/resident/fellow for long periods of time from the program’s own clinic and primary faculty oversight, and deliberate on the sufficiency of formative learning and summative (competency) skill development if “minor” site rotations remove the student/resident/fellow from the program for a significant length of time, and 2) program use of best practices and quality assurance review systems to ensure calibration of faculty, and student/resident/fellow training and evaluation (formative and summative) comparable to the program’s on-site clinic facility, with a report to the Commission in Summer 2021.

At its Summer 2021 meeting, the PREDOC RC considered the Accreditation Standards for Dental Education Programs and the Accreditation Standards for Dental Therapy Education Programs for potential revision to address expectations related to the use of U.S.-based educational activity sites, as directed by the Commission.

The PREDOC RC discussed item #1, consideration of time away from the program, which removes the student for long periods of time from the program’s own clinic and primary faculty oversight, and deliberate on the sufficiency of formative learning and summative (competency) skill development if “minor” site rotations remove the student from the program for a significant length of time. The Review Committee also discussed item #2, the program’s use of best practices and quality assurance review systems to ensure calibration of faculty, and student training and evaluation (formative and summative) comparable to the program’s on-site clinic facility.

The Review Committee noted that there appears to be variability in the use of educational activity sites among CODA-accredited predoctoral dental education programs. Some programs minimally use educational activity sites, while others use these sites extensively throughout the clinical phase of the program. The Committee believed that programs should ensure patient care learning experiences are sufficient to ensure competency in all areas as required by the
Accreditation Standards. The Committee considered whether students obtain a wide variety of experiences if they spend a considerable amount of time at a site where specialized patient care occurs. Additionally, the PREDOC RC noted that calibration of site supervisors is critical to ensure consistent quality education at educational activity sites. Following discussion, the PREDOC RC believed that further review and consideration of potential revision to the Accreditation Standards for dental and dental therapy education should occur in conjunction with the work of the Ad Hoc Committee to further study the results of the Validity and Reliability Study of the Accreditation Standards for Dental Education Programs, with a report to the Commission in Winter 2022. Following discussion by the Commission at its Summer 2021 meeting, the Commission directed that the Ad Hoc Committee further review the Accreditation Standards for dental and dental therapy education programs related to educational activity sites.

Proposed Revision to Accreditation Standards for Dental Education Programs Related to Patients With Special Needs: On June 22, 2021, the Commission on Dental Accreditation (CODA) received a request from the American Dental Association’s Council on Dental Education and Licensure (CDEL) to consider revising the Accreditation Standards to require that graduates be competent in treating patients with special needs. The Council on Dental Education and Licensure’s request is found in (Appendix 4).

In Summer 2021, the PREDOC RC considered the request and noted the dental education Accreditation Standard that addresses patients with special needs is Standard 2-25. The Review Committee noted CDEL’s comment that the intent statement could be strengthened, although the PREDOC RC believed the intent statement as currently written appears clear and provides adequate guidance to programs and site visitors. Nonetheless, the PREDOC RC considered whether the portion of the intent statement that reads “as defined by the program” should be expanded to include the nationally accepted scope of the definition for patients with special needs. Following consideration by CODA at its Summer 2021 meeting, the Commission directed review of Standard 2-25 related to patients with special needs within the Accreditation Standards for Dental Education Programs.

December 2, 2021 and December 7, 2021 Meetings of the Ad Hoc Committee to Review Accreditation Standards for Dental and Dental Therapy Education Programs:
The Ad Hoc Committee met on December 2, 2021 and December 7, 2021 for the purpose of considering the Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental Therapy Education Programs, as directed by the Commission on Dental Accreditation.

December 2, 2021 Meeting: The following PREDOC RC members were in attendance: Dr. Bruce Rotter (chair), Dr. Charles Berry, Dr. Chester Evans, Dr. Ana Karina Mascarenhas, Dr. Thomas McConnell, and Dr. Linda Wells. Dr. William Akey, Mr. Drew Christianson, and Dr.
Susan Long were unable to attend. Dr. Sherin Tooks, director, and Ms. Peggy Soeldner, manager, Advanced Dental Education, CODA, were also in attendance.

December 7, 2021 Meeting: The following PREDOC RC members were in attendance: Dr. Bruce Rotter (chair), Dr. William Akey, Dr. Charles Berry, Mr. Drew Christianson, Dr. Chester Evans, Dr. Susan Long, Dr. Ana Karina Mascarenhas, and Dr. Linda Wells. Dr. Thomas McConnell was unable to attend. Dr. Sherin Tooks, director, and Ms. Peggy Soeldner, manager, Advanced Dental Education, CODA, were also in attendance.

The Ad Hoc Committee began its discussion with a review of its charge related to each of the topics directed by the Commission for review by the Committee. The Committee reviewed the recent validity and reliability study and determined that its first meeting would focus on a review of the data collected in the validity and reliability study, noting which Accreditation Standards, if any, warranted further review for potential revision. The Committee noted that its second meeting would focus on the additional items directed by CODA for consideration, including: 1) the definition of “Should” within the Standards, 2) terminology related to institutional accreditation, 3) a discussion related to use of educational activity sites, and 4) consideration of the proposed revisions related to patients with special needs.

Consideration of Results of the Validity and Reliability Study: The Ad Hoc Committee reviewed the data collected through the Validity and Reliability Survey, with discussion on the following Dental Education Standards:

- Standard 1-4, related to dental school policies and procedures to achieve appropriate levels of diversity among students, faculty and staff: The Ad Hoc Committee noted multiple comments on the phasing “achieve appropriate levels” but the Ad Hoc Committee believed that this Standard is important and should be retained.
- Standard 2-3, related to curriculum length: Several comments were received suggesting clarification of “four academic years” and, as such, the Committee believed that a definition or intent statement may be appropriate. The Committee will also consider whether there is a federal definition (through the US Department of Education) on an academic year.
- Standard 2-6, related to instruction and assessment at all sites where educational activity occurs: The Ad Hoc Committee believed this Standard should be considered in conjunction with the discussion on educational activity sites.
- Standard 2-19, related to functioning successfully as the leader of the oral health care team: The Ad Hoc Committee noted substantial variability in responses to this standard, including potential ambiguity in CODA’s expectation and how a program may demonstrate compliance with the component of the Standard related to “how to function successfully as a leader of the oral health care team.” The Ad Hoc Committee believed the standard should be further reviewed to remove ambiguity, add an intent statement as needed, and perhaps move components related to leadership to Standard 2-20.
• Standard 2-24h, related to replacement of teeth, including fixed, removable and dental implant prosthodontic therapies: The Ad Hoc Committee engaged in a lengthy discussion related to this standard, the changes in dentistry and dental care provided to patients, and the availability of patients for programs to meet this requirement. The Ad Hoc Committee determined that further discussion of this standard is warranted.

• Standard 4-4, related to admission policies and procedures to include recruitment and admission of a diverse student population: It was noted that Standard 4-4, like 1-4, is an important component and should be retained.

• Standard 4-7g, related to instruction in personal debt management and financial planning: The Ad Hoc Committee noted that the practicing community and organizations felt this standard was not demanding enough. The Ad Hoc Committee found this standard aligned with federal guidelines to instruct students in debt management and no further modification required. Additionally, Dental Standard 4-8 further requires that students be advised of the total expected cost of their dental education at the time of acceptance.

• Standards 6-1 and 6-2 related to research. It was noted that dental deans and site visitors agreed with these standards as written but national and state organizations reported the standard was not demanding, too demanding, and not relevant. The Ad Hoc Committee noted that clinical track faculty may have difficulty conducting research as their primary focus may be teaching. Nonetheless, the Ad Hoc Committee believed all faculty should have opportunities to engage in scholarly activity as appropriate to the purpose/mission of the program. The Ad Hoc Committee believed further discussion and clarification of these standards was warranted.

Additional Dental Education Standards considered by the Ad Hoc Committee and which will require further consideration included:

• Standard 1-2, related to program effectiveness: The Ad Hoc Committee believed that terms such as “ongoing,” “broad-based,” “systematic,” and “continuous” may warrant further review to ensure that programs understand the expectations when these terms are used.

• Standard 2-5, related to student evaluation methods that measure its defined competencies was reviewed and it was determined no changes were warranted at this time.

• Standard 2-9 related to adequate patient experiences that afford students the opportunity to achieve stated competencies: The Ad Hoc Committee believed this standard should be further reviewed in association with Standards 2-23 and 2-24. Additionally, the placement of this standard may be better suited to the clinical section of the Accreditation Standards document.

• Standard 2-20 related to communicating and collaborating with other members of the health care team: The Ad Hoc Committee noted that further clarification of this standard
may be warranted related to CODA’s expectations (for example, didactic, clinical, or other educational experiences).

- Standard 2-23 related to providing oral health care within the scope of general dentistry to patients in all stages of life: The Ad Committee believed further discussion was warranted to determine if stages of life should be further defined and, if so, how this standard relates to Standard 2-24.
- Standard 2-25 related to assessing and managing the treatment of patients with special needs: The Ad Hoc Committee believed this standard should be considered with the topic on patients with special needs.
- Standard 5-3b, c, d, and e, related to continuous quality improvement for the patient care program: The Ad Hoc Committee believed further review was warranted to expand the intent statement and terms.

Following lengthy discussion, the Ad Hoc Committee determined that the Accreditation Standards noted above, and perhaps others, should be further reviewed in Spring 2022, with a report on potential revisions for consideration by the PREDOC RC and Commission at the Summer 2022 meetings.

Use of the Term “Should” Within the Accreditation Standards for Dental Education Programs and the Accreditation Standards for Dental Therapy Education Programs: The Ad Hoc Committee considered the revised definition of “Should” and the potential impact on the dental and dental therapy Accreditation Standards.

Related to the Accreditation Standards for Dental Education Programs, the Ad Hoc Committee concluded that Standards 1-2, 2-26, and 3-2 warrant further consideration. Related to the Accreditation Standards for Dental Therapy Education Programs, the Ad Hoc Committee determined that Standards 1-2, 2-4, 2-6, 2-12, and 3-7 warrant further consideration. Potential revisions were discussed and will be further considered by the Ad Hoc Committee in Spring 2022, with a report on potential revisions for consideration by the PREDOC RC and Commission at the Summer 2022 meetings.

Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental Therapy Education Programs Related to Institutional Accreditation: The Ad Hoc Committee considered the language related to institutional accreditation in Dental Education Standard 1-8 and Dental Therapy Standard 1-7. The Ad Hoc Committee also reviewed a listing of regional/national accrediting agencies from the United States Department of Education website.

Following discussion of the dental education standards, the Ad Hoc Committee determined that the Definition of Terms section of the Standards may need to include a definition of institutional sponsor and the institutional accrediting agencies deemed appropriate. The Ad Hoc Committee also believed that Standard 1-8 should include an intent statement to identify the specific
institutional accrediting agencies accepted by the Commission, which have the proper authority
to accredit doctoral level degree-granting institutions.

Following discussion of the dental therapy standards, the Ad Hoc Committee determined that
Dental Therapy Standard 1-7 may not require further revision as language currently exists which
clarifies the “regional or appropriate* national accrediting agency” that is accepted by the
Commission.

The Ad Hoc Committee will further consider this topic in Spring 2022, with a report on potential
revisions for consideration by the PREDOC RC and Commission at the Summer 2022 meetings.

Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental
Therapy Education Programs Related to Educational Activity Sites: The Ad Hoc Committee
began its discussion with a review of Dental Education Standards, particularly Standard 2-6,
noting the requirement that “Students must receive comparable instruction and assessment at all
sites where required educational activity occurs through calibration of all appropriate faculty.”
The Ad Hoc Committee was not sure that this standard alone met the charge of the Commission
and may require further review. The Committee noted there needs to be adequate and meaningful
 calibration of faculty at all educational activity sites. The Committee also discussed use of
educational activity sites, noting that some sites are used to count student experiences while others
are supplemental to clinical training obtained elsewhere. This may be a consideration for CODA
oversight of educational activity sites. The Ad Hoc Committee also noted that within the Dental
Education Standards, the Definition of Terms (community and service learning) and Standards 2-
26, 3-1, and 4-6 may require further review related to this topic.

In consideration of the dental therapy Standards, the Ad Hoc Committee noted that Standard 2-5
is identical to the Predoctoral Standard 2-6 and may warrant review of the statement requiring that
“Students must receive comparable instruction and assessment at all sites where required
educational activity occurs through calibration of all appropriate faculty.” Further, Dental
Therapy Standards 1-8, 2-24, 3-4 and 5-6 may require review and possible revision related to this
topic.

The Ad Hoc Committee will further consider this topic in Spring 2022, with a report on potential
revisions for consideration by the PREDOC RC and Commission at the Summer 2022 meetings.

Proposed Revision to Accreditation Standards for Dental Education Programs Related to Patients
With Special Needs: Related to the request submitted by the ADA’s Council on Dental
Education and Licensure that CODA consider revising the Accreditation Standards to require
that graduates be competent in treating patients with special needs, the Ad Hoc Committee
reviewed Dental Standard 2-25. Discussion occurred focused around further clarifying the
Commission’s expectation related to treating patients with special needs; however, the Ad Hoc
Committee believed that further consideration of this topic, including the potential revision of Standard 2-25, was warranted.

The Ad Hoc Committee also noted that the Dental Therapy Standards define patients with special needs in the Definition of Terms; however, there is no standard related to this patient population within the dental therapy standards. The Ad Hoc Committee believed further consideration of this topic should occur as it relates to the dental therapy requirements.

The Ad Hoc Committee will further consider this topic in Spring 2022, with a report on potential revisions for consideration by the PREDOC RC and Commission at the Summer 2022 meetings.

Summary: The Review Committee on Predoctoral Dental Education and Commission on Dental Accreditation are requested to consider progress made by the Ad Hoc Committee to consider proposed revisions to the Accreditation Standards for Dental Education Programs and Accreditation Standards for Dental Therapy Education Programs. It is noted that the Ad Hoc Committee will further consider the topics noted above in Spring 2022, with a report on potential revisions for consideration by the PREDOC RC and Commission at the Summer 2022 meetings.

Recommendation:

Prepared by: Dr. Sherin Tooks
Accreditation Standards for Dental Education Programs
Commission on Dental Accreditation
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Document Revision History

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<th>Date</th>
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<td>August 6, 2010</td>
<td>Accreditation Standards for Dental Education Programs</td>
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<tr>
<td>February 1, 2012</td>
<td>Revised Compliance with Commission Policies section (Complaint)</td>
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<td>February 3, 2012</td>
<td>Revision to Standard 2-23 e and 3-2</td>
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<td>Revised Mission Statement</td>
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<td>August 9, 2013</td>
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<td>January 30, 2014</td>
<td>Revision to Policy on Complaints (Anonymous)</td>
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<td>Revision to Standard 4-6</td>
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<td>Revised Accreditation Status Definitions</td>
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<td>August 3, 2018</td>
<td>Revision to Standards 2-8 and 3-1</td>
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<td>February 8, 2019</td>
<td>Revised Intent Statements Standards 2-20 and 2-24; New Intent Statement Standard 2-9</td>
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<td>Definition of Terms (Research and Health Literacy); Standard 2-17; Standard 6-Research</td>
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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and profession 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
Accreditation Status Definitions

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

Programs Which Are Not Fully Operational

The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “Initial Accreditation.”

Initial Accreditation: Initial Accreditation is the accreditation classification granted to any dental, advance dental or allied dental education program which is in the planning and early stages of development or an intermediate stage of program implementation and 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 program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s) and until the program is fully operational.
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 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.

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 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 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 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 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
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. 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 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 inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising and small group interaction. A dental school environment characterized by respectful professional relationships between and among faculty and students establishes a context for the development of interpersonal skills necessary for learning, for patient care, and for making meaningful contributions to the profession.
Scientific Discovery and the Integration of Knowledge

The interrelationship between 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 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.

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.

**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 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.

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**Faculty 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.

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**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 interdisciplinary team present a 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

Diversity in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas and from various geographic regions; and have a wide variety of interests, talents, 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 create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines.

Summary

These principles 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 of their patients and of society.
Definition of Terms Used in Accreditation Standards for Dental Education Programs

**Community-based 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.

**Comprehensive patient 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.

**Competencies:** Written statements describing the levels of knowledge, skills and values expected of graduates.

**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.

**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, concerns 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.

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.

Examples of evidence to demonstrate compliance 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.

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

Predoctoral: Denotes training leading to the DDS or DMD degree.
Quality assurance: 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 involves identification and implementation 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.

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.

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.
The dental education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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

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

The dental school **must** have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty and staff;

b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and

c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

**Intent:**
*The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.*
1-5 The financial resources must be sufficient to support the dental school's stated purpose/mission, goals and objectives.

**Intent:**

*The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, reference material and teaching aids as reflected in annual operating budget. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes 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 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

1-8 The dental school must be a component of a higher education institution that is accredited by a regional accrediting agency.

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 of each course, the nature of the course content, the method(s) of evaluation to be used, and how 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 The curriculum must include at least four academic years of instruction or its equivalent.

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.
The dental education program must employ student evaluation methods that measure its defined competencies.

**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 that can measure not only the acquisition of knowledge and skills but also assess the process and procedures which will be necessary for entry level 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

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

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.

The dental school must have a curriculum management plan that ensures:
- an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;
- evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;
- elimination of unwarranted repetition, outdated material, and unnecessary material;
d. incorporation of emerging information and achievement of appropriate sequencing;
e. 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 Graduates must be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry and research methodology.

Intent:
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 Graduates 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 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 Biomedical science instruction in dental education must ensure an in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems.

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.
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.

Graduates must be competent in the application of biomedical science 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.*

**Behavioral Sciences**

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.

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 multidimensionally 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 Graduates must be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.

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.

2-25 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.

2-26 Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.

Intent:
Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.
**STANDARD 3- FACULTY AND STAFF**

3-1 The number, distribution and qualifications of faculty and staff must be sufficient to meet the dental school’s stated purpose/mission, goals and objectives, at all sites where required educational activity occurs. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.

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

3-2 The dental school must show evidence of an ongoing faculty development process.

**Intent:**

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

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

- Participation in development activities related to teaching and learning
- Attendance at regional and national 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 Faculty **must** be ensured a form of governance that allows participation in the school’s decision-making processes.

3-4 A defined evaluation process **must** exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

3-5 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 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/residents will not result in an increase of the program’s approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for 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 4-4:
The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate
institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.

Facilities and Resources

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 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 Services

4-7 Student services must include the following:
   a. personal, academic and career counseling of students;
   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.
Student Financial Aid

4-8 At the time of acceptance, students must be advised of the total expected cost of their dental education.

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

4-9 The institution must be in compliance with all federal and state regulations relating to student financial aid and student privacy.

Health Services

4-10 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.

4-12 Students must be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.
5-1 The dental school must have a published policy addressing the meaning of and commitment to patient-centered care and distribute the written policy to each student, faculty, staff, and patient.

**Intent:**

A written statement of patient rights should include:

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

5-2 Patient care must be evidenced-based, integrating the best research evidence and patient values.

**Intent:**

*The dental school should use evidence to evaluate new technology and products and to guide diagnosis and treatment decisions.*
5-3 The dental school must conduct a formal system of continuous quality improvement for the patient care program 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.

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.

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 a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste, consistent with accepted dental practice.

5-9 The school’s policies and procedures must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.
STANDARD 6- RESEARCH PROGRAM

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

Intent:
The institution should develop and sustain a research program on a continuing basis. The dental school should develop 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 mission statement, strategic plan, and financial support
- Evidence of regular ongoing research programmatic review
- Extramural grant and/or foundation support of the research program
- Other evidence of the global impact of the research program

6-2 The dental school faculty, as appropriate to meet the school’s purpose/mission, goals and objectives, must engage in research or other forms of scholarly activity.

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. The program should employ an adequate number of full-time faculty with time dedicated to the research mission of the institution. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty.

Examples of evidence to demonstrate compliance may include:
- Faculty roster of full-time equivalents dedicated to research
- Extramural funding of faculty
- Documentation of research faculty recruitment efforts
- Peer reviewed scholarly publications (manuscripts, abstracts, books, etc.) based on original research
Dental education programs **must** provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.

**Intent:**

The dental education program should provide students with opportunities to experience research including, but not limited to, biomedical, translational, educational, epidemiologic and clinical research. Such activities should align with clearly defined research mission and goals of the institution. The dental education program should introduce 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
2021 Accreditation Standards Validity and Reliability Survey – Predoctoral Dental Education Programs

Final Results
INTRODUCTION

At its Winter 2021 meeting, the Commission on Dental Accreditation (CODA) directed that a validity and reliability study be conducted for the Accreditation Standards for Dental Education Programs. The 2021 Accreditation Standards Validity and Reliability Survey – Predoctoral Dental Education Programs was designed and implemented as a result of this decision.

CODA, in conjunction with the ADA Health Policy Institute (HPI), designed the survey instrument used for this study (see Appendix). The survey was sent electronically by HPI to a diverse array of groups, including:

- A random sample of professionally active dentists in the United States
- Deans of CODA-accredited dental schools
- CODA site visitors for Predoctoral Dental Education programs
- Presidents of state dental societies
- Chief executive officers of the Federal Dental Services
- Executive directors of state boards of dentistry
- Executive directors of clinical testing agencies
- Executive directors of the following national dental organizations:
  - American Association of Public Health Dentistry
  - American Association of Endodontists
  - American Academy of Oral & Maxillofacial Pathology
  - American Association of Oral and Maxillofacial Surgeons
  - American Association of Orthodontists
  - American Academy of Pediatric Dentistry
  - American Academy of Periodontology
  - American Academy of Oral & Maxillofacial Radiology
  - American College of Prosthodontists
  - American Society of Dentist Anesthesiologists
  - American Academy of Oral Medicine
  - American Academy of Orofacial Pain
  - American Board of Dental Public Health
  - American Board of Endodontics
  - American Board of Oral and Maxillofacial Pathology
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Orthodontics
  - American Board of Pediatric Dentistry
  - American Board of Periodontology
  - American Board of Oral and Maxillofacial Radiology
  - American Board of Prosthodontics
  - American Dental Board of Anesthesiology
  - National Dental Board of Anesthesiology
  - American Board of Oral Medicine
  - American Board of Orofacial Pain
  - American Board of General Dentistry
  - American Association of Dental Boards
  - Academy of General Dentistry
  - American Dental Education Association
  - American Student Dental Association
  - American Dental Association

A total of 5,302 individuals were invited by email to complete the online survey on April 22, 2021. In order to increase the response rate, follow-up mailings were administered to all non-respondents on May 3 and May 12. Data collection ended on May 18, yielding 302 responses, for an overall adjusted response rate of 6.0% (excluding 229 individuals whose email addresses were undeliverable). A breakdown of responses by category is found in the table on the next page.
The survey had an abandonment rate of 47.0%, meaning that nearly half of all recipients who opened the online survey did not complete it. The incomplete responses of those who abandoned the survey are not included in this report. It is worth noting that abandonment rates of 20% or higher in an online survey may signify issues to consider with the survey instrument, such as whether the length is appropriate, the difficulty of the questions, whether or not a programming glitch may be present, and the relevance of the survey topic to the recipients.

NOTES TO THE READER

Respondents were asked to rate each criterion in the survey using the following rating scale:

- **Too demanding** = Criterion is relevant to type of program but too demanding for programs and/or students
- **Sufficiently demanding** = Criterion is relevant to type of program and sufficiently demanding for programs and/or students
- **Not demanding** = Criterion is relevant but not demanding enough for programs and/or students
- **Not relevant** = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or students
- **No opinion** = No opinion on this criterion

The tables in this report provide frequency distributions for each question in the survey overall and by type of respondent. Please note that the respondent categories are based on the samples from which the individuals were drawn. Since many respondents were found in more than one sample, a hierarchy was established to determine the most appropriate category in which to place these individuals. For instance, if an individual appeared in both the professionally active dentist and site visitor samples, that person would be assigned to the site visitor category.

The report is divided into two main sections: frequencies for the survey questions, and a list of open-ended responses. Each standard is numbered in the frequencies so that it can be cross-referenced with the copy of the survey in the Appendix in order to view the complete wording of the standard.

Although redactions have been made where comments identify a respondent or an educational institution, they are otherwise presented in the report as entered on the survey by respondents; misspellings and typographical errors have not been corrected.
Executive Summary – Professionally Active Dentists

The survey was sent to a random sample of 4,980 professionally active dentists in the United States. A total of 420 recipients opened the survey; 180 completed it, yielding a response rate of 3.6% (and a survey abandon rate of 57.1%).

Among all 87 individual “must” statements from the Predoctoral dental education program accreditation standards listed in the survey, between 45.0% and 95.0% of the 180 dentists who responded indicated the standards were “Sufficiently demanding.”

The standards that were identified as “Too demanding” by the highest percentages of dentists who completed the survey were:

- 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. (Standard 6-2) 12.8%
- Graduates must be competent in assessing and managing the treatment of patients with special needs. (Standard 2-25) 12.2%
- a. The dental school must have policies and practices to achieve appropriate levels of diversity among its students, faculty and staff; (Standard 1-4) 10.6%

A total of 25 separate standards were identified as “Not demanding” by 10% or more of dentists who completed the survey.

Four standards, all related to diversity, were identified as “Not relevant” by at least 20% of the dentists who responded to the survey:

- Three of these were in Standard 1-4: The dental school must have policies and practices to:
  - a. Achieve appropriate levels of diversity among its students, faculty and staff; 28.9%
  - b. Engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and 23.9%
  - c. Systematically evaluate comprehensive strategies to improve the institutional climate for diversity. 21.7%
- Admission policies and procedures must be designed to include recruitment and admission of a diverse student population. (Standard 4-4) 21.1%

The standard with the highest percentage of dentists had no opinion was: 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. (Standard 6-2) 7.2%
Executive Summary – Dental School Deans

The survey was sent to 68 deans of dental schools accredited by CODA. A total of 35 recipients opened the survey; 29 completed the survey, yielding a response rate of 42.6% (and a survey abandon rate of 17.1%).

Among all 87 individual “must” statements from the Predoctoral dental education program accreditation standards listed in the survey, between 69.0% and 96.6% of the 29 dental school deans who responded indicated the standards were “Sufficiently demanding.”

The five standards that were identified as “Too demanding” by the highest percentage of the 29 dental school deans who completed the survey were:

- *Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.* (Standard 2-6) 24.1%
- *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.* (Standard 2-19) 13.8%
- b. *The dental school must have policies and practices to engage in ongoing systematic and focused efforts to attract and retrain students, faculty and staff from diverse backgrounds;* and (Standard 1-4) 10.3%
- *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;* (Standard 2-24) 10.3%
- *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.* (Standard 4-3) 10.3%

The two standards that were identified as “Not demanding” by more than 10% of the 29 dental school deans who completed the survey were both in Standard 2:

- *Graduates must be competent in assessing and managing the treatment of patients with special needs.* (Standard 2-25) 17.2%
- *Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.* (Standard 2-26) 13.8%

The two standards that were identified as “Not relevant” by more than 10% of the 29 dental school deans who completed the survey were both part of Standard 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:

- c. *Recognizing the complexity of patient treatment and identifying when referral is indicated;* 10.3%
- k. *Oral mucosal, temporomandibular, and osseous disorders;* 10.3%

The standard for which the most respondents in this group had no opinion was *Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program.* (Standard 4-2) 6.9%
Executive Summary – Predoctoral Dental Education Program Site Visitors

The survey was sent to 109 Predoctoral dental education program site visitors. A total of 81 recipients opened the survey, and 71 completed it, yielding a response rate of 65.1% (and a survey abandon rate of 12.3%).

Among all 87 individual “must” statements from the Predoctoral dental education program accreditation standards listed in the survey, between 70.4% and 95.8% of the 71 site visitors who responded indicated the standards were “Sufficiently demanding.”

The three standards with the largest percentage of site visitors selecting “Too demanding” (14.1% in each case) were:

- The dental school must have policies and practices to: a. achieve appropriate levels of diversity among its students, faculty and staff; (Standard 1-4)
- 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. (Standard 2-19)
- Graduates must be competent in assessing and managing the treatment of patients with special needs. (Standard 2-25)

A total of 15 separate standards were identified as “Not demanding” by 10% or more of the site visitors who completed the survey.

No more than 2.8% of site visitors who responded to the survey identified any standard as “Not relevant”, and no more than 5.6% had no opinion.
Executive Summary – Leaders of National Dental Organizations

The survey was sent to the executive directors of five clinical testing agencies and 30 national dental organizations, as well as four chiefs of federal dental services. Of the 39 total recipients in this group, 11 opened the survey, and seven completed the survey, yielding a response rate of 17.9% (and a survey abandon rate of 36.4%).

Among all 87 individual “must” statements from the Predoctoral dental education program accreditation standards listed in the survey, between 71.4% and 100.0% of the seven leaders of state and national dental organizations who responded indicated the standards were “Sufficiently demanding.”

No standard was identified as “Too demanding” or “Not demanding” by more than one of the seven leaders of national dental organizations (14.3%) who completed the survey.

No standard was identified as “Not relevant” by this group.

No more than one of the seven leaders of national dental organizations (14.3%) who completed the survey had no opinion on any standard.
Executive Summary – Leaders of State Dental Organizations

The survey was sent to the executive directors of state dental boards and presidents of state dental societies (53 in each group). Of the 106 total recipients in this group, 23 opened the survey, and 15 completed the survey, yielding a response rate of 14.2% (and a survey abandon rate of 34.8%).

Among all 87 individual “must” statements from the Predoctoral dental education program accreditation standards listed in the survey, between 53.3% and 93.3% of the 15 leaders of state dental organizations who responded indicated the standards were “Sufficiently demanding.”

The two statements that were identified as “Too demanding” by the largest percentage of state dental organization leaders who responded to the survey (13.3%) were:

- 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. (Standard 2-17)
- 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. (Standard 6-2)

Over half of the statements (46) were identified as “Not demanding” by 20% or more of the 15 state dental organization leaders who responded to the survey.

The two statements, both in Standard 6, that were identified as “Not relevant” by the largest percentage of state dental organization leaders who responded to the survey (13.3%) were:

- 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. (Standard 6-1)
- 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. (Standard 6-2)

No more than one of the 15 leaders of state dental organizations (6.7%) who completed the survey had no opinion on any standard.
Accreditation Standards for Dental Education Programs
STANDARD 1 – INSTITUTIONAL EFFECTIVENESS

(ST1-1) 1. The program must develop a clearly stated purpose/mission statement appropriate to dental education, addressing teaching, patient care, research and service.

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<td>71</td>
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(ST1-2) 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.

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<td>71</td>
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(ST1-3) 3. The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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<td>29</td>
<td>71</td>
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4. The dental school must have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty and staff;

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b. engage in ongoing systematic and focused efforts to attract and retrain students, faculty and staff from diverse backgrounds; and

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c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

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(ST1-5) 5. The financial resources must be sufficient to support the dental school’s stated purpose/mission, goals and objectives.

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(021-6) 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.

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(021-7) 7. The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

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(ST1-8) 8. The dental school must be a component of a higher education institution that is accredited by a regional accrediting agency.

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(ST1-9) 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.

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STANDARD 2 – EDUCATIONAL PROGRAM

Instruction

(ST2-1) 10. In advance of each course or other unit of instruction, students must be provided written information about the goals and requirements of each course, the nature of the course content, the method(s) of evaluation to be used, and how grades and competency are determined.

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(ST2-2)11. 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.

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Curriculum Management

(ST2-3) 12. The curriculum must include at least four academic years of instruction or its equivalent.

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(ST2-4) 13. 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.

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(ST2-5) 14. The dental education program must employ student evaluation methods that measure its defined competencies.

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(ST2-6) 15. Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.

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(ST2-7) 16. 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.

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Curriculum Content

(ST2-8) 17. The dental school must have a curriculum management plan that ensures:

a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;

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

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

d. incorporation of emerging information and achievement of appropriate sequencing;

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

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(ST2-9) 18. 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.

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Critical Thinking

( ST2-10) 19. Graduates must be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry and research methodology.

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Self-Assessment

(ST2-11) 20. Graduates 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.

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Biomedical Sciences

(ST2-12) 21. Biomedical science instruction in dental education must ensure an in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems.

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(ST2-13) 22. The biomedical knowledge base must emphasize the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

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(St2-14) 23. 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.

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(ST2-15) 24. Graduates must be competent in the application of biomedical science knowledge in the delivery of patient care.

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**Behavioral Sciences**

(ST2-16) 25. 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.

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(ST2-17) 26. 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.

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**Practice Management and Health Care Systems**

(27) Graduates must be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.

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(ST2-19) 28. 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.

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(ST2-20) 29. Graduates must be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

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Ethics and Professionalism

(ST2-21) 30. Graduates must be competent in the application of the principles of ethical decision making and professional responsibility.

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Clinical Sciences

(ST2-22) 31. Graduates must be competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care.

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Graduates must be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.

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(ST2-24) 33. 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:

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b. Screening and risk assessment for head and neck cancer:

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c. Recognizing the complexity of patient treatment and identifying when referral is indicated:

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At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

d. Health promotion and disease prevention, including caries management;

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e. Local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;

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f. Restoration of teeth;

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(continued, ST2-24) 33. At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

g. Communicating and managing dental laboratory procedures in support of patient care;

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h. Replacement of teeth including fixed, removable and dental implant prosthodontic therapies;

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i. Periodontal therapy

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At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

j. Pulpal therapy;

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k. Oral mucosal, temporomandibular, and osseous disorders;

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l. Hard and soft tissue surgery;

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(continued, ST2-24) 33. At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

m. Dental emergencies;

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n. Malocclusion and space management; and;

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o. Evaluation of the outcomes of treatment, recall strategies, and prognosis.

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(ST2-25) 34. Graduates must be competent in assessing and managing the treatment of patients with special needs.

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(ST2-26) 35. Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.

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STANDARD 3 – FACULTY AND STAFF

(ST3-1.1) 36. The number, distribution and qualifications of faculty and staff must be sufficient to meet the dental school’s stated purpose/mission, goals and objectives, at all sites where required educational activity occurs.

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<td>29</td>
<td>71</td>
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(ST3-1.2) 37. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.

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(ST3-2) 38. The dental school must show evidence of an ongoing faculty development process.

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( ST3-3) 39. Faculty must be ensured a form of governance that allows participation in the school’s decision-making processes.

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(ST3-4) 40. A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

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(ST3-5) 41. The dental school must have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.

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STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

(ST4-1) 42. Specific written criteria, policies and procedures must be followed when admitting predoctoral students.

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(ST4-2) 43. Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program.

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(ST4-3) 44. 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.

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(ST4-4) 45. Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.

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Facilities and Resources

(ST4-5) 46. 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.

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Written Agreements

(ST4-6) 47. 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.

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Student Services

ST4-7 - 48. Student services must include the following:

a. Personal, academic and career counseling of students;

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b. Assuring student participation on appropriate committees;

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c. Providing appropriate information about the availability of financial aid and health services;

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(continued, ST4-7) 48. Student services must include the following:

d. Developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;

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e. Student advocacy

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f. Maintenance of the integrity of student performance and evaluation records; and

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(continued, ST4-7) 48. Student services must include the following:

g. Instruction on personal debt management and financial planning.

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**Student Financial Aid**

(ST4-8) 49. At the time of acceptance, students must be advised of the total expected cost of their dental education.

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(ST4-9) 50. The institution must be in compliance with all federal and state regulations relating to student financial aid and student privacy.

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Health Services

(ST4-10) 51. The dental school must advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental studies.

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(ST4-11) 52. There must be a mechanism for ready access to health care for students while they are enrolled in dental school.

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</table>
(ST4-12) 53. Students must be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.

<table>
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**STANDARD 5- PATIENT CARE SERVICES**

(ST5-1) 54. The dental school must have a published policy addressing the meaning of and commitment to patient-centered care and distribute the written policy to each student, faculty, staff, and patient.

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(ST5-2) 55. Patient care must be evidenced-based, integrating the best research evidence and patient values.
Appendix 2

Report on Validity and Reliability Study for Dental Education Predoctoral Dental Education RC CODA Summer 2021

No opinion 0.6% 1 0.0% 0 1.4% 1 0.0% 0 6.7% 1
Total 180 29 71 7 15

(ST5-3) 56. The dental school must conduct a formal system of continuous quality improvement for the patient care program 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;
e. implementation of corrective measures as appropriate.

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(ST5-4) 57. The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive patient care.

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(ST5-5) 58. The dental school must ensure that active patients have access to professional services at all times for the management of dental emergencies.

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(ST5-6) 59. 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.

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(ST5-7) 60. Written policies and 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.

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(STAT-8) 61. The dental school must establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste, consistent with accepted dental practice.

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(ST5-9) 62. The school’s policies and procedures must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

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STANDARD 6 – RESEARCH PROGRAM

(ST6-1) 63. 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.

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(ST6-2) 64. 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.

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(ST6-3) 65. Dental education programs must provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.

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Responses to Open-ended Questions
Standard 1, Institutional Effectiveness

Questions 1-9 (ST1-1 to 1-9)

Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

**Dentist, Questions 1-9 (ST1-1 to 1-9)**

"Achieve appropriate levels of diversity among students, faculty and staff"-I'm not sure what appropriate means here but I don't think this statement is enough. More sufficient would be to achieve a "highly diverse" group of students, faculty and staff.

#3: I believe I agree with the spirit of this requirement, but I don't think the the specific term "humanistic" is necessary and/or its exact meaning in this context is unclear to me.

#4. The desire to include a diverse group has ruined the upper capacity/limit of all education. Diversity should be an added bonus to the selection process not a key factor of it. Understanding that students of the best quality should be accepted should be the goal of any governing body for any program. Diversity does lead to enhanced experiences but if we are allowing undeserving applicants into programs just to fulfill a diversity quota, we are handicapping the programs. This is written as a minority (Asian American).

1) I would specify and clarify Student Academic and Clinical Proficiency under the school’s dental education goals. 2) The statement reads too broadly and needs more specificity.

3. “Humanistic” is ambiguous in its definition how you use it 4. “Must achieve diversity” is also ill defined. How do you define diversity? Age gender race nationality? How do you define when we have reached this? 7. The sponsoring entity should not have final authority. The final authority should be the dental school that determines the curriculum . 9. Why should the dental school prove they interact with other higher education in which they may or may not have anything to do with. The question is too broad.

4 a and b The best qualified candidates should be selected irregardless of diversity. REDACTED stands for the best and if diversity means admitting below the standard of REDACTED then it will reflect on all of us.

4 A B C THE PROGRAM IS OPEN TO ALL THAT MEET THE STANDARDS DIVERSITY SHOULD NOT BE MANDATED

4. A candidate should not be evaluated by skin color or ethnicity but by scores, accomplishments and interview.
Dentist, Questions 1-9 (ST1-1 to 1-9)

4. Not relevant to providing society with competent, ethical practitioners and future educators. Criteria for future dentists must remain based on academic merit and ethics independent of genetic factors.

4a 4b and 4c. Diversity for the sake of being "different" has no place in this situation, thus, irrelevant.

4A: I think the use of "diversity" in any requirements is merely a political buzzword that has very little impact on determining whether the institution is able to produce professionals suited for dentistry. The institution needs to be able to turn out professionals that are skilled, compassionate, and community minded regardless of whether those students/faculty meet a changing criteria of what is politically correct at any certain time. 4B: I am unsure as to the meaning of "attract and retrain"

5. Students are almost going half a million dollars into debt, and at some institutions ARE going half a million dollars into debt, to receive a dental education. If achieving diversity really is a goal, then perhaps this should be addressed first.

5If class size increases, demonstrate there are sufficient resources to support the action; tuition increases should be proportional to operational costs.

5-the devil rests in the details. Although the requirement is relevant, an institution can justify any decision made, even with negative consequences, in lieu of the “bigger picture in mind”. Example is lack of available funding for instructors salaries, material, staff while saving or using available funds to build a new clinical facility that in the future will “transform dental education” even though current students and staff may suffer the consequences.

8. Not all dental schools need to be associated with a university, however, they should be accredited

A school may try to make decisions or accept a wide diversity of applicants but this may not always happen or be possible. I do not think that standards should be lowered to require a certain amount of diversity. The most qualified applicants should be accepted first. For equally talented applicants, one may chose in favor of diversity.

All candidates for dental school or faculty positions should be viewed equally based on the criteria they are to be evaluated

Better to focus on more important issues, choose candidates based on their overall academic performance and projected successful development than on issues such as diversity that in the end do not reflect on good healthcare services

By not demanding, I meant they should be the accepted standards

DEMANDING DIVERSITY IS A FORM OF RACISM; ENSURING DIVERSITY COULD EASILY COMPROMISE THE INTEGRITY OF THE CURRICULUM!

Dental schools and specialty programs should select students based on achievement and accomplishments only. (grades, extracurricular activities, etc.)
Dentist, Questions 1-9 (ST1-1 to 1-9)

Dental schools are much too expensive. Students are paying outrageous prices for dental school that they'll never be able to pay off. Ie So much money was wasted on pre clinic materials that were never used.

Dentistry has been well ahead of the proverbial curve, when it comes to issues of diversity and inclusion. Stop harping over Progressive talking points, and just keep doing what you've been doing over the past two (2) decades.

Dental education has gone down hill . Student lack clinical talent. This is due to the haphazard educational process that exists

Diversity at the institution on all levels needs to be addressed.

Diversity is a function of perople who apply and seek positions in education. The moment you try to manipulate one group over another you always tend to discriminate against another group.

Diversity issues have no place in our profession. Color, sex, religion, background do not matter. What matters is the QUALITY of the student, teacher, or administrator.

Faculty students and staff should be chosen on the quality of their character and objective assessment of their ability to eventually provide quality diagnosis and treatment of dental disease. Any other criteria are dangerous to the dental health and well being of the public and therefore irrelevant.

Forced diversity programs are, in the long run, detrimental to the mission of the learning institution. All authority of curriculum, student matters, and faculty selection should be maintained by the school. No outside influence should be tolerated.

I believe that students and faculty should be chosen on merit.

I believe that the top students should be selected regardless of race, creed or sexual orientation; not hustled just because they fall into a certain group.

I believe that there should be more required procedures in the areas of Endodontics and oral surgery to graduate. These young doctors should be able to preform these procedures to diversify them more to increase their potential incomes.

I believe the most qualified applicants should be selected for dental school be it diversified or not in the student population or faculty. I attended school with minority students who dropped out of the program because they could not keep up with the demanding program. I myself am a petite Asian female and I persevered so it spends on the person if they wish to succeed or not.

I do believe diversity is very important, but the most qualified student I know will be overlooked because of diversity quotas. In the long run, that brings the standards of the institutions down. The school I went to, had many minorities, but they deserved to be there because of the their academic achievement.
**Dentist, Questions 1-9 (ST1-1 to 1-9)**

I feel diversity is over emphasized; skill and academic achievement are more relevant.

I feel that an emphasis on the merits of the individuals/programs should be emphasized and not dictated by a quota of diversity! A student who has better grades, scores, application should be admitted, regardless of background.

I generally agree with the final responsibility of curriculum development lying with the dental school, however I believe our profession would benefit from more educational standardization - assuming the standardization is good. I feel that dental schools these days by and large do not adequately prepare graduates for private practice.

I think dental student acceptance should be solely based on applicant qualifications and not race.

Many schools are falling short on their education of dental practitioners. They have chipped away at the necessary medical education in favor of technical education. This has created a number of practitioners that are merely technicians and not true clinicians. In my opinion schools have taken on too many students and do not have the case load to support the clinical education of the students. This has been driven by increasing tuition revenue at the detriment to the students. They constantly roll back the clinical requirements watering down the experiences and education. This needs to be more congruent and standardized across all schools and that is where curriculum should not rest only with the school but in a broader over seeing body.

No aspiring, ambitious, hardworking person applying to a graduate school should be included or excluded based upon their ethnicity, race, or gender. Every candidate should be considered based on their merits, accomplishments, character, and academic performance. I personally have witnessed advantage given to applicants simply due to their gender. This is discrimination.

Not demanding to me indicates that the article in question should be a standard.

On matters of diversity, while it is important, it is counterproductive to admit or hire any but the best qualified. If that makes a school ethnocentric (regardless of the ethnicity) then a search should be made to find more qualified applicants of other diverse cultures. In the event that no such applicants can be found, then the best qualified must be accepted or hired. Making a school more diverse does not improve the quality of education. Seeking out the best qualified students, teachers and researchers should produce the best quality education.

Policies and practices to achieve diversity - I believe my institution has done that but it is very challenging since we are all competing for those who are well-qualified. There also seems to be insufficient numbers of URMs applying.

question 3 - to have a "stated commitment" does not seem sufficient. There should be a mechanism in place to assure that there is a regular review.

Questions 6 and 7. What do the answers have to do with this type of question? The question should be: do you think outside entities should influence the sponsoring institution? No. A college program should not be run based on people or companies contributing. It should be a neutral program that
Dentist, Questions 1-9 (ST1-1 to 1-9)

- teaches the students the information correctly and factually regardless of whom is contributing money to the program.
- The culture is saturated with an emphasis on "diversity". Having these statements as part of the dental school's policies and practices is not necessary. What is necessary is to attract students that are ready and capable of the educational demands of dental training.
- The learning environment should remain neutral and unbiased.
- When a patient is seeking dental care, they deserve the best and brightest to treat them.

Dean, Questions 1-9 (ST1-1 to 1-9)

- Question 6. This seems redundant when you consider some of the other "must" statements within the Institutional Effectiveness Standard. This seems like a solution looking for a problem.
- 4c - institutions vary in their ability to evaluate and climate and the response are difficult to assess for validity and reliability 9 - every institution is different with different relationships so this standard does not provide real information to ensure quality for students.
- I think the level of detail required to satisfy the accreditation site visitors is too much.
Site Visitor, Questions 1-9 (ST1-1 to 1-9)

1-3 The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated. This standard leaves a lot of leeway in the interpretation of what is a commitment. While that is often the goal of CODA to leave it up to the institution, this just comes across as very vague in what is wanted, and how it will be evaluated.

CODA should strengthen the financial resources Standard to assure that resources are sufficient to support the dental school’s stated mission. Consider adding benchmark indicators based on national dental education revenue and expenditures to compare an individual dental school to a subset of comparable institutions based on mission.

As a must statement, CODA should either define what is broad-based, systematic, continuous because site visitors often are too demanding on what is considered broad-based, even when school are using best practices in curriculum and institutional reviews. What some feel is broad-based is too prescriptive. Site visitors should not prescribe the curriculum development and review process when the school has one. The standards should not be designed to be prescriptive. That is also true for the humanism standard. As long as school is evaluating and looking at the learning environment, site visitors determine that it isn’t enough. Again prescriptive interpretation should not be the intent.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

referring to #5 above: It has become too usual that schools increase enrollment either in the traditional classes of advanced standing classes strictly to increase revenue because they truly are not supported by the higher institution, and the increase does not have anything to do with the mission of the school and usually only makes maintaining educational standards more difficult for the faculty.

4A. who defines what “Appropriate levels of Diversity” means. Too often the lack of applicants to certain geographical areas might make this difficult if not impossible depending on whpo is defining “appropriate”. 4C. Systematically evaluating strategies to improve diversity is the first step but does not really ask for a deliverable. 7. The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution. - this seems that there is no common standard to be met

Humanistic environment. I believe that additional emphasis should be placed on the creation and maintenance of a humanistic environment.

1 &2: Much of the assessment information that must be provided is extremely repetitive, taxing to provide and not enough guidance is given. 4: Diversity has been difficult to documents and work toward effectively since I’ve been involved in dental educationREDACTED... 8: The university needs to be regionally accredited, so it's pretty easy to note that 9: This is difficult but we need to get there anyway!

2, 3 - both are so hard to evaluate and tend to result in the same type of response from institutions. 6 - no institution that I have site visited has ever had an outside entity involvement.
Site Visitor, Questions 1-9 (ST1-1 to 1-9)

. Too many site visitors misinterpret the meaning of broad based. While all this verbiage is exalted it is over-interpreted by too may prescriptive site visitors. 3. Humanism is a soft term which you are asking to be quantitated. This concept will vary based on the culture of the entire university as opposed to simply the dental school. This is noble but should not be a must statement. 4.a. Often over interpreted by site visitors who cannot understand the entire culture of the state, region, or institution much less the demographics. Again you are asking for quantitation which really does not reflect total diversity. The resources and other external factors may affect the results even when the school and university are acting with the greatest efforts. Should not be a must statement. 4.c. Again you are asking for quantitation of a soft qualitative concept. While every university wants its students, faculty and staff to always be so warm and fuzzy, there are both external and internal factors that can affect the outcome. It is clearly demonstrated that through surveys and interviews, the only individuals that will give any opinion are the most disgruntled and therefore the bad will always outweigh the good. A worthy effort, but should not be a must statement.

Integration of oral health must be within the context if general health and accomplished by integration of allied health care delivery

Humanism is relevant but challenging to related supply hard evidence, other than perception.

"The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated." - A stated commitment is not evidence of working towards that commitment. "The financial resources must be sufficient to support the dental school’s stated purpose/mission, goals and objectives." - I believe there should be some element of financial resource statement around longevity of the program. Staying in operation for the next twenty years is not usually part of a mission statement. So, what is your facility deferred maintenance plan?

National Org, Questions 1-9 (ST1-1 to 1-9)

No comments
State Org, Questions 1-9 (ST1-1 to 1-9)

#3 and #4: Dental Schools should seek to enroll the most qualified students regardless of ethnicity or background. Standards should not be lowered in the name of "diversity."

4a and 4b  Ensuring diversity is equally important and challenging. When I was young and naive I believed in meritocracy, and was confused how Affirmative Action could use race to decrease racism. I had terrible blindspots that obscured the fact that the playing field is not level. CODA is acknowledging this too, but then allowing each school to make their own determination of how to ensure diversity. Certainly the results will vary, yet one may reasonably predict that some standards will be less effective than others. Ironically, some standards may even be set by administrations that lack diversity. Why accept this? CODA and dental school administrations should pool their diversity AND consult professionals REDACTED. This company is one example of specialists in this field, and we must hold ourselves to the standard of the specialist. Work with these experts to define the accreditation standard for all institutions, and make revisions after the outcomes are evaluated. (I recommend watching REDACTED TED talks) 7. Referring curriculum development to the sponsoring institution is “not demanding” enough. Accreditation is defined by officially recognizing someone as qualified to perform a particular activity. Certifying an institution as qualified to pronounce their graduates ready to perform dentistry, is tantamount to saying that there is, in fact, a standard by which to determine this. I recognize that it is challenging to define qualitative standards for each core competency. However, CODA delegates the educational objectives that define “qualified” to the institution, and the resulting variations are producing dentists with wildly different skill sets that fall short of the (sparsely) defined competencies. Before you dismiss this as hyperbolic or inaccurate, please consider the fact that graduates do lack competency in core areas of practice. REDACTED Depending what school is attended, a graduate will have adequate or inadequate clinical competency in commonly performed procedures. This is an anecdote, but I am certain that CODA forfeits too much authority regarding accreditation standards. Dental school curricula are poorly standardized. If this statement was false, then we could challenge the existence of discrete clinical state board exams and limit them to a national standard plus state specific jurisprudence. We should each have the confidence to lay in the chair of a new degree-holding dentist, but I know that I do not. CODA must determine and specify what qualifies a student to earn a dental degree. I assert that many competencies listed in section 2-24 are not being met by graduates. This section must be expanded. Even if a dental school attests to have satisfied the scope of competencies listed in section 2-24, is that meaningful? Consider competency “l. hard and soft tissue surgery”. What does this mean? Technically drilling a tooth is hard tissue surgery. Is a graduate to be competent in simple exodontia, “surgical” exodontia, alveoplasty, and/or clinical crown lengthening? If any are considered necessary for competency, then why are they not specified? Could a dentist be competent in dental emergencies when exodontia is either required, or the only option affordable to the patient? Is competency reached at 6-10 procedures? I know the goal is qualitative, not quantitative, but ask yourself if you would volunteer (let alone pay) to be this new doctor’s seventh? What if the dentist had only extracted six teeth with advanced periodontal disease and class III mobility? I’m not trying to get in the weeds and suggest every possible scenario, but expand the list into something far more substantive. CODA could retain a qualitative approach by doing so. “Malocclusion” is apparently a competency; surely this does not mean orthodontic treatment. In my school we got to perform some abstract art, bending wires one day, and maybe remove some elastics from brackets. Define what is intended. It would be great if a general dentist knew enough to evaluate an Invisalign treatment plan, we don’t. How many GP’s fail to refer pediatric patients with posterior crossbites in time for Phase I ortho to avoid the rarely performed surgical solution? Does “pulpal therapy” mean pediatric pulpotomy, apexification, anterior endo, and/or molar...
endo? Between leaving it completely up to dental schools to design curricula and providing a minimal framework, it is no wonder that graduates can be strong in some areas yet questionably (frighteningly?) competent in others. Section 2-24 may be interpreted to include pediatric treatment planning and treatment under the umbrella of subsections “a, c, e, f, j, and n”, but does not specify pediatrics. Not all dentists will serve a community with a pediatric dentist, yet so many are ill prepared to treat a child (let alone diagnose and treatment plan). It is not reasonable to expect a third year dental student that takes an hour to perform a class II cavity preparation (not counting anesthesia, restoration, or checks from their attending doctor) to successfully or appropriately treat a pediatric patient. At least one of the REDACTED programs sends dental students to visit a pediatric residency. There, students can observe a pediatric resident who is working on a sedated patient and get the kind of instruction that cannot be reasonably performed over a conscious child.

I imagine that dental schools may object, seeking to retain autonomy. Survey senior dental students and learn what their graduation requirements actually are. You will find these frequently include a quantity. In my program (at that time) our operative dentistry grade was a combination of a qualitative exam and, predominantly, quantitative ranges. You could demonstrate quality treatment, but “A, B, or C” grades were determined by a specified quantitative range. Ability to reach these quantities reflected effort, but was greatly effected by involuntary variables like getting clinic times reserved when your patient could show, and if your patient showed. I believe that greater quantities are beneficial. Ask students if they had the resources to meet their requirements. Survey graduates one year into practice and learn what they felt prepared and unprepared for.

Many schools have demographic limitations. Institutions seem to accept that if their students cannot get adequate experience in a particular discipline, then lower standards will be set accordingly. Sometimes students are competing with residencies and faculty practice for a finite number of patients that call the school. The solution is to send students to other facilities. I’ve seen a fantastic variety of these solutions, but they are not universally applied. At my school, students were excited to fulfill a denture unit in a single day by visiting the VA. It wasn’t merely a short cut, but a better look at how to treat patients in the real world. We had two week-long extramural rotations, and the amount of operative dental procedures performed there far exceeded what could be done during the same time spent at school. Address endo/ext imbalances with grants so patients don’t elect extraction for solely financial reasons? Limit these to anterior teeth that would not require a build up and crown, if that cannot be afforded. To meet my final endo requirement, I paid for the patient’s treatment.

Revise the curriculum. It is deeply flawed. Dental educators may accept that there simply is not enough time to teach clinical principles and procedures. However, there was time to spend on subjects completely forgotten. My school, like most, taught a semester of Histology yet no more than five hours of Ethics. Ask yourself which is applied more frequently. The practicing general dentist need not differentiate slides of purple circles, but certainly will face ethical dilemmas. Should they refer that procedure, even if the corporation that employs them pressures them to keep things “in house”? Will lowered reimbursements affect what billing codes are used? Teach a week of histology, and if that sparks an interest in pursuing a pathology residency, give the full course then. Imagine how much more effective it will be than hoping the pathology resident recalls the course given three years earlier. IREDACTED and I was deeply embarrassed by what passed for our ethics course. It certainly would not meet what is described in section 2-21.
## Standard 1 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 1 - Institutional Effectiveness.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

<table>
<thead>
<tr>
<th>Dentist – Standard 1 Comments</th>
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<tbody>
<tr>
<td>All the parameters stated are important to develop a well rounded student.</td>
</tr>
<tr>
<td>REDACTED Discussion has been abundant to perhaps include a 5th year or mandatory year of residency as a national standard REDACTED a 3 year curriculum is adequate instruction for Board and licensure. REDACTED didactic and clinical training of Dental providers should reflect this standardization. If increasing the time of any student in training is considered all institutions should adhere to the same didactic and clinical courses and hours required.</td>
</tr>
<tr>
<td>Dental school education needs to include how to be a leader and how to run a business. Too much time and energy is placed on clinical procedures that are never done in the real world. Also students need to be assessed more rigorously. Schools are putting profit over quality and graduating too many students every year, many of whom don't have the hand skills to practice. But because the school wants the tuition they are allowed to graduate.</td>
</tr>
<tr>
<td>Dental schools remain &quot;behind the times&quot; despite everyone's efforts. It's a simple fact. How do we change that? It's complicated, but it can be done.</td>
</tr>
<tr>
<td>Diversity is always a goal but it can't be achieved if the supply of qualified students and faculty do not currently exist. These are outside the control of the institution.</td>
</tr>
<tr>
<td>Have always thought that institutions were too lenient on students who underperformed or cheated on exams. As soon to be, health care professionals, they should be held to a higher level of ethics and behavior. Code of ethics should be set high and consequences well established and upheld like the recent West Point case where several cadets were expelled for cheating on a calculus exam. If our military expects future officers to be held to a higher standard, I don't see why our dental institutions don't do the same.</td>
</tr>
<tr>
<td>I believe all of the above questions are relevant and need to be sufficiently demanding.</td>
</tr>
<tr>
<td>I don't necessarily see how Diversity is relevant under Institutional Effectiveness.</td>
</tr>
<tr>
<td>I feel that we should base the diversity of the school, wether it is faculty, students, or staff, based on natural selection as opposed to a quota type system. We shouldn't care if a school is based on a balance of sexes, races, religions, etc., as we are all equally important. We should value a school based on the academic excellence of the individuals and not be forced to take a certain &quot;type&quot; of person to fit the diversity mix if they aren't adequately qualified.</td>
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</table>
Dentist – Standard 1 Comments

If a dental school is to be effective at educating the future providers of oral medicine, it must establish from the onset what is expected of students, teachers and researchers. It is difficult for the parties involved to reach an appropriate endpoint if that endpoint is not specified for all to understand.

Institutions should strive to develop and maintain a culturally diverse faculty, trainee, and patient population.

Record high cost of tuition should eliminate the need for corporate sponsorship of dental schools.

Striving to achieve goals of diversity among faculty, students, and staff is admirable and must me attempted. However, the ability to reach “appropriate levels” of diversity (whatever that is or how it’s defined) may prove problematic.

The institution should graduate students who stand out not only with educational excellence, but with compassion in providing care.

The quest for diversity takes away from students achieving acceptance based upon their academic merit. Example a male Caucasian student of high academic achievement is not chosen because of their race/ethnicity, and replaced by a minority (female, AA, Asian/Pacific Islander, Native American, gender, sexual persuasion etc....") despite having a superior academic record.

The statement is very generic in this standard.

There is no true demand to reflect the percentage of population in regards to race and regions of origin of students in dental school

There should be continuous improvement with diversity and inclusion throughout the school

While the dental school program is effective in delivering quality education to the students, there is a sense that these students are not treated professionally even at this graduate level. Students’ voices are often ignored.
Dean – Standard 1 Comments

#2/#4.b should better direct "broad-based" and "systematic". Also, in 4b, it is retain, not retrain?

4b. says attract and retrain?? Do you mean retain???

I think for some of these, particularly the standards related to diversity, that there needs to be more guidance to the institutions.

It is very unfortunate that 1.9 does not mention 'research-focused' or 'research intensive.' The dental profession and the people we serve have lost as the vision of Gies and others has been diluted almost to extinction by the rise of for-profit, pseudo-university-affiliated dental schools.

The definition is local and under scrutiny by the parent academic university. The problem lies with inexperienced site visit consultants that are not calibrated such that their personal bias impacts their judgement.

Site Visitor – Standard 1 Comments

All are needed

Demand in the diversity may cause in enrolling underqualified candidates to the program to ensure the fulfillment. It can be highly recommended however not mandated in my opinion.

Diversity should be reflective of the community composition of the state or area of the institution. It is unfair to the state or regional community to impose standards that are reflective of the populace constituency.

Evidence of ONGOING assessment is critically important to meeting this standard

For #3 - the intent is quite appropriate and necessary but the concern is how to weed out or how the Commission determines which complaints are valid and which are not based in fact? For item #4b - retrain or retain?

Humanistic culture should exist everywhere. So unfortunate that we need to include it as a point of evaluation but I understand. We must assure that it is so.

I have observed on too many recent site visits that this standard is evaluated more on personal bias of the site visitors rather than the picture from the self-study or on-site evaluation. Site visitors have lost site of the fact that school resources vary and only look at this from their own institution. Weak, novice, site visit team chairs let their site visitors run amuck and don’t keep them on track and unbiased. The site visit process has become too prescriptive.
Site Visitor – Standard 1 Comments

It appears that many site visitors overstep the intent and try and prescribe. This has really been an issue in the last few site visits and that needs to be addressed.

Question 4a on diversity is not easy to interpret as stated. It is very difficult to say what is "appropriate" and especially to "achieve" particular numbers of various categories for students, staff, and faculty without adopting a quota system or scholarships that do not exist (which may not be the intent of the statement, but hard to see it otherwise). What is appropriate and by what measure? We can look at the demographics (staff, for example) of people with at least some post-HS education in our area from a census report but it does not mean we can get the same "appropriate" representation who want to work in the dental school. We can expand the definition of diversity beyond URM but it is not clear if that is acceptable to have people from different cultures but who still identify as "white" as included in our diversity measures. It is also difficult to have "our own policies and procedures" when the university drives the policies for faculty recruitment, etc. An expectation instead to have a school create a welcoming and inclusive environment for anyone who wants to work here would be more achievable and get away from "levels" of diversity, which still imply numbers. Although we met this Standard at our last site visit, I assume you are looking at frequency with which this Standard is cited for a recommendation or a suggestion.

Regarding the dental school being associated with a university . . . some schools would be stronger without this affiliation.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

National Org – Standard 1 Comments

No comments

State Org – Standard 1 Comments

Please take seriously what I wrote regarding diversity and curriculum development. If I could make an impact on our profession it would be to improve our diversity and education. I spent time considering these and made constructive suggestions. I can only imagine that implementation is easier said than done. I am happy to help, and for that matter will identify myself. [Name redacted]
Standard 2 – Educational Program

Questions 10-16 (ST2-1 to 2-7)

Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

Dentist, Questions 10-16 (ST2-1 to 2-7)

"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."-insufficient. I would like to see a statement that shows schools are willing to address the cause of a student's failure to meet criteria prior to evaluating and making a decision about the students. Every dental student was accepted into the school by that school's admissions and every student paid tuition. The school should be required to make an attempt to help failing students prior to making any decisions about the student's status at that school.

11. I see no need to handle incompetency in a student with kid gloves. If a student hasn't got what it takes, then he/she should be dropped from the school. IE, everyone should be treated equally.

12. Students need more clinical time to develop their clinical skills. A Mandatory 1-2 year GDR would greatly help students to move into practice with confidence in their abilities. In a 1-2 year internship/residency there should be a heavy focus on ethics, integrity and dental disease eradication. Disease first crowns and implants later.

13. I think some programs provide students with more experience than others. Some students struggle to complete procedures, whereas other students receive much better practice just based on their patient pool. If students would just rotate around various clinics (prosthodontic, endodontic, restorative, denture, oral surgery, etc) every couple of months instead of getting procedures as a piece meal, they would gain much more experience and confidence prior to graduation.

15. The practice of dentistry is very diverse in approaches, techniques, and outcomes. It cannot be a "cookbook" with "calibration" of faculty. Actually, not enough training in decision making and judgement skills with measurable student outcomes is provided, even though there are precedents of these skills in other disciplines.

15. Often off site programs may have less than ideal working conditions and patient populations that are unfamiliar to dental students.

3 year program can be effective

Clinical assessment of the students competency, whether in simulation labs or during patient care is very subjective and solely depends on the instructors opinion. A subjective evaluation does not
**Dentist, Questions 10-16 (ST2-1 to 2-7)**

indicate competency or its lack of if the criteria for evaluation has not been strictly set by a monitoring organization, thus, an incompetent student may graduate while a more competent student whose fate is locked to a certain evaluator may have difficulty surviving the process.

education shouldn’t be restricted to 4 years, if the institution can get it done in 3 or 3.5 years, great.

Four years of schooling is not sufficient to teach the necessary skills and medical knowledge to perform as a competent dentist. Most students graduate and have an informal associateship with the practicing doctor they are working with. It should be required that all dental graduates have at least 1 year of a residency program. They are simply not competent to perform solo out of dental school currently.

Graduates are leaving dental schools without the sort of requirements of their peers from years earlier.

I believe the program should be one year longer. I also believe there should be a prerequisite that applying students should dental assist. The extra year should be on finance and how to succeed in business and running a dental office.

I don’t see the relevance of requiring 4 years of instruction. Some students need 3 years some will require 5 or more. I find that work expands to fill the time - if you require 5 years of education, you will find that many students will not achieve any greater proficiency than if they were in school for 4 years. They’ll just waste the extra time. To illustrate my point - REDACTED. My point here is that graduation should be based on competency, not number of years spent in school.

I think there should be greater understanding of biological principles as well as psychology of dealing with diverse populations/mental states.

It is difficult to calibrate faculty as we all have differing opinions on treatment planning.

Most institutions’ due process for students failing is too lenient.

Question 12: the length of a program should not necessarily be dictated by number of years alone. Quality of the educational experience should dictate the length of a program.

Students not meeting the didactic, behavioral and/or clinical criteria as published and distributed, must evaluate a. the student b. the instructor, and c. the curriculum.

students should learn more dental technology, such as how to fix a broken denture and not just send it to a lab

Too many kids graduate and they’re bad dentists! They have bad judgement and bad hand skills and they should not be allowed to graduate or at a minimum be required to do a residency.
Dean, Questions 10-16 (ST 2-1 to 2-7)

#15. May restrict advancement of students as they move beyond school to rotations in the community. While students should not be confused, growth of concepts could be excluded by this statement.

15 - sites may be valuable in bringing different instruction and assessment options to students and round out their learning so this is not relevant.

15. This is too demanding as stated because the calibration of multiple faculty in multiple sites can never be fully assured and there is no way to easily demonstrate that objectively. I believe programs make every effort to provide for this "must" statement but for programs with multiple sites and faculty the ability to meet this Standard as written is nearly impossible. There needs to be some reassessment of this from a practical standpoint. 16. This is a challenge as stated in programs where the Biomedical Sciences courses are provided by another College within the university with faculty independent of the dental school. There is often minimal potential to ensure that the level of integration, depth, scope, and timeliness as required by this "must" statement is well documented and achieved.

2-3 CODA Standards are based on student competency. The program length become irrelevant if the outcome is competence. Program length is an old standard when CODA focused on clock hours and curriculum standards. CODA has moved to evaluating the program outcomes and therefore Standard 2-3 is irrelevant. The length of the program has no influence on program outcomes or competence.

315. The demand for students to enhance their clinical skills by expanding the use of offsite clinics is increasing, and sometimes cross state lines, thus it is difficult sometimes to calibrate clinicians in all these community clinics

A program will and should constantly strive for faculty calibration. The problem lies in that CODA site visit consultants are not calibrated and lack full understanding of how to interpret efforts. This is a constant struggle as applies to clinical instruction.

In my experience there have been issues with the accreditation site visitors making their own decisions about what constitutes appropriate experience for the institution's stated outcomes.

Not sure why a time statement is necessary if a School is able to educate competent dentists in a shorter period of time.

Site Visitor, Questions 10-16 (ST 2-1 to 2-7)

10. Curriculum site visitors have become too focused on peripheral information not prescribed in the standard. This is also a standard where site visitor bias is highly reflected. Some site visitors are so ingrained with how they do it that they become more concerned about typos than content. This standard only states certain things, all other info that may be in a syllabus as well as whether or not there is a standard syllabus format is irrelevant. Again the weak, novice team chairs along with staff continue to let site visitor bias affect the outcome. 13. This has become a standard that is over
Site Visitor, Questions 10-16 (ST 2-1 to 2-7)

interpreted and overwhelmed by the site visitor's internal bias, even if not stated. This standard no longer evaluates clinical excellence but rather whether some psychobabble statistical presentation can "wow" the site visitor.

10: Giving the students a syllabus with the info noted is not demanding.

12. Program completion should be competency based not time line based. 15. With more programs using offsite clinical experiences, more than faculty calibration is needed to insure comparable education.

15. It is hardly practical for an institution to achieve calibration of all remote faculty, especially at sites that are not owned by institution. Enforcement of the ALL SITES requirement could lead to a reduction in the number of extramural opportunities for students. In other words, students will have calibrated faculty wherever they go but may miss valuable opportunities that were cancelled.

16- there are so many descriptors it is hard to adequately address all of them.

16. it seems that a site visitor can determine what is "sufficient depth, scope, timeliness, quality". I think the deliverable is if students are passing the Integrated Boards.

16: Since this standard is evaluated by high level scientists, who may not have a clinical background, they do not always know what REDACTED information is needed to achieve the curriculum's competencies. So how do you define this depth? It comes down to the opinion of the site visitor, instead of having a national benchmark. This results in some schools teaching information that is irrelevant to competency in dentistry in order to show "depth". The problem is not inherent in the writing of the standard: it is an issue of the site visitors who perhaps need guidance.

COVID has made calibration severely challenging over the past year.

Domains of dentistry and foundational knowledge are not sufficiently rigorous and will never be able to be rigorous unless the years in dental school increase or the extent of science training needed for admission are increased.

Question 15 re calibration of faculty. What is meant by "comparable"? For example, when our students are off-site, each step of a procedure is checked less frequently as students are in the last year of the program. Also, supervisors at these sites are given the very detailed rubrics used in the home site predoctoral program, but they cannot use the same forms for various reasons so they have an adapted form.

This is a standard of accreditation, this information must be present regardless if it is too demanding.
National Org, Questions 10-16 (ST 2-1 to 2-7)

No comments

State Org, Questions 10-16 (ST 2-1 to 2-7)

No comments
Question 17 (ST2-8)

(Optional) Please specify the element(s) of Question 17 that was Too Demanding, Not Demanding, or Not Relevant, and describe the reason for the rating. Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

**Dentist, Question 17 (ST2-8)**

I "learned" a lot of material that has no relevance to dentistry today. For example, spent way too much time learning amalgam fillings when 95% of the population requests composite.

The input from students has lead to a wash out of topics that they do not want to learn because they are too complicated. I have seen this in their pharmacology education and basic science education. They suffer understanding anatomy and basic physiology. This standard does not help define what needs to be covered to make a competent dental clinician.

The requirement may require input from students/staff but fails to ensure proper response that may help alleviate the issue by the administration.

**Dean, Question 17 (ST2-8)**

There are robust plans but interpretation is the problem. The school defines their own robust plan but others perceive frequency or other details are not following their college.
Site Visitor, Question 17 (ST2-8)

Again defining what is ongoing is often taken to the extreme. Ongoing is defined as still in progress. When the site visitors define that annually isn't sufficient, etc. that is prescriptive. This has gotten to be more prescriptive based on the site visitor's decision.

COVID has made calibration severely challenging over the past year.

e. incorporation of emerging didactic and clinical technologies to support the dental education program curriculum. - This is tricky. Bleeding edge versus cutting edge. And the fiscal responsibility associated with it. A lot of clinical and didactic technologies seem to be a flash in the pan (MOOG simulators?). Additionally, when is the line of needing to only teach a new technology verses having to teach the old technique as well as the new - and where does that curricular time come from? We have seen this with digital radiographs - currently, does anyone still teach wet films? We are watching it with rotary endo. We are still teaching hand instruments and rotary but that may not be much long. But the current one is digital impressions. Some may think this means we have to mill on site and some may think this is scan and send. With the initial cost of entry so high, it is difficult to say you MUST incorporate EMERGING tech. This used to say you must evaluate, I believe.

Over the years this standard has been affected too much by site visitor bias or how their respective institution does something. This standard again has become more focused on psychomagic presentations than actual outcomes of the program being visited. Site visitors have lost site of the the great diversity of curricula among the numerous dental schools. The commission as well as site visitors are applying the "one shoe fits all" rather than respecting the diversity of institutional curricula which is based on everything from finances, to ability to recruit faculty, to patient availability, etc.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

This requires a lot of repetition and many words. Check off boxes with evidence that we do this would be awesome!

National Org, Question 17 (ST2-8)

No comments

State Org, Question 17 (ST2-8)

No comments
Questions 18-24 (ST2-8 to 2-15)

Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

**Dentist, Questions 18-24 (ST2-8 to 2-15)**

#18. It has been my experience that there are never enough patients at the dental schools to complete a significant volume of diverse procedures.

#18: It is unrealistic to expect the dental school to "provide" patients that have issues demonstrating ALL the problems the student must be prepared to solve after graduation. The school must provide adequate instruction to arm the student with enough knowledge and confidence to tackle issues he/she may not have seen in patient contact experiences while at school.

18. I don't think all student receive adequate patient experiences because of the way in which patients are assigned. They should rotate around various clinics for extended periods of time to follow cases to completion and better understand the processes. 19. More problem solving "thinking outside the box" solutions that apply in real world situations would be helpful. Not all patients can afford a treatment plan, or they simply don't want to proceed with treatment, so we need to help them with alternative options that aren't necessarily textbook, but they can still work.

18. The number of procedures a student has to complete to graduate now is laughable compared to what was asked from students decades ago. For example, I had to do 7 crowns to fulfill graduation requirements and my father had to do 40 in 1989. As a result, I have observed newly graduated students face very steep learning curves once they start working, and I suspect this was not the case before. This problem is tied directly to the amount of students a dental school graduates every year versus the amount of patients that it serves. Assuming the overall size of a dental school remains the same, it is easier to add more spaces for didactic and preclinical learning than it is to add space for clinical activities. As a result, over the years students have had less and less opportunities to practice their clinical skills on patients, because there are not enough patients, and therefore procedures, to go around.

20. This statement is a little unclear without reading the intent. Is it expected that the school develop self-assessment competencies? If so, I think this is too demanding. If you disagree, at least provide guidance on whether it should be diagnostic, formative, interim or summative.

21. Most of biomedical knowledge was gained in undergrad courses and are needlessly repeated in dental school.

More pathology
Dentist, Questions 18-24 (ST2-8 to 2-15)

students are not good at self reflection and just want to pass and so hope they can sway faculty to pass them. they also all expect to pass and so when they get things wrong rather than looking at what they did not know they argue for extra points. they cannot see the clinical end goal, and frequently lack the ability to apply to clinic. I find didactic courses and student mentality here in the US with mostly multiple choice examinations and lack of drive and provision for them to apply their knowledge is limited as to my experiences with teaching elsewhere. this also stems to the litigious society that is the US, and the lack of time and resources in some schools to provide a more stimulating education path.

There is definitely an over emphasis on understanding diseases in certain dental schools.

These standards to not sufficiently define the minimal acceptable level of what must be learned. This leave it open to interpretation and manipulation to constantly water down the information provided to students.

Dean, Questions 18-24 (ST2-8 to 2-15)

The critical thinking standard has been problematic. The Commission needs to provide clearer guidance on what constitutes compliance with this standard. Also, I think there is redundancy and lack of clarity in biomedical science standards. The Commission should take another look at them.

The standard related to self-assessment is important and clearly can be demonstrated. The caveat of "Lifelong learning" is considered a value that can be interpreted in many manners which is challenging to consultants. The term is a vestige of previous leaders who pushed to add their fingerprint onto expanding number of standards.

Site Visitor, Questions 18-24 (ST2-8 to 2-15)

19. You have created a must statement that you expect to be quantitated when there is not any current methodology to truly evaluate this. From a "must" statement standpoint, this is pure pie in the sky and again creates a sticky point for evaluation by a site visitor. It is must statements like this that lend themselves to site visitor bias, expressed or not. Again you ask for quantitative evidence for something that is qualitative.

20. is both too demanding and leaves too much to interpretation.
Site Visitor, Questions 18-24 (ST2-8 to 2-15)

2-20 the portion of the standard that reads "demonstration of professional values and capacities associated with self-directed, lifelong learning." The must statements help with this, but the demonstration of life-long learning is always problematic.

24. How assessed.

I believe everything that comes after the comma (i.e, including the development of professional competencies and the demonstration of professional values and capacities associated with self-directed, lifelong learning) is too prescriptive, vague, and difficult to demonstrate evidence for compliance. I would suggest the "must" statement focus on critical thinking, broadly speaking.

More clarity in terms of patient experience expectations would enhance this standard.

Not enough is done to promote critical thinking during dental school. This standard must be made more stringent.

Q24 With the single Integrated National Board Examination, dental schools must be more explicit in assessing the depth, breadth and application of how graduates are in deed competent in biomedical sciences particularly for the most common biomedical conditions a general practitioner will encounter in practice.

Requiring schools to provide a patient experience in implant restoration is demanding. Many schools are in low income areas and patients cannot afford this treatment.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

National Org, Questions 18-24 (ST2-8 to 2-15)

No comments
### State Org, Questions 18-24 (ST2-8 to 2-15)

18. I recommend CODA ask students if the institution is meeting this requirement. Answers may be illuminating. CODA seems to be asking the school to self-assess, but some may be shy to reveal challenges. 19. I have sat through a few CE lectures given by an endodontist specifically about research methodology. The audience of general dentists fails to identify that meta-analysis is stronger than randomized controlled studies, or how to look up studies. This is a cross-section of general dentists that graduated long ago and recently, and from a variety of schools. I doubt that this is taught adequately. 21. I want to completely agree, but "in-depth" can be so broad as to include an inordinate amount of time on less relevant topics at the expense of a practical dental education. Perhaps CODA can be more specific.

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All dental schools need to incorporate medical education in the first 2 years. Oral health is integrated into total health.
Questions 25-32 (ST2-16 to 2-23)

Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

**Dentist, Questions 25-32 (ST2-16 to 2-23)**

26: Students should be exposed, as much as pragmatically reasonable, to a diverse patient population, but clearly cannot be expected to "have the interpersonal and communications skills to function successfully..." with all the non-English speaking patients found in our country after four years in dental school (unless half the time spent during the four years is devoted to learning basic Spanish, Mandarin, Farsi, etc.). #32: Students should have an awareness of basic principles involved in treating all ages of patients, but "must be competent in providing oral health care within the scope of general dentistry to patients in all stages of life" implies that a graduate must be able to assume (for example) the care of the dental needs of 5 month old infants after graduating.

25/26. There can never be enough social and multicultural education. This sometimes takes years to develop 27/28/29. Students must be aware of the myriad of state and federal regulations that they will have to abide. 30 Having an practice that is both ethical and profitable is sometimes a difficult thing to do. More emphasis on the disease and less on the most profitable procedures would go a long way to treating dental disease.

25: I believe competency in application of behavioral sciences can only be achieved after experience in actual dental practice, four years of lab/clinical education cannot provide that level of competency.

26. This is not the students responsibility, an institutions responsibility, or part of CODAS governance. Students are responsible to treat all patients ethically regardless of heritage, race, or religion. 30. This is not a sufficient statement for ethics. There needs to be a more specific definition for ethical educational requirements. The standard of practice for each area (specialty) of dentistry needs to be incorporated into the category of ethics.

26. To ask that graduates have the communication skills to function in a multicultural environment is excessive. A primary form of communication is verbal. The statement asks that graduates be competent in verbal communication to function in a multicultural work environment. I do not believe that is the intention, but that is what this statement says. That could easily mean the graduate should speak Spanish, for example. Although it is wonderful to be multi-lingual, including it as a standard is irrational for many reasons. I think the word "communication" should be removed or clarified as verbal, nonverbal, and/or visual. Also, we have deaf students.

27. We have too many regulations placed upon us. There is no way we can remember everything. 32. Programs could be more helpful with treatment ideas and alternative options for the elderly population.
Dentist, Questions 25-32 (ST2-16 to 2-23)

28. Much has been said about the need to teach business in dental school. While that may be true, the dental student and the institutional program should not be burdened by competent leadership of a health care organization, this is better in MPH and MBA programs. The dentist needs to be competent in leading a team toward the best patient outcome.

32. I would encourage wording about "realizing when they are beyond their scope and making decisions to refer as necessary"

Gradautes need more exposure to the business side of dentistry, more exposure on how to manage patients chairside, not to just "refer" out patients to specialists

Gradautes should be aware of where their weaknesses are within the scope of general dentistry.

I believe that it is important to focus on all phases of life since our people are Living longer.

I often found I could not understand clinicians treating me. Once a family member put a complaint that they could not understand the clinician to a board that was headed by someone you could not understand!

more education is needed for pediatric and geriatric dentistry

Not enough courses on practice management and financial aspects of dentistry.

students are not exposed to how a practice runs, laws, coding issues and how to code correctly, intricacies of what is required of us from the insurance companies.

Students don’t learn enough about diverse patient populations or how to be a leader.

This applied to competency in practice management and leadership. Practice management is a part of the puzzle but it's difficult to achieve competency and adequate leadership depending on the person. REDACTED You learn to be an administrator on the job.

This leaves the ethics portion too open to interpretation. There is a great focus on production and money making procedures than what is good for the patient's health.
Dean, Questions 25-32 (ST2-16 to 2-23)

#32 states in "providing oral health care" and in my opinion would be better stated as "managing oral health care"... depending on a definition of "stages of life" there are some stages that of life that all students will not have the ability to treat and provide care during their dental school tenure.

28. The phrase that make this must statement difficult is "applying the basic principles and philosophies of practice management". It is very difficult in the existing clinical spaces in most programs to determine competency in practice management as there is often very little in the clinical context of a dental program that allows someone to operate as if they were in an independent practice setting. The application expectation is what makes this "must" statement difficult.

A standard that dictates "must be competent" and contains the conjunction "and". When this is present, the dental institution must address each component of the standards which in essence expands the number of standards that continue to grow based on modifications and legacy terms.

To me # 25 appears too broad and open for interpretation. There are MSc degrees and full course of other studies that deal with these concepts.

Site Visitor, Questions 25-32 (ST2-16 to 2-23)

#28 Requiring programs to demonstrate compliance that graduates are leader of the health care team is too demanding. Leadership is a skill which requires time and experience to develop. Most dental students are in a clinical setting for 2 years at most, having to focus on learning an increasing variety of clinical skills, so expecting that they graduate as competent leaders is too demanding. #31 This standard is very complex, as it in reality it includes a variety of competencies (access, critically appraise, apply, communicate, scientific and lay literature). It should be simplified to reduce the burden on programs to assess for competency in a multitude of tasks.

20." how to function successfully as the leader of the oral health care team" seems to require the presence of dental assistants and hygienists which may not be the case for many schools. My opinion is that a dental student may not be a leader until they have real life experiences. Many need more direction. Faculty development programs are charging lots of fees to train for leadership but do we truly expect all new graduates to display these behaviors?

25.27.28.29.30. While these currently are not "too demanding" these again are 'soft' standards where too many site visitors are looking for some quantitation. Competent is also a term to easily interpreted with site visitor bias. Without meaning to do so, these may become too prescriptive while they are all dependent on both internal and external factors of the respective dental institution.

28: Students are not able to show clinical competency in different models of healthcare delivery, since they engage in so few. I wonder if this component should be pulled out and stated differently? (eg they must be aware of, and know how to engage in).
### Site Visitor, Questions 25-32 (ST2-16 to 2-23)

Competence in managing a diverse population is a nebulous requirement. To show competence in models of healthcare delivery is an odd requirement and this seems better suited as a requirement for exposure and not competence.

Competency in oral healthcare delivery models is an exercise in didactic exposure.

For question 28, regarding successful functioning as the leader of the health care team: not everyone will be a leader but can still be a successful and competent general dentist.

**How assess these standards?**

Legal issues are different in each state. Thus to complex to know it all.

More can be done to modeling ethical practice in the dental curriculum.

Question 26 about diverse populations and a multi-cultural work environment. This seems to address two different things (managing patients and working in a multi-cultural environment, which could include patients but also includes staff and others) and therefore different measures are needed to assess to a level of competence as written...is the intent about diverse patients or about communication? Is there a difference between diverse and multi-cultural, since both terms are used?

Question 28 re practice management. This is one of the most difficult standards to interpret - the sentence itself does not read clearly if you remove any one of the items and try to figure it out from the stem. There are 3 different areas to assess, all related to practice management, but what does being competent in "models of oral health care delivery" mean? For question 32 on all stages of life - this seems to be what general dentistry is and seems to be covered across all Standards. How do you measure this? Numbers? If students meet all other competencies, wouldn't this be covered? If not, perhaps define what is expected for "all stages of life."

This is a standard of accreditation, this information must be present regardless if it is too demanding.

too vague not sure what every stage of life is and what competencies apply. All schools struggle with this.

### National Org, Questions 25-32 (ST2-16 to 2-23)

No comments
25. This sounds great, but I certainly was not instructed how to tailor a motivational case presentation or hygiene instructions to different personalities until after graduation. Perhaps be more specific. 28. What passed for leadership and practice management during my education would not satisfy this description. I wish CODA could expand the goals so that accreditation could better assess if these educational goals were met. 30. During my education, my school's interpretation of this was to present the ethical principles of veracity, justice, beneficence, and nonmaleficence. Students were asked which was their favorite and why. There was no further critical discussion of these answers. That was it. No nuance or complexity was further explored. I imagine my school would attest that we were competent. CODA could better assure competency by expanding this description.

A few business and practice management and law courses are necessary for success in private practice.

Effective communication for multi cultural ethnicities important, but students should not be expected to speak multiple languages. Regulatory and compliance issues, legal process and management of the team as a leader are way beyond basics for most students.
Questions 33-35 (ST2-24 to 2-26)

Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dentist, Questions 33-35 (ST2-24 to 2-26)

#33: The three items indicated are way too broad as areas that graduates should be expected to have "competence" as far as rendering care on their own. #34: The same applies to this area of expected competence. WAY too broad a requirement.

33(b). Too many times I've heard patients tell me that they have "never had that done before" and personally at my initial exam, my dentist did not do a CA screen or Head and Neck exam 33(d). Setting up a caries control program is a hard sell unless "will insurance pay for that?" But that is ground zero for the practice of dentistry 35. This should be done by all students.

34 ELECTIVE MIGHT NEED TO BE SPECIALISTS

34. out of the required realm of pre-doctoral education

A lot of this the students just aren't going to be as proficient until they have experience. It's going to be difficult to improve on this unless you lengthen the program times.

e,f,k,m,n,o Just being competent is not good enough when dealing with a variety of patients and patient personalities.

Externships in different clinics were always a waste of time. They didn’t go to our requirements and there was only a limited amount of time to get them done. With residency programs located in dental schools dental students have a hard time getting any cases beyond the basics. No Tmj cases ever.

I believe another year to learn how to care for patients spent in a dental office for a year will help treatment planning and also running a business would Be great or other options beside private practice

k. Orofacial Pain should be specifically noted in addition to temporomandibular disorder

My personal training in special needs patient was minimal, I believe more emphasis on special-needs training within the schools is needed.
### Dentist, Questions 33-35 (ST2-24 to 2-26)

**Question 34** - Treatment of patients with special needs is a highly specialized skill. It is not clear in your statement whether the requirement is to able to actually perform procedures on this patient population. I think the opportunity to treat these patients should be made available to students, but it should not be a requirement. Making it a requirement will lead to stress in students and less than optimal patient care.

*Some syndromic patients require high training level*

students should be allowed to do posterior endodontics within reason rather than just end doing it all. I also think they need to do more interceptive orthodontics or at least attend clinics to assess children and know when the refer.

*Those areas listed as not demanding are simply too vague.*

*Those areas noted may be best referred to Specialists when encountered in the General Dental Clinic.*

*Treatment of patients with special needs may require additional training compared to what is attainable in dental school. Awareness of this and training is helpful, but they may not be competent for all special needs patients.*

*Unsure about what is being done today regarding special needs patients. I know 30 years ago we didn't get much of it.*
Dean, Questions 33-35 (ST2-24 to 2-26)

#20 "Capacity" is a bit confusing #33 h - Does not track the same at "f, i & j. Tooth replacement does not specify PRDP or PRCP, so it is unclear why "h" specifies fixed bridge AND implant replacement. Should this just read "tooth replacement or prosthodontics"?

33 a-o - This section is irrelevant and should be one statement related to competency in diagnosis, prevention, and treatment.

34. Competent in providing limited care 35 Require at least minimal Community-Based experience

34. Managing yes, treating no. Special needs patients often need referral.

Current dental institutions serve a large percentage of populations that are uninsured, underinsured, lack access to care. Many patients who can benefit from exquisite prosthodontic care can least afford. Interpretation of care should be allowed for schools on how best to teach and demonstrate evidence of competence and not limited to whether or not a specific number of procedures are performed on a patient.

In K, language should change to evaluation and managing oral mucosal, tempromandibular and osseous disorders. There are not enough cases that are part of a dental school patient base to provide adequate experiences for students.

In Q33, agree with the parent statement but a. - o. are unnecessary specificity.

It's time to break out tempromandibular disorders and make it its own category with orofacial pain.

question 34 -- Too demanding -- pre-doctoral students are not capable of fulfilling this requirement. The profession needs to state that to treat such patients, you need advanced training.
33 h. Please replace "and" with "or."

33f. Restoration of teeth (fillings, inlays, onlays, and crowns) 33h. Replacement of teeth (this is too prescriptive given the variability of different programs patient populations). Consider phrasing (fixed bridges, removable prostheses, and/or implant supported prostheses)

33H. Dental Implant Prosthodontic solutions as a must statement is difficult for most schools to provide adequate experiences to obtain and demonstrate competency. Additionally, the statement is too broad - does it include the surgical placement of the implant or just the restorative portion connected to the implant that has been placed. Is it including competency in assessment of whether an implant can be surgically placed?

33K now includes temporomandibular disorders which is not only multi factorial but should also be treated by a team that includes physical therapy and stress management. I do not think that dental students can manage these patients on their own so who would that be measured.

33l- Soft tissue surgeries are few and far between. Most schools have to "fudge" this. We have to realize what the schools can and can't provide for the students.

34. "assessing and managing the treatment of" gives programs the flexibility to allow students to observe (i.e. "manage") the treatment of special needs patients without actually touching the patient or doing a proper intra-oral assessment. It needs to be made very clear that in the absence of doing a physical exam themselves, the students are not meeting the competency.

34. Graduates must be competent in assessing and managing the treatment of patients with special needs. - measuring the management of treatment of patients with special needs seems to be a high bar.

Assuring that all students are competent in managing patients with special needs is very difficult and almost impossible if trying to do it in a clinical setting where all students get the same types of experience.

How assess and assure competence?

I believe that many of the site visitors are too prescriptive when it comes to these. I am not sure how to ensure the site visitors stick to the intent of the standard.

If we're serious about graduating clinicians who serve underserved communities....I think the standard around patients with special needs should be a little more demanding in requiring actual hands-on care. Similarly, pulpal therapy may allow some to perform emergency direct capping in lieu of endo most students are not competent in soft and hard tissue surgery. This standard needs to be re written
Site Visitor, Questions 33-35 (ST2-24 to 2-26)

Q34 I question if there are sufficient patient care experiences for graduates to document competence in "managing the treatment of patients with special needs." CODA may consider modifying the Standard to read: Graduates must be competent in assessing the treatment of patients with special needs and the dental education program must make available opportunities and encourage students to engage in managing the treatment of patients with special needs.

Question 33 a. There is simply too much in one standard (which is actually a portion of one standard), so assessment of competence is challenging to include all of this. Question 33 c. How is "complexity of treatment" measured or defined? This should already be part of all the other Standards in this section. Question 33 d. Why is caries management added here and separated from other specific disease management processes within this Standard? For example, why wouldn't perio be part of health promotion rather than its own Standard? Consistency would help. Question 33 l. What is expected regarding "soft tissue surgery"? Should it be "soft tissue management", rather than surgery, if we are looking at the level of a general dentist? Question 33 n. Malocclusion and space management. This could be combined in the "complexity of care and referral" part. As entry-level general dentists, the focus should be on assessment and referral. Perhaps add "management" to this item.

The service standard is a very low bar to meet.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

While I understand the inclusion of TMD, this may become a "competency in referring" issue and is likely not best suited for predoc competency.

National Org, Questions 33-35 (ST2-24 to 2-26)

No comments

State Org, Questions 33-35 (ST2-24 to 2-26)

33. As is the theme of my comments, these bullet points are insufficient to describe what a competent graduate can be expected to know or perform. I have no expectation for a school to teach "everything" in four years. Competency must be better defined, or we will continue to graduate students with highly inconsistent "competencies".

Assessment of patients with disabilities important, but management and care for such patients beyond scope of practice for many seasoned dentists, let alone a new grad or student
**Standard 2 Comments**

Optional) Please use the space below to enter any comments you have related to Standard 2 - Educational Program.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

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**Dentist, Standard 2 Comments**

"Must" is a nice word, but how do you measure the outcome. You cannot improve what you do not measure.

All these goals are great goals, but realistically, after being involved in 2 schools, both have had trouble giving ample/adequate clinical experiences. This should be looked at and if CODA is going to require a certain amount, they need to make sure that the schools are doing the right thing and not just passing students for their graduation rate.

Dental science has progressed to a point that advanced treatments require complementary education beyond the scope of 4 years of dental school. Advancements in edodontics, periodontics, and implant dentistry are examples that best left with graduates of residency programs, thus, requiring general dentist to be competent in such broad spectrum of treatment modules will harm patients as the required knowledge or expertise may be lacking.

Everything is great on paper, but in reality students don’t have the same clinical exposure. Some get more PT in clinic, some less, but everyone pays the same tuition. That is not ok. Students who plan to apply to residency programs get more PT’s to have better grades so they can get in the residency. At the end most of them don’t even practice general dentistry. Students have to be very assertive to have all requirements and procedures done.

Graduates need more training in the treatment of special healthcare needs, dental treatment for OSA, and minimally invasive dentistry (to include hard tissue laser).

I've spent the last 20 years treating NOTHING but sleep apnea. Very few schools have even a single hour of education on this topic. Perfect example of being "behind the times"

Schools should be asked how they measure these competencies. Minimal standards should be defined, especially since the pause in practice from COVID-19

Special needs patients may and often require specialized care beyond the scope of a general practice. However diagnosis and referral of such treatment should be considered as part of the training for general dentistry.

Students must be introduced and taught airway as a part of their therapy and how to screen. Implications with Pedo. and ortho.
Dentist, Standard 2 Comments

students should demonstrate competency (skills) on patients, not dentoforms

Students should have the opportunity to learn, not only what is taught in school, but also what is being done in real life dental offices in addition to what is taught in the school. Systems and materials from practicing dentists are often different and often an improvement over what is taught is the school.

The statement "graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school" is a bit of a problem. Leaving the definition of general dentistry to individual schools may be a problem. If a particular school for example, does not believe that implant dentistry is part of "general dentistry", they may de-emphasize that part of the educational experience. I don't profess to have an answer, but there needs to be an agreement on what subject matter and the hours of exposure to the subject matter is appropriate.

There needs to be far more education on how to start a business, run a business and manage a business. A course teaching insurance company relationships and credentialing. General employee protocols. Using and understanding financial statements. Equipment and supplies needed, how to manage overhead. Dental photography course would be great.

These are a lot of competencies; we must be clear as to the minimal competency.

These are all great. Yet somehow, institutions should be held accountable when graduates FAIL to meet the standards. ie. part of assessment should be to include whether or not graduates end up with sanctions by their state dental boards,

Your questions were so basic that I question the importance of the survey

Dean, Standard 2 Comments

"All stages of life" continues to be problematic for evaluation.

question 34 -- Too demanding -- pre-doctoral students are not capable of fulfilling this requirement. The profession needs to state that to treat such patients, you need advanced training.

The standards continue to grow in number, and passively through the use of conjunctions within standards. At times the laundry list of items become a laundry list of "to-do's" mandated by CODA.

Site Visitor, Standard 2 Comments

33. The most important standard of all in terms of producing a good clinician.

33H as long as site visitors recognize that implant replacement is now replacing the 3 unit fixed partial denture and therefore willing to accept simulation as a replacement for the "fixed" replacement, this
can work. It might also be difficult in certain populations to find implant restorations for every student to do this more than once. If "Once" is acceptable as a measure of "competency" than implant restorations might work. In my opinion, simulation should be able to substitute some of these "requirements" but obviously students do need to learn these skills.

e. Anxiety control is very complex and I believe it is too demanding to expect graduates to be fully competent. A lot of programs have struggled with this standard, particularly in relation to implant therapy. Also, often times these exclude one another (ie. an increase in patients wanting implants would lead to a reduction in patients seeking bridges). At the same time, this standard is very broad in that it doesn't make a distinction between RPD and full denture. It is difficult to have students be exposed to TMD and become competent.

If dental education truly embraces competency based progress and promotion, should we not trust our evaluations and offer variable time to degree?

The measurement of outcomes that support compliance are vague. Chairside teaching is avoided to allow students the needed time to provide patient care and have it evaluated. Teaching opportunities are great, but yield is low as the outcome is completion of the therapy. Review of the biomedical and behavioral standards are not easily or readily provided as the clinic floor is regarded more as a revenue center and not as a teaching opportunity. Clinical faculty are not sufficiently comfortable with the biomedical and behavioral curriculum content to reinforce principles. Lack of time is also a major driver of incomplete teaching. Clinical teaching teams consisting of biomedical, behavioral and clinical science faculty are needed to ensure integration at this essential teaching opportunity.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

Unclear on the definition of what hard tissue surgery is within the scope of general dentistry. Maybe it could be a separate question from soft tissue surgery, and also could be defined better.

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**National Org, Standard 2 Comments**

*No comments*
State Org, Standard 2 Comments

An understanding of health equity is important, especially in developing care plans for patients. Might be good to start an understanding of the issues during predoctoral training.

I described many statements as "sufficiently demanding", but feel the competencies could be better defined. I refrained from selecting "not demanding" more often because I do not wish to overwhelm CODA, and because if section 2-24 could be expanded enough it could encompass many of these areas.

Students need clinical skills that are basic to everyday practices. I recently spoke to a student completing their program next month and this student can scan preps and digitally very competent, but has yet to place an amalgam in a patients mouth! I think they need more education on lab processes for fabrication of crowns, partial dentures so they can work with labs more effectively.
Standard 3 – Faculty and Staff

Questions 36-41 (ST3-1 to 3-5)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dentist, Questions 36-41 (ST3-1 to 3-5)

"The dental school must have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty."—The school must make tenure available to full time staff. It is a standard in high education and it is not acceptable that dental schools can hire non tenure track full time doctorate level faculty.

"Those who can't do, teach." All too common for faculty that "couldn't make it" in private sector become teachers. Clinical faculty are usually practicing dentists, always, without fail, my best faculty mentors while in dental school.

38. Our existing faculty development program is not geared toward actual “development” of faculty. Its purpose seems to be more maintenance of the status quo. 39. The current Annual Self Evaluation & Annual Review process at our institution is essentially a joke and certainly not demanding enough. CDE courses taught and attended are listed in these reviews. However, administration has failed to provide ample time to actually attend or participate or to fund attendance at REQUIRED CDE. How do we adequately maintain our clinical and didactic skills without the ability to attend continuing education courses? Creating a cadre of poorly trained instructors will simply continue the accelerating downward trend in the competencies and capabilities of current and future dental students.

faculty review is usually just an informality rather than providing constructive criticism. also students tends to give negative feed back rather than positive also. Also the schools need to provide adequate opportunity for the faculty to develop their careers in terms of not just being on the clinic floor but allowing time and resources and connections to develop research as a junior faculty and provide ample opportunity in the faculty practices to continue to develop and advance their skills to ensure they can be the best they can be when teaching students and residents

Faculty should be properly trained to deliver the highest standard of care so students can learn ideals as their most fundamental core of learning

I do not believe that all faculty members should have a say in how a dental school operates. There are people or groups who make the decisions on how a certain thing runs or is managed and there is a group who follows that lead.
Dentist, Questions 36-41 (ST3-1 to 3-5)

Leaving evaluation of a faculty member to the institution has led to presence of instructors that have suboptimal qualifications as a teaching entity. There should be national standard for faculty selection that takes that authority out of an institution hands and ensures the competency of instructors with an acceptance level.

One of the reasons I went back to dental school immediately after I graduated as a volunteer faculty member was because there were never enough faculty members to go around for such a large class size when I was a student.

question 37 - leaving the university to define "appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution" is a problem. As an illustration - Orofacial pain and TMJ disorders has just been recognized as a specialty. If the school is left to determine the definition of an Orofacial pain specialist, they may choose someone they FEEL is qualified, but they may not in fact have the credentialing. Credentialing should not be solely defined by the school. There should be a requirement that specialized areas need to be staffed by Board Certified/eligible faculty.

some instances of staff that are not competent at all.

Students should be able to also evaluate clinical faculties for their ability to teach and mentor students. I've had some really bad ones, who would just yell at me, not give me feedback or show me how to improve so I can learn. All they said were this is not acceptable and dismissed me to try again. Everyone avoided these faculty members in clinic. That is not acceptable teaching attitude nor is it helpful for students.

There is a lack of faculty development process and stated goals are not clearly communicated to the graduating class. Perhaps that would help with retention of talents who express interests in academia.

Dean, Questions 36-41 (ST3-1 to 3-5)

Colleges need direction on faculty needs for students, student faculty ratio, eg. for colleges to have sufficient defense for upper administration in faculty / staff needs. Many colleges are moving away from the traditional tenure process.

The university mandates similar compliance qualifications under regional accrediting agencies. Herein lies additional means for bias based on misinterpretation from consultants.
Site Visitor, Questions 36-41 (ST3-1 to 3-5)

3-39 Faculty must be ensured a form of governance that allows participation in the school's decision-making processes. How much participation is needed, at what level, and in what circumstances? Is having a faculty senate enough? This standard just seems superfluous.

36. If a program successfully and consistently produces competent clinicians that graduate on time, then who can state what the # of needed faculty has to be. Unless there are significant issues with such things as an excessive number of students that don't graduate on time, failure to graduate, failure to pass regional board, failure to gain licensure, then this statement has no relevance and should not have any quantitation associated with it. Faculty:student ratios are not necessarily indicative. Site visitors only hear complaints about this from faculty who are lazy and don't want to work, or students, by their own slothfulness, get behind. 37. You've made a must statement out of something that the commission and site visitors have no way to truly evaluate. Someone with great experience may be better qualified that some individual that was an "all A" student. Transcripts alone do not necessarily provide a picture of effectiveness of qualification. It should be assumed that qualifications for hire are sufficient as institutions do have standards. Either remove this standard or remove the must. 40. What the institution requires should be sufficient for this standard. Once again site visitor bias enters too heavily into interpretation.

37. Consider "privileging" instead of "credentialing"

38. Faculty development is too vague - this needs to include faculty development in education, scholarship and service as some schools only define it related to the education mission. 39. This statement does not explain that non-administrator faculty be allowed an opportunity to convene in the absence of administrators (also faculty) to discuss issues relevant to non-administrator faculty and then have an opportunity to report these issues to the administrative faculty up the chain of command. 41. Needs to include that there is a stated process for appealing a denial of promotion and/or tenure in an AFRT (academic freedom, responsibility/rights and tenure) style document/SAP/rule.

Compliance must be more than a check-list of the existence of the process, but the process must also achieve the intended goals.

More stringent assessment of faculty credentials, particularly basic sciences, would be desirable to ensure that budgetary considerations do not compromise the quality of instruction (i.e., insufficiently-qualified faculty teaching subjects for which they do not have adequate depth and breadth/training).

Question 37. Perhaps "too vague" is a better answer. Does it mean knowledge and experience in the discipline or also in teaching? Is credentialing formal or informal? What if someone has a degree in one area in the basic sciences, for example, but has experience teaching another basic science area but no degree (formal credential) in that subject? Maybe the Standard should state that the faculty member "responsible for instruction in a certain clinical discipline" should be included if the intent is to focus on the clinical credentials (licensure, etc) of those faculty only.

This is a standard of accreditation, this information must be present regardless if it is too demanding.
National Org, Questions 36-41 (ST3-1 to 3-5)

No comments

State Org, Questions 36-41 (ST3-1 to 3-5)

36. I agree, but recommend exit interviews with students. These exit interviews should not have the school as an intermediary. CODA could make their own interpretations about student objectivity, but it may provide CODA with specific things to inquire about. I had some spectacular teachers in most departments. However, over the years speaking with new grads, at times there have been departments in transition or other problems preventing competency in certain areas.


Standard 3 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 3 - Faculty and Staff.

Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

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**Dentist, Standard 3 Comments**

37. There is a need for broad based expertise in faculty. Too often, credentialing and research leads to departmentalized patient care and very little experience for the students to care for the whole patient (diagnosis, restorative, periodontal restoration, etc)

Faculty are the strength of the dental school. They need to be given more freedom and time to teach hands on dentistry.

Faculty should have time available to improve their knowledge and teaching ability.

I think evidence based dentistry is really important; therefore, faculty should also be held responsible for keeping skills up-to-date (whether the dental school funds the CE or the faculty him/herself).

If faculty has never practiced in a private dental office, they are insufficiently informed.

It would be nice if faculty had "real world" experience.

Mandatory research should not be a prerequisite for all disciplines of dentistry as it frequently is when impacting tenure and promotions.

Metrics for evaluation, praise and remediation should be defined within the school or accreditation

No enough faculty development. There seems to be a close network of people, and outsiders are not welcome.

Those who do, do; those who can't.....teach. Y’all need more doers on your staffs.

---

**Dean, Standard 3 Comments**

The university mandates similar compliance qualifications under regional accrediting agencies. Herein lies additional means for bias based on misinterpretation from consultants.
Site Visitor, Standard 3 Comments

Dental hygienists with masters degrees need to be given the same consideration in clinical orientation and nsp that dentists have, since they are the experts in nsp. This lack of acknowledgement and lack of opportunity for rank promotion is driving dental hygiene educators out of predoctoral dental programs.

The faculty and staff are the human capital of each institution but, unfortunately, at times neglected because of emphasis on infrastructure, etc. Merit raises are often non-existent or hardly ever keep up with the inflation. These aspects can undermine morale thereby affecting commitment to and quality of educational activities.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

Nat’l Org, Standard 3 Comments

There should be sufficient number of full-time faculty members

State Org, Standard 3 Comments

I think process for tenure and promotion should be determined by each educational institution. Same for governance process for faculty input

No faculty should be stated for ever. All faculty must be evaluated regularly and fired if they have weak student reviews and performance. All faculty must participate in private/clinical practice of dentistry Themselves.
Standard 4 – Educational Support Services

Questions 42-48 (ST4-1 to 4-7)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dentist, Questions 42-48 (ST4-1 to 4-7)

#45: "include recruitment and admission" should be changed to "include recruitment that will HOPEFULLY lead to admission" #48g: The dental school's mission should NOT include ensuring that graduates are trained in financial planning, debt management, etc. These are all college graduates that can learn these skills from sources that have the requisite knowledge and training to afford them these "skills." The dental school faculty should be made up of staff with expertise in teaching dentistry, not business/financial/wealth accumulation skills.

45. Not relevant to providing society with competent, ethical practitioners and future educators. Criteria for future dentists must remain based on academic merit and ethics independent of genetic factors.

45. Admission policies and procedures should be the same across the board. 48g. I don't feel personal money management relevant to dental school education.

45. Admitting students on the basis of "diversity" as opposed to their academic competency is ridiculous. It happened at my school, and those students had to be mollycoddled all the way through school. With all things being equal, they would have flunked out.

48g. I do not believe schools are asked to do enough here.

Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.---- see previous entry. I disagree with diversity at all costs

Admissions should select applicants based on who they deem to be the best.

Again I feel there is too much emphasis on diversity to a fault.

As before, the emphasis should be on attracting and enrolling the best candidates who apply, confident that the emphasis on diversity in our overall culture will be manifest in these candidates.

Cheating was rampant in dental school, diversity is a joke in my opinion, schools pass on qualified applicants just so applicants of different races or ethnicities are enrolled. May the best applicants be admitted.
I do not think schools should be run by those who are not yet fully qualified to do so. The faculty and administration should be in charge of this.

I love the concept of diversity. I do not believe that a school should lower standards to admit a diverse culture.

It is very hard to get into Advance Programs for international students due high number of applicants. Admission programs are not the same for traditional and international programs. In most schools Board exams must be already passed; GRE test is required in some schools. In some schools only students who already have Masters are getting in. There is not enough diversity, clinical skills should be more important.

Metrics and definitions to measure diversity within the system, faculty and students should be defined by either the institution or CODA.

Not enough financial courses available. Not enough attention to student's concerns.

Part of the admission of students to dental school should require and evaluation of hand/eye coordination. When I applied to dental school, we had to carve a piece of chalk to test our coordination. If you have no coordination, you shouldn't become a dentist.

Patients should be treated by the most qualified individuals.

Predoctoral students must be upheld to the highest responsibility.

PROGRAMS ARE OPEN TO ALL THAT MEET THE STANDARDS DIVERSITY SHOULD NOT BE MANDATED.

question 42 - yes - written criteria are needed - but it must not be so restrictive as to not allow for exceptional circumstances. question 48 c - in regards to health services - "providing information" is not sufficient. When I was in dental school - the information provided to me was "the school has no health insurance, you are required to provide your own insurance." This is not acceptable. The school should make every effort to provide options for health insurance for the students even if the students have to share in the cost.

Recruitment and admissions must be based on objective performance criteria only because we must graduate dentists that can provide the quality of care patients should expect and receive - this shouldn't be a social experiment admissions should be about who are the very best mentally, emotionally and physically able to provide care.

Schools are pricing themselves out of existence. Too much debt with a graduate. Now they can't go out and buy a practice like we used to; instead, they go to work for a DSO. If ya'll are in bed with the DSO's, then keep doing exactly what you're doing. Private practice will be dead within a couple of decades.
Dentist, Questions 42-48 (ST4-1 to 4-7)

Some of these questions do not work well with the format of Too Demanding, etc. This would have been better as Agree, Disagree, Strongly Agree, etc.

STRIVING TO ADMIT STUDENTS BASED ON DIVERSITY MAY COMPROMISE THE QUALITY OF EDUCATION AND THE PERFORMANCE OF THE STUDENT. THIS IS A FORM OF RACISM!

The facility I attended was dated in the pre-lab area as well as the clinical treatment area. Students did not get much instruction on financial planning, etc.

The questions that include "advanced standing" are unclear. I am unfamiliar with the term. Again, a requirement to admit students based upon their race or gender is discrimination.

This is important in life, but would better as a prerequisite to entering the dental school program.

Too much focus is placed on scares for admittance. Not enough is placed on inter personal skills or hand skills. Socially awkward people who can’t sell are not going to be good dentists and you’re setting them up for failure. Also the advanced standing program is just a way for the school to make a lot of money of these students. First it was 2 years, now 3, now 4.

Why would a student admitted with advanced standing be assessed differently than other predoc students? Are we not all training to be dentists on the same path? If they have a different curriculum, how can it be assured that they are as qualified for specialties if not assessed by the same measures?

Dean, Questions 42-48 (ST4-1 to 4-7)

#44 It is unclear why advanced standing students must receive an individualized curriculum plan. The standard should equal other students, in which schools assure they achieve the same standards for graduation. Should Student Services section be called Student Services and Student Affairs?
Site Visitor, Questions 42-48 (ST4-1 to 4-7)

#45 Recruiting a diverse student body is extremely challenging, due to the low number of applicants nationwide. While the standards says that the program must have policies and procedures, it is somewhat ambiguous and can be interpreted that a diverse student body must be admitted as well.

43. Suggest changing same to same or greater. I think an institution should be able to choose to require higher standards for advanced standing students. 44. Suggest deleting individual assessment. This is overly burdensome; the institution should be permitted to apply a blanket curriculum plan for a group of advanced standing students.

47. This needs to include that these sites need a calibration process as their staff/clinicians are likely not faculty at the dental college.

Admission standards must be increased in the sciences that support health care--anatomy, physiology, biochemistry, behavioral sciences. These must be across the board statements for all accredited schools so as to ensure a uniform outcome of entry level competency of graduates.

Q48g. This statement pertains to instruction but is located along with a list of institutional administrative responsibilities. I suggest CODA consider making it a Standard and expect dental institutions to produce competent graduates in personal debt management and financial planning as the average predoctoral student debt upon graduation is now over $300K on average (ADEA data 2020). The Standard could read: Graduates must be competent in personal debt management and financial planning.

See previous comments on student diversity based on drawing area composition. Not demanding enough on advanced standing students included in the same curriculum as D3 and D4 students.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

National Org, Questions 42-48 (ST4-1 to 4-7)

No comments
State Org, Questions 42-48 (ST4-1 to 4-7)

#45: Admissions should be color-blind. Only the applicant's ability should be considered. Race based admissions are immoral.

45. Again, I believe that a universal directive can be set by CODA after consultation with diversity and inclusion experts. This is too important to be left for each program to interpret. This must be more specific.

I feel schools should have written criteria for admittance that also allow for some subject evaluation of the potential students. Diversity is always a goal to include underrepresented populations, but admittance should not preclude excellent academic standing. Assuring student participation on committees should be the discretion of the school. Financial planning and understanding cost of loans very important, but not the responsibility of the school beyond basic information. School should be responsible for keeping costs of education down and helping students find scholarships!
Questions 49-53 (ST4-8 to 4-12)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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<table>
<thead>
<tr>
<th>Dentist, Questions 49-53 (ST4-8 to 4-12)</th>
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<tbody>
<tr>
<td>&quot;At the time of acceptance, students must be advised of the total expected cost of their dental education.&quot;-this will be sufficiently demanding only if the students are advised of the total expected cost of their dental education including interest and shown sample repayment plans. Students need to be aware of what their expected monthly payments will be after graduation at the time of acceptance. Students should be shown a sample 10 year repayment plan and a 20 year repayment plan. &quot;There must be a mechanism for ready access to health care for students while they are enrolled in dental school.&quot;-This mechanism for ready access to health care needs to be an &quot;easily accessible, on the dental school campus.&quot; Many dental students are without any form of transportation, have no means of financial help and no family or support system in the city where they are attending school. Health care is crucial and needs to be incredibly easy to access by foot and at a low cost or free.</td>
</tr>
<tr>
<td>#52: Again, way too broad. Providing access to &quot;health care&quot; for young adults over four years of time implies a responsibility of a dental school to be responsible for all the medical needs of all of their students.</td>
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<tr>
<td>49. Formal annual itemized report regarding projected cost and actual cost with explanation</td>
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<td>49. Same comment as for 48.</td>
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<td>53. Vaccinations should required</td>
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<tr>
<td>53. As responsible health care providers, students should be required to have immunizations.</td>
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<tr>
<td>53: As long a a student does not have a medical or religious exemption they should be required to have the previously mentioned vaccinations.</td>
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<tr>
<td>Governing bodies should not be responsible for making personal decisions for anyone</td>
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<tr>
<td>I do not think that it is a Dental School’s responsibility or requirement to provide health care services for it's students. That is the responsibility of each student.</td>
</tr>
<tr>
<td>Incoming students should dental assist for a couple of years prior to entry so when they arrive be fully aware of what is expected and also are more mature as a person.</td>
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</table>
### Dentist, Questions 49-53 (ST4-8 to 4-12)

It should be required to be immunized to be able to treat patients, so as not to protect yourself but patients, students, faculty as well.

Should include mental and emotional health as well.

This has always been a requirement for the last 15 years I have been in health care. Encouraging is weak and statement about exceptions for whatever reason should be included.

Upholding ethical responsibilities are not demanding

Why do vaccines have to be mandated? Why can't you emphasize boosting the immune system and ways to do that? Proper instruction on infection control procedures and knowledge of disease transmission will automatically minimize risk of infection. Give people information and allow them to assess and mitigate their personal risk.

### Dean, Questions 49-53 (ST4-8 to 4-12)

It is very challenging to give students a full financial picture for 4 years of education when the external environment is so fluid and changing

Vaccine hesitancy and resistance by students should not be accepted. Students refusing to be vaccinated is a public health concern. If they do not want to be vaccinated, they should pursue a non-health related profession.

### Site Visitor, Questions 49-53 (ST4-8 to 4-12)

I believe that students if in the health field should be required to be vaccinated.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

### National Org, Questions 49-53 (ST4-8 to 4-12)

No comments

**Standard 4 Comments**

(Optional) Please use the space below to enter any comments you have related to Standard 4 - Educational Support Services.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

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**Dentist, Standard 4 Comments**

53. Is it viewed as acceptable if it is mandated by the University President?

Demand COVID immunization

If someone wanted to give me $250K for four years, I'm 100% positive I could teach them how to have a career in something they enjoyed where they could make more money than they could as a dentist. Out of control. See previous comment about DSOs

No clue what advanced standing means

Now with covid-19. students should also be required to have this vaccine in board.

Prospective students need to understand that dentistry is a physically and emotionally demanding career.

Words are nice but your goals are not measurable.

---

**Dean, Standard 4 Comments**

It might be time to expand the list of immunizations at least in the "such as" group to include influenza and COVID-19.
Site Visitor, Standard 4 Comments

This is a standard of accreditation, this information must be present regardless if it is too demanding.

Unfortunately, the issue of COVID-19 vaccination has become a politically-charged issue. With the move towards in-class instruction, it would be greatly reassuring if vaccination for infectious diseases be required (and not optional).

evaluate inclusion of COVID vaccination in future?

53. Students must be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves. - perhaps consider adding annual flu vaccine as well as COVID

National Org, Standard 4 Comments

No comments

State Org, Standard 4 Comments

Question 53 - perhaps add COVID-19
Standard 5 – Patient Care Services

Questions 54-62 (ST5-1 to 5-9)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dentist, Questions 54-62 (ST5-1 to 5-9)

... not compromise the quality or delivery of comprehensive patient care.

56. Standards of practice is a more appropriate term where Standard of Care is listed. Standard of care is vague, whereas Standard of Practice is well defined in current literature and by specialty organizations.

58. Any patient should have enough common sense to contact an ER or an outside dentist if they are experiencing an emergency and they cannot reach their student or the school. I don't see the need to require the school to provide 24 hour emergency care.

Again as expected the highest standards must be upheld and availability of help for students must be encouraged

CPR is a joke. Have a defibrillator in each clinic area. Next question.

Good luck trying to get an oral surgeon to come into the oral surgery department for a non-clinical hours emergency. Never happened the whole time in my dental school career.

I find in the dental schools I have worked in, infection control needs tighter control, i.e. a dedicated officer patrolling on each floor as both students and faculty alike violate all the time.

It was very hard getting an active patient in for emergencies. They would have to wait in line with the general public, which is not fair. There was too much variability between the quantity of cases that students got. Some had a ton of case and finished their requirements by 3rd year and others graduated late. There needs to be a better more equitable system.

Unfortunately, "evidenced-based" treatment is not always the best or most appropriate treatment. Again, it's book date versus real life experiences.
Dean, Questions 54-62 (ST5-1 to 5-9)

#55 If you incorporate best research evidence with patient values, how can this be proven when they are in conflict. Perhaps this should be a "should" statement

Site Visitor, Questions 54-62 (ST5-1 to 5-9)

#61. I personally think it is too demanding to require PRECLINICAL asepsis.

55. This standard is too prescriptive and open for site visitor bias. 56. This standard has qualitative components that too many site visitors try to correlate with quantitative data.

61 - this is very subjective depending on who the site visitor is. There needs to be set guidelines that the site visitors uniformly know and apply.

Standard 5-2 Patient care must be evidence-based, integrating the best research evidence and patient values. The patient values statement in this standard is confusing and does not appear to be understood by most institutions. More clarity would be helpful on what is expected in regards to the patient values and how it related to evidence-based dentistry

This is a standard of accreditation, this information must be present regardless if it is too demanding.

this standard should be rewritten- you are asking the program "not to do" something rather than specifying an objective

National Org, Questions 54-62 (ST5-1 to 5-9)

No comments

State Org, Questions 54-62 (ST5-1 to 5-9)

No comments
### Standard 5 Comments

Please use the space below to enter any comments you have related to Standard 5 - Patient Care Services.

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<table>
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<tbody>
<tr>
<td>After hours emergencies are important whether the student takes call with an available GPR/AEGD program (should one be associated with the dental school), or have a system in place for students/faculty to cover call.</td>
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State Org, Standard 5 Comments

No comments

Standard 6 – Research Program

Questions 63-65 (ST 6-1 to 6-3)

(Optional) You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Dentist, Questions 63-65 (ST6-1 to 6-3)

63 and 64. Don't feel research is needed for a predoctoral student and I don't think it is a must for faculty.

64. I have always found it onerous to require research activity, having published papers as a requirement for full time faculty. The result is a lot of poorly designed studies, papers of questionable quality. "Publish or perish" is a problem not easily solved.

64. Dental school faculty should NOT be forced to engage in research or other forms of scholarly activity, especially if the institution will not foster adequate time be made available outside of clinic to complete such activities.

64. I do not see the need for every single faculty member to do research. Some people are just not cut out to do that, and some are.

A portion of the faculty should be involved in research but this should not be required of all faculty.

I don't think research should be required of faculty or students. If faculty want to focus on research, I believe that they should be able to as their sole focus, funding should come from outside (non-tuition) sources as is their own salaries. It's a hard things to do but I do believe that students should be taught research (how to read, understand, interpret, and apply research) but not required to participate, nor do I think that faculty who want to do just research should be forced to teach.

I never had interest in research, so why should it be required, I never had any intention of doing research, I wanted to do dentistry, period. So don't make research mandatory for those that only want to practice dentistry.
Dentist, Questions 63-65 (ST6-1 to 6-3)

I think it's too demanding to say that ALL faculty should engage in research. We have many volunteer faculty from private practice who do not engage in research. We also have some faculty with such a heavy clinical load that there is no time for research.

more opportunity and support for research is needed. Granted each school is different but faculty need to be given time for faculty advancement which includes research time.

Not all faculty members should be required to be involved in research.

Not enough research opportunities.

Not everyone wants to do research, I do not think IG should be a requirement for graduation.

Perhaps some faculty would benefit students' professional development best if their time was not spent over-engaged in research.

Research or other forms of scholarly activity does not enable faculty to teach real-life dentistry.

Research should not be a faculty requirement, but can be encouraged or made more easily completed based on a basic research foundation of the school. Research is a lot harder than it looks.

Students are there to learn how to be dentists. Research comes after that.

Dean, Questions 63-65 (ST6-1 to 6-3)

It appears that ALL faculty, whether full or part time, whether hired solely for clinical care vs. teaching faculty, need to produce either research or scholarly activity. This might be best served with a "should" statement.

The CODA research standards are inadequate. I can't recall any institution being cited for failure to comply with any of the research standards. There needs to be a much higher standard for dental schools in the area of research. The profession depends on new knowledge and the dental schools have a responsibility to generate this new knowledge. This also gets to the role of dental schools in the university and in the academic health center. The REDACTED dental school is an outstanding example of what a dental school should be in terms of research and being an integral part of the University.
<table>
<thead>
<tr>
<th>Site Visitor, Questions 63-65 (ST6-1 to 6-3)</th>
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<tbody>
<tr>
<td>Most dental schools do not invest in research, especially in selection of research-competent faculty, support for infrastructure and faculty development systems to enhance research efforts.</td>
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<tr>
<td>The level of participation in scholarship is too vaguely defined—it must include a measurement of the impact of that scholarship on the body of human knowledge and on the evidence based improvement in patient care.</td>
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<tr>
<td>These standards are not rigorous enough.</td>
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<tr>
<td>This is a standard of accreditation, this information must be present regardless if it is too demanding.</td>
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<th>National Org, Questions 63-65 (ST6-1 to 6-3)</th>
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<td>No comments</td>
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<th>State Org, Questions 63-65 (ST6-1 to 6-3)</th>
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<tr>
<td>#64 As stated, this implies that all faculty are required to engage in research - something that seems overstated. Faculty research should exist in some form at the institution but not be required of all faculty.</td>
</tr>
<tr>
<td>I do not feel that research must be a component of a clinical educational experience.</td>
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<tr>
<td>Not every instructor must engage in research. There are many qualified part time instructors who would be lost if they were required to engage in research.</td>
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</table>
**Standard 6 Comments**

(Optional) Please use the space below to enter any comments you have related to Standard 6 - Research Program.

*Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).*

---

**Dentist, Standard 6 Comments**

Adequate time must be set aside for faculty and student participation in research activity.

Many times strict scientific study protocols lead to "evidence" that is so isolated that it is not applicable to clinical practice. An understanding of engineering principles and how components and therapies work together for better patient outcomes is the ideal use of the evidence of individual components.

Remove the self serving politics from the continuing education dept.

Research is important for several reasons. Experiences for faculty and students should result in better critical thinkers and more evidence based care.

Research isn't everyone's cup of tea, so making it mandatory will not be effective.

Research opportunities should be made available to those who want a career in research or in graduate programs. The aim of a dental school is to educate its students to become the best dentists they can be.

You can't force ALL faculty to become interested in research. Some of us are more engaged in these scholarly activities than others unfortunately.

---

**Dean, Standard 6 Comments**

*No comments*
Site Visitor, Standard 6 comments

63, 64, 65: Each individual dental school should be permitted to decide to what extent research and scholarly activity will be part of their mission, and expend resources accordingly, as long as the dental school is consistent with regulations put forth by the parent institution.

Pleased to see that accountability for engagement in research by faculty and students has been augmented.

Research is an integral part of scholarly activity, but not obligatory to all faculty members.

The way the research standards are written makes these seem totally unimportant--such a low bar to meet.

This is a standard of accreditation, this information must be present regardless if it is too demanding.

National Org, Standard 6 Comments

No comments

State Org, Standard 6 Comments

I came from a dental school almost solely focused on creating practitioners, not researchers. While I believe there is a place for research in dentistry, I hope we do not lose track of the need for well trained clinical practice dentists.

Not all dental schools promote research and that needs to change. A strong medical education will help in mitigating this problem.
(Optional) Any other comments? Note that comments will be reviewed individually by CODA; if you wish to remain anonymous, make sure that your response does not identify you (or your education program, if applicable).

Dentist – Any other comments?

A wise counselor once said if the world were to come to an end leaving only another Adam and another Eve to repopulate and re-educate humanity, either Adam or Eve should have been a dentist. A dentist is in a unique position to have received a very broad education in multiple disciplines that represent many of the rungs on the educational ladders that ultimately give rise to medicine, engineering, law, sociology, psychology, mathematics, physics, and others. Dental School programming helps maintain this broad excellence as witnessed by the questions in this survey. Thank you.

During CODA visit for accreditation, does CODA provide anonymous random selection one on one interview with students? Sometimes, students have feedbacks/comments regarding to the program/institution they are in. And they have no way/where to express those comments outside of institution.

From my perspective, dental education is in serious trouble. We are creating clinical practitioners with no real understanding of anatomy, human physiology, dental materials, restorative techniques (even simple ones), patient management, practice management, etc., etc. We are taking their $400,000 dollars in tuition and printing diplomas as fast as we can pass them out. Is this in the best interests of our patients? Live-patient exams are Medieval. Let's work toward final elimination of them once and for all.

I also believe that students need to be held to high expectations. This "student-centered" model with a lack of disciplinary action from administration is leading to graduates that are not prepared and who are entitled. Gen Y and Gen Z students are walking all over faculty and program administrators without any strict guidelines in place that holds students accountable for their actions.

I believe CODA's standards are appropriate. My only concern is that CODA's standards are not being routinely met by institutions and that often, institutions which have been shown not to meet certain standards, are allowed to continue without significant consequences and often continue to operate without correcting the issue.

I believe that I completed the first part without a true reading of the criteria In my 40+ years of practicing Dentistry I have unfortunately met too many dentists who do not respect or understand their role as odontologists. Some are even scared to be true dental surgeons or to practice dental medicine Dentists of the present & future need to respect their profession & see their role as "regular doctors"

I didn't like the way the survey responses were worded. I don't think you get an accurate impression of what my opinions were to the items.
**Dentist – Any other comments?**

I don't feel there is enough lab work exposure in dental school any more. You can't accomplish good dental work unless you know what is required during the entire process. I don't feel there is enough emphasis on cast restorations anymore. The longevity of these is proven time and time again. Instead dentists are getting out and milling restorations that, in my opinion, are not conservative nor long lasting and comfortable for patients. The use of materials that are in harmony with enamel should be emphasized.

I think CODA needs a big revamp. The technology, techniques, and application in dentistry is changing. The way it is run now is only hindering the future generations of dentists as they have to start learning as soon as they graduate. We should be preparing them with a standardized clinical and didactic curriculum, and if there is one already in place, then it should be enforced more and rewarded more when approved. CODA almost seems like a publicity stunt, all for aesthetics with no substance behind it.

More must be done to address the cost of dental education

Nice goals but are they measurable? Are they obtainable? You have no time frame? You have no monitors? You cannot improve what you do not measure.

Over the past 10 years the educational programs have continued to water down the patient experiences of students in favor of admitting more students than they can provide adequate training for. They have diluted the medical education of students and are creating technicians and not true clinicians/Doctors. This has continued to create problems while in practice and creates significant risk to the population.

**PLEASE CREATE A STANDARD OF CONSISTENCY. THESE ADVANCED STANDING STUDENTS ARE NOT CAPABLE YET GRADUATE. A GRADUATE OF ANY SCHOOL SHOULD BE CAPABLE. TOO MANY ARE SLIPPING BY AND QUALITY OF CARE IS GOING WAY DOWN**

The system of accreditation by CODA needs to be on a yearly basis instead of a 4 year period to avoid abusing the system by the programs admins. There should be centralized and standard clinical competency requirement system that would ensure an standard education system across the nation rather than leaving it in the hands of an school to meet the generalized criteria proposed by the program at the most minimum level to keep its accreditation. That way, students competency in clinical or scientific education will also be standardized across the nation, e.g. same books, standardized competent instructors, same graduating criteria, etc.

There needed to have been a section on tuition. Tuition is rising at a rate that makes dental school unattainable for some students, and student debt is a burden carried by many for 20+ years after graduation. This rise in tuition is not justifiable. I believe CODA needs to address this problem immediately.

While the program appears as a fine program from the outside, you can always improve it by actually listening to all stakeholders, not just the school and administration. The students are an integral part of the system, and their voices/concerns should be heard in order for progress to move forward.
Dean – Any other comments?

Having faculty required to fill out CODA's biosketch is a huge waste of resources. Recording CE is a state mandate and not in my view something that makes a better teacher. Huge time sinks for little outcome..

It is time to rethink the current standards that have grown in number, detail, and unilateral vision. The site visit process is cloaked in professional intenti related to compliance, yet calibration among site visitors is lacking. Dental institutions now must devote 24 to 36 months of time (diverted teaching time, money and people), in addition to other resources to prepare in advance of a site visit in what should be an important review, peer assessment based on calibrated individuals.

It would be helpful if CODA could provide more guidance as to the Commission's expectations for educational programs as we come out of the COVID pandemic. The Commission has been very helpful and much appreciated for its efforts to this point.

Need to take this opportunity to simplify standards and not burden schools more than CODA already does.

Site Visitor – Any other comments?

Covid 19 has prevented actual on site "site visits". The mention of potential "zoom" or other on-line site visit proposals because of Covid is ludicrous. Site visits MUST mean actual physical site visits by the team, even if it is required that all CODA site visitors must be fully vaccinated.

I appreciate the opportunity to comment.

I did provide some comments earlier. Thank you, [initials redacted]

I really think the standards are appropriate and good!

It is recognized that site visit teams consists of consultants that should be knowledgeable in the areas for which they are selected. It has become painfully obvious that many of the new site visitors bring too much personal bias for their respective institutions and they are not all particularly competent in the areas to which they are assigned. Those not particularly competent bring the greatest personal bias. Also, dental deans are always chosen as site visit team chairs. With then increasing number of new deans that do not have a lot of experience do not appropriately manage their site visit teams. Training is good, but it is only theoretical. Also, shadowing for only 1 site visit prior to being chair is totally inadequate and does not prepare a chair to be able to manage a team that may consist of well-seasoned and/or novice consultants. Having served as a test constructor for over 13 years and now over 18 years as a CODA site visitor, I have seen this process somewhat deteriorate based on the over prescriptive nature of some of the standards as well as the creep of bias by many, generally, newer site visitors. In an effort to focus on "competency" the site visit has been reduced to looking...
Site Visitor – Any other comments?

more at number and data rather than the quality of the educational process and the quality of clinician a program produces. The concept of competency based education originated in the 1970's and still no one fully understands it and more importantly there are perhaps too many ways it can be interpreted. The accreditation process has become one that is more focused on charts, tables, and numbers than may or may not have relevance rather than the quality of the competent general dentist the program produces.

Ongoing Institutional Assessment, assessment of progress toward student competence, and sufficient patient experiences to assess clinical competence are all paramount in determination of the meeting of accreditation standards in additional to ALL of the other must statements of the accreditation standards being met by the program.

Really all needed items

Thank you for seeking feedback.

Thanks for asking this site visitor's opinion on the Standards.

National Org – Any other comments?

No comments

State Org – Any other comments?

Thank you for taking the time to read and consider my feedback. I appreciate being included in this survey.
Appendix

Survey Instrument
Validity and Reliability Surveys - PREDOC

Start of Block: INTRODUCTION

To begin, click the "Next" button below. Please note that the "Next" button will allow you to move from one page to the next.

Please complete all questions either by selecting the appropriate response or typing your answer in the appropriate field.

If at any point you need to pause the survey and return to it at a later time, simply complete the page you are on and go to the next page, then close your browser. You can return to your survey with your answers saved by clicking the link in your email invitation.

When you reach the end of the survey, click "Finish" to submit your responses.

Listed in this survey are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate predoctoral dental education programs for accreditation purposes. "Predoctoral dental education programs" are those with training leading to the DDS or DMD degree. (The complete standards for predoctoral dental education programs are available here.)

For each "must" statement in the standards, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

Please be aware that, while every effort has been made to present the standards in their original wording, certain modifications to the presentation and arrangement have been made in order to incorporate the standards into the survey design.

Please note that certain standards have multiple items to be rated.

End of Block: INTRODUCTION
DEFINITIONS

Refer to the following definitions as you rate each "must" statement in the standards:

Too demanding = Criterion is relevant to type of program but too demanding for residents
Sufficiently demanding = Criterion is relevant to type of program and sufficiently demanding for residents
Not demanding = Criterion is relevant but not demanding enough for residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents
No opinion = No opinion on this criterion

STANDARD 1 - INSTITUTIONAL EFFECTIVENESS

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

   - Too demanding
   - Sufficiently demanding
   - Not demanding
   - Not relevant
   - No opinion
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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

3. The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
4. The dental school must have policies and practices to:

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<th>Not relevant</th>
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<tr>
<td>a. achieve appropriate levels of diversity among its students, faculty and staff;</td>
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<tr>
<td>b. engage in ongoing systematic and focused efforts to attract and retrain students, faculty and staff from diverse backgrounds; and</td>
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<td>c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.</td>
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</table>
5. The financial resources must be sufficient to support the dental school’s stated purpose/mission, goals and objectives.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
7. The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

8. The dental school must be a component of a higher education institution that is accredited by a regional accrediting agency.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Please use the space below to enter any comments you have related to Standard 1 - Institutional Effectiveness.

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For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents
No opinion = No opinion on this criterion

STANDARD 2 - EDUCATIONAL PROGRAM

Instruction

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

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
11. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Curriculum Management

12. The curriculum must include at least four academic years of instruction or its equivalent.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
13. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

14. The dental education program must employ student evaluation methods that measure its defined competencies.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
15. Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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STANDARD 2 - EDUCATIONAL PROGRAM (continued)

Curriculum Content
17. The dental school must have a curriculum management plan that ensures:

a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;
b. evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;
c. elimination of unwarranted repetition, outdated material, and unnecessary material;
d. incorporation of emerging information and achievement of appropriate sequencing;
e. incorporation of emerging didactic and clinical technologies to support the dental education program curriculum.

☐ Too demanding
☐ Sufficiently demanding
☐ Not demanding
☐ Not relevant
☐ No opinion

Please specify the element(s) of Question 17 that was Too Demanding, Not Demanding, or Not Relevant, and describe the reason for the rating.

________________________________________________________________
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18. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

**Critical Thinking**

19. Graduates must be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry and research methodology.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

**Self-Assessment**
20. Graduates 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

---

**Biomedical Sciences**

21. Biomedical science instruction in dental education must ensure an in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
22. The biomedical knowledge base must emphasize the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

23. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
24. Graduates must be competent in the application of biomedical science knowledge in the delivery of patient care.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

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STANDARD 2 - EDUCATIONAL PROGRAM (continued)

Behavioral Sciences

25. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
26. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Practice Management and Health Care Systems

27. Graduates must be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
28. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

29. Graduates must be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Ethics and Professionalism
30. Graduates must be competent in the application of the principles of ethical decision making and professional responsibility.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Clinical Sciences

31. Graduates must be competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
32. Graduates must be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Page Break
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

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STANDARD 2 - EDUCATIONAL PROGRAM (continued)

33. At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:
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<tr>
<td>a. Patient assessment,</td>
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<td>diagnosis,</td>
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<td>k. Oral mucosal, temporomandibular, and osseous disorders;</td>
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<td>n. Malocclusion and space management; and</td>
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<td>o. Evaluation of the outcomes of treatment, recall strategies, and prognosis</td>
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34. Graduates must be competent in assessing and managing the treatment of patients with special needs.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
35. Dental education programs must make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Please use the space below to enter any comments you have related to Standard 2 - Educational Program.

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For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

Too demanding = Criterion is relevant to type of program but too demanding for residents
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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents
No opinion = No opinion on this criterion

STANDARD 3 - FACULTY AND STAFF

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

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
37. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

38. The dental school must show evidence of an ongoing faculty development process.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
39. Faculty must be ensured a form of governance that allows participation in the school’s decision-making processes.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

40. A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
41. The dental school must have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Please use the space below to enter any comments you have related to Standard 3 - Faculty and Staff.

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End of Block: STANDARD 3 - Q36-41
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents
No opinion = No opinion on this criterion

STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Admissions

42. Specific written criteria, policies and procedures must be followed when admitting predoctoral students.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
43. Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

44. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
45. Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Facilities and Resources

46. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Written Agreements
47. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Student Services

48. Student services must include the following:
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<tbody>
<tr>
<td>a. Personal, academic and career counseling of students;</td>
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<td>b. Assuring student participation on appropriate committees;</td>
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<td>c. Providing appropriate information about the availability of financial aid and health services;</td>
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<td>d. Developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;</td>
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<td>e. Student advocacy</td>
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<td>f. Maintenance of the integrity of student performance and evaluation records; and</td>
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</table>
g. Instruction on personal debt management and financial planning.

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Page Break
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents  
No opinion = No opinion on this criterion

STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Student Financial Aid

49. At the time of acceptance, students must be advised of the total expected cost of their dental education.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
50. The institution must be in compliance with all federal and state regulations relating to student financial aid and student privacy.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

Health Services

51. The dental school must advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental studies.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
52. There must be a mechanism for ready access to health care for students while they are enrolled in dental school.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Please use the space below to enter any comments you have related to Standard 4 - Educational Support Services.

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End of Block: STANDARD 4 - Q42-53

Start of Block: STANDARD 5 - Q54-62

For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the predoctoral dental education program.

Too demanding = Criterion is relevant to type of program but too demanding for residents
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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents
No opinion = No opinion on this criterion

STANDARD 5 - PATIENT CARE SERVICES
54. The dental school must have a published policy addressing the meaning of and commitment to patient-centered care and distribute the written policy to each student, faculty, staff, and patient.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

55. Patient care must be evidenced-based, integrating the best research evidence and patient values.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
56. The dental school must conduct a formal system of continuous quality improvement for the patient care program 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.

   - Too demanding
   - Sufficiently demanding
   - Not demanding
   - Not relevant
   - No opinion

57. The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive patient care.

   - Too demanding
   - Sufficiently demanding
   - Not demanding
   - Not relevant
   - No opinion
58. The dental school must ensure that active patients have access to professional services at all times for the management of dental emergencies.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

59. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
60. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

61. The dental school must establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste, consistent with accepted dental practice.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
62. The school’s policies and procedures must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Please use the space below to enter any comments you have related to Standard 5 - Patient Care Services.

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Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for residents
No opinion = No opinion on this criterion

STANDARD 6 - RESEARCH PROGRAM

63. 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.

- [ ] Too demanding
- [ ] Sufficiently demanding
- [ ] Not demanding
- [ ] Not relevant
- [ ] No opinion
64. 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.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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65. Dental education programs must provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion

You indicated that one or more of the standards on this page was "Too demanding", "Not demanding", or "Not relevant". Please identify the standard(s) by question number and explain the rating(s) in the space below.

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Please use the space below to enter any comments you have related to Standard 6 - Research Program.

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End of Block: STANDARD 6 - Q63-64

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Any other comments?

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Thank you for your assistance with this research project.

Please click "Finish" to complete the survey.

End of Block: FINISH
Commission on Dental Accreditation

Accreditation Standards for Dental Therapy Education Programs
Accreditation Standards for Dental Therapy Education Programs

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org/en/coda

Effective: February 6, 2015

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Commission on Dental Accreditation
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## Document Revision History

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<tr>
<td>February 6, 2015</td>
<td>Accreditation Standards for Dental Therapy Education Programs</td>
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<tr>
<td>August 7, 2015</td>
<td>Accreditation Standards for Dental Therapy Education Programs</td>
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<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
<td>Approved,</td>
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<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
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<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
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<td>January 1, 2018</td>
<td>Areas of Oversight at Sites Where Educational Activity Occurs (new Standard 2-5, revisions to Standards 3-4, 3-5, and 3-7)</td>
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<td>February 8, 2019</td>
<td>Definition of Terms (Health Literacy) and Intent Statements for Standards 2-14, 2-15, 2-19 and 2-21</td>
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<td>August 5, 2021</td>
<td>Definition of Terms (Should)</td>
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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and profession 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
Accreditation Status Definitions

Programs Which Are Fully Operational

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

Approval (with reporting requirements): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within 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.

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.

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).
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.

Dental Therapy Accreditation
The first dental therapy accreditation standards were developed by the Commission on Dental Accreditation in 2013. In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation used the following procedures: conducting surveys of communities of interest, holding open hearings and distributing widely a draft of the proposed revision of the standards for review and comment. Prior to approving the standards in February 2015, the Commission carefully considered comments received from all sources. The accreditation standards were implemented in August 2015.

Standards
Dental therapy education programs must meet the standards delineated in this document to achieve and maintain accreditation.

Standards 1 through 5 constitute The Accreditation Standards for Dental Therapy Education Programs by which the Commission on Dental Accreditation and its consultants evaluate Dental Therapy 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 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.

DTEP Standards
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Although the standards are comprehensive and applicable to all institutions that offer dental therapy 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 education and 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 Therapy 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.
Statement of General Policy

Maintaining and improving the quality of dental therapy education is a primary aim of the Commission on Dental Accreditation. In meeting its responsibilities as a specialized accrediting agency recognized by the dental profession and by the United States Department of Education, the Commission on Dental Accreditation:

1. Evaluates dental therapy education programs on the basis of the extent to which program goals, institutional objectives and approved accreditation standards are met;

2. Supports continuing evaluation of and improvements in dental therapy education programs through institutional self-evaluation;

3. Encourages innovations in program design based on sound educational principles;

4. Provides consultation in initial and ongoing program development.

As a specialized accrediting agency, the Commission relies on an authorized institutional accrediting agency’s evaluation of the institution’s objectives, policies, administration, financial and educational resources and its total educational effort. The Commission’s evaluation will be confined to those factors which are directly related to the quality of the dental therapy program. In evaluating the curriculum in institutions that are accredited by a U.S. Department of Education-recognized regional or national accrediting agency, the Commission will concentrate on those courses which have been developed specifically for the dental therapy program and core courses developed for related disciplines. When an institution has been granted “candidate for accreditation” status by a regional or national accrediting agency, the Commission will accept that status as evidence that the general education and biomedical science courses included in the dental therapy curriculum meet accepted standards, provided such courses are of appropriate level and content for the discipline.

The importance of institutional academic freedom is recognized by the Commission, and the Accreditation Standards allow institutions considerable flexibility in structuring their educational programs. The Commission encourages the achievement of excellence through curricular innovation and development of institutional individuality. Dependent upon its objectives, resources, and state practice act provisions, the institution may elect to extend the scope of the curriculum to include content and instruction in additional areas.

Programs and their sponsoring institutions are encouraged to provide for the educational mobility of students through articulation arrangements and career laddering (e.g., between dental therapy education programs and dental hygiene or dental assisting education programs).
Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying or proficiency examinations.

This entire document constitutes the Accreditation Standards for Dental Therapy Education Programs. 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. Expanded guidance in the form of examples to assist programs in better understanding and interpreting the “must” statements within the standards follow. 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 Therapy 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 therapy 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 therapy 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 service missions. The assessment process should include:

1. establishing a clearly defined purpose/mission appropriate to dental therapy 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 Therapy 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 therapy 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.

The foundation of these Standards is a competency-based model of education through which students acquire the level of competence needed to begin the practice of dental therapy. 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 practice of dental therapy. 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. The assessment process focuses on measuring the student’s overall capacity to function as an entry-level, beginning dental therapist rather than measuring individual skills in isolation.
In these *Standards* the competencies for dental therapy are described broadly. The Commission expects each school to develop specific competency definitions and assessment methods in the context of the broad scope of dental therapy practice. These competencies must be reflective of an evidence-based definition of dental therapy. To assist schools in defining and implementing their competencies, the Commission strongly encourages the development of a formal liaison mechanism between the school and the practicing dental community.

The objectives of the Commission are based on the premise that an institution providing a dental therapy 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.
Definition of Terms Used in Accreditation Standards for Dental Therapy Education Programs

The terms used in this document indicate the relative weight that the Commission attaches to each statement. Definitions of these terms are provided.

**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.

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

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

**Intent:** Intent statements are presented to provide clarification to dental therapy education programs in the application of, and in connection with, compliance with the *Accreditation Standards for Dental Therapy 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.

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

**Understanding:** Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

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

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

**Competencies:** Written statements describing the levels of knowledge, skills and values expected of graduates.

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

**Dental Therapy:** Denotes education and training leading to dental therapy practice.

**Community-based experience:** Refers to educational opportunities for dental therapy students to provide patient care in community-based clinics or private practices under the supervision of faculty licensed to perform the treatment in accordance with the state dental practice act. Community-based experiences are not intended to be synonymous with community service.
activities where dental therapy students might go to schools to teach preventive techniques or where dental therapy students help build homes for needy families.

**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 clinician’s expertise and the patient's treatment needs and preferences.

**Patients with special needs:** Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

**Quality assurance:** 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 involves identification and implementation 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 therapists through provision of patient care and related services in response to community-based problems.

**Advanced Standing:** Programs and their sponsoring institutions are encouraged to provide for educational mobility of students through articulation arrangements and career laddering (e.g. between dental therapy education programs and dental hygiene or dental assisting education programs). Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying or proficiency examinations.

Advanced standing means the program has the authority to grant full or partial course credit for a specific course toward the completion of the dental therapy program. This may apply to one or more courses in the dental therapy program curriculum.

**Humanistic Environment:** Dental therapy programs are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic pedagogy inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising and small group interaction. A dental therapy program environment characterized by respectful professional relationships between and among faculty and students establishes a context for the development of interpersonal skills necessary for learning, for patient care, and for making meaningful contributions to the profession.

**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.”
STANDARD 1-INSTITUTIONAL EFFECTIVENESS

1-1 The program must develop a clearly stated purpose/mission statement appropriate to dental therapy 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 program.

1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness 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 therapy 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 dental therapy.

**Examples of evidence to demonstrate compliance may include:**
- program completion rates
- employment rates
- success of graduates on licensing examinations
- surveys of alumni, students, employers, and clinical sites
- other benchmarks or measures of learning used to demonstrate effectiveness
- examples of program effectiveness in meeting its goals
- examples of how the program has been improved as a result of assessment
- ongoing documentation of change implementation
- mission, goals and strategic plan document
- assessment plan and timeline
The dental therapy education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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

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

The program must have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty and staff;
b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and
c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

**Intent:** The program should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The program should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Programs could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Programs should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.
1-5 The financial resources must be sufficient to support the program’s stated purpose/mission, goals and objectives.

**Intent:** The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, reference material and teaching aids as reflected in an annual operating budget. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes 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.

**Examples of evidence to demonstrate compliance may include:**
- program’s mission, goals, objectives and strategic plan
- institutional strategic plan
- revenue and expense statements for the program for the past three years
- revenue and expense projections for the program for the next three years

1-6 The program must be a recognized entity within the institution’s administrative structure which supports the attainment of program goals.

**Intent:** The position of the program in the institution’s administrative structure should permit direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program. The administration of the program should include formal provisions for program planning, staffing, management, coordination and evaluation.

**Examples of evidence to demonstrate compliance may include:**
- institutional organizational flow chart
- short and long-range strategic planning documents
- examples of program and institution interaction to meet program goals
- dental therapy representation on key college or university committees
1-7 Programs **must** be sponsored by institutions of higher education that are accredited by an institutional accrediting agency (i.e., a regional or appropriate* national accrediting agency) recognized by the United States Department of Education for offering college-level programs.

* Agencies whose mission includes the accreditation of institutions offering allied health education programs.

1-8 All arrangements with co-sponsoring or affiliated institutions **must** be formalized by means of written agreements which clearly define the roles and responsibilities of each institution involved.

**Examples of evidence to demonstrate compliance may include:**
- affiliation agreement(s)

1-9 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.)

1-10 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

1-11 The program **must** show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems.
There must be an active liaison mechanism between the program and the dental and allied dental professions in the community.

**Intent:** The purpose of an active liaison mechanism is to provide a mutual exchange of information for improving the program, recruiting qualified students and meeting employment needs of the community. The responsibilities of the advisory body should be defined in writing and the program director, faculty, and appropriate institution personnel should participate in the meetings as non-voting members to receive advice and assistance.

**Examples of evidence to demonstrate compliance may include:**
- policies and procedures regarding the liaison mechanism outlining responsibilities, appointments, terms and meetings
- membership list with equitable representation if the group represents more than one discipline
- criteria for the selection of advisory committee members
- an ongoing record of committee or group minutes, deliberations and activities
STANDARD 2-EDUCATIONAL PROGRAM

The dental therapist is a member of the oral healthcare team. The curriculum for dental therapy programs will support the overall education, training and assessment to a level of competency within the scope of dental therapy practice.

2-1 The curriculum **must** include at least three academic years of full-time instruction or its equivalent at the postsecondary college-level.

**Intent:** *The scope and depth of the curriculum should reflect the objectives and philosophy of higher education. The time necessary for psychomotor skill development and the number of required content areas require three academic years of study and is considered the minimum preparation for a dental therapist. This could include documentation of advanced standing. However, the curriculum may be structured to provide opportunity for students who require more time to extend the length of their instructional program.*

Examples of evidence to demonstrate compliance may include:
- copies of articulation agreements
- curriculum documents
- course evaluation forms and summaries
- records of competency examinations
- college catalog outlining course titles and descriptions
- documentation of advanced standing requirements

2-2 The stated goals of the 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 dental therapy.

2-3 The program **must** have a curriculum management plan that ensures:
   a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;
   b. evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;
   c. elimination of unwarranted repetition, outdated material, and unnecessary material;
   d. incorporation of emerging information and achievement of appropriate sequencing.
The dental therapy education program must employ student evaluation methods that measure its defined competencies and are written and communicated to the enrolled students.

**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 evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills but also assess the process and procedures which will be necessary for entry level practice.

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

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

**Intent:** The program should identify the dental therapy fundamental knowledge and competencies that will be included in the curriculum based on the program goals, resources, current dental therapy practice responsibilities and other influencing factors. Individual course documentation needs to be periodically reviewed and revised to accurately reflect instruction being provided as well as new concepts and techniques taught in the program.

Academic standards and institutional due process policies and procedures must be provided in written form to the students and followed for remediation or dismissal.

**Intent:** If a student does not meet evaluation criteria, provision should be made for remediation or dismissal. On the basis of designated criteria, both students and faculty can periodically assess progress in relation to the stated goals and objectives of the program.
Examples of evidence to demonstrate compliance may include:
- written remediation policy and procedures
- records of attrition/retention rates related to academic performance
- institutional due process policies and procedures

2-8 Graduates **must** demonstrate the ability to self-assess, including the development of professional competencies related to their scope of practice 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 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

2-9 Graduates **must** be competent in the use of critical thinking and problem-solving, related to the scope of dental therapy practice including their use in the care of patients and knowledge of when to consult a dentist or other members of the healthcare team.

**Intent:** *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

Curriculum

2-10 The curriculum must include content that is integrated with sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum’s defined competencies in the following three areas: general education, biomedical sciences, and dental sciences (didactic and clinical).

Intent: Foundational knowledge should be established early in the dental therapy program and be of appropriate scope and depth to prepare the student to achieve competence in defined components of dental therapy practice. Content identified in each subject may not necessarily constitute a separate course, but the subject areas are included within the curriculum.

Curriculum content and learning experiences should provide the foundation for continued formal education and professional growth with a minimal loss of time and duplication of learning experiences. General education, social science, and biomedical science courses included in the curriculum should be taught at the postsecondary level.

Programs and their sponsoring institutions are encouraged to provide for educational mobility of students through articulation arrangements and career laddering (e.g. between dental therapy education programs and dental hygiene or dental assisting education programs) that results in advanced standing permitted for dental hygienists or dental assistants.

2-11 General education content must include oral and written communications, psychology, and sociology.

Intent: These subjects provide prerequisite background for components of the curriculum, which prepare the students to communicate effectively, assume responsibility for individual oral health counseling, and participate in community health programs.

2-12 Biomedical science instruction in dental therapy education must ensure an understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems in each of the following areas:

a. head and neck and oral anatomy
b. oral embryology and histology
c. physiology
d. chemistry  
e. biochemistry  
f. microbiology  
g. immunology  
h. general pathology and/or pathophysiology  
i. nutrition  
j. pharmacology  

**Intent:** These subjects provide background for both didactic and clinical dental sciences. The subjects are to be of the scope and depth comparable to college transferable liberal arts course work. The program should ensure that biomedical science instruction serves as a foundation for student analysis and synthesis of the interrelationships of the body systems when making decisions regarding oral health services within the context of total body health. The biomedical knowledge base emphasizes the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

Dental therapists need to recognize abnormal conditions to understand the parameters of dental therapy care. The program should ensure that graduates have the level of understanding that assures that the health status of the patient will not be compromised by the dental therapy interventions.

**2-13** Didactic dental sciences content **must** ensure an understanding of basic dental principles, consisting of a core of information in each of the following areas within the scope of dental therapy:

a. tooth morphology  
b. oral pathology  
c. oral medicine  
d. radiology  
e. periodontology  
f. cariology  
g. atraumatic restorative treatment (ART)  
h. operative dentistry  
i. pain management  
j. dental materials  
k. dental disease etiology and epidemiology  
l. preventive counseling and health promotion  
m. patient management  
n. pediatric dentistry  
o. geriatric dentistry  
p. medical and dental emergencies  
q. oral surgery  
r. prosthodontics  
s. infection and hazard control management, including provision of oral health care services to patients with bloodborne infectious diseases.
**Intent:** These subjects provide the student with knowledge of oral health and its consequences as a basis for assuming responsibility for implementing preventive and therapeutic services. Teaching methodologies should be utilized to assure that the student can assume responsibility for the assimilation of knowledge requiring judgment, decision making skills and critical analysis.

**2-14** Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

**Intent:** Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:
- basic principles of culturally competent health care;
- basic principles of health literacy and effective communication for all patient populations;
- recognition of health care disparities and the development of solutions;
- the importance of meeting the health care needs of dentally underserved populations, and;
- the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.

Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).

**Examples of evidence to demonstrate compliance may include:**
- student projects demonstrating the ability to communicate effectively with a variety of individuals and groups.
- examples of individual and community-based oral health projects implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance
2-15 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 participate in the coordination of patient care within the health care system relevant to dentistry.

**Ethics and Professionalism**

2-16 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.

2-17 Graduates must be competent in applying legal and regulatory concepts to the provision and/or support of oral health care services.

**Intent:** Dental therapists should understand the laws which govern the practice of the dental profession. Graduates should know how to access licensure requirements, rules and regulations, and state practice acts for guidance in judgment and action.

**Examples of evidence to demonstrate compliance may include:**
- evaluation mechanisms designed to monitor knowledge and performance concerning legal and regulatory concepts
- outcomes assessment mechanisms

**Clinical Sciences**

2-18 Graduates must be able to access, critically appraise, apply, and communicate information as it relates to providing evidence-based patient care within the scope of dental therapy practice.
Intent: The education program should introduce students to the basic principles of research and its application for patients.

2-19 The program must ensure the availability of adequate patient experiences that afford all students the opportunity to achieve its stated competencies within a reasonable time.

Intent: Sufficient practice time and learning experiences should be provided during preclinical and clinical courses to ensure that students attain clinical competence. Recognizing that there is a single standard of dental care, the care experiences provided for patients by students should be adequate to ensure competency in all components of dental therapy.

Examples of evidence to demonstrate compliance may include:
- program clinical experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation system policy and procedures demonstrating student competencies
- clinic schedules for each term

2-20 Graduates must be competent in providing oral health care within the scope of dental therapy to patients in all stages of life.

The dental therapist provides care with supervision at a level specified by the state dental practice act. The curriculum for dental therapy programs will support the following competencies within the scope of dental therapy practice.

2-21 At a minimum, graduates must be competent in providing oral health care within the scope of dental therapy practice with supervision as defined by the state practice acts, including:

a. identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals
b. comprehensive charting of the oral cavity
c. oral health instruction and disease prevention education, including nutritional counseling and dietary analysis
d. exposing radiographic images
e. dental prophylaxis including sub-gingival scaling and/or polishing procedures
f. dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider

g. applying topical preventive or prophylactic agents (i.e. fluoride), including fluoride varnish, antimicrobial agents, and pit and fissure sealants

h. pulp vitality testing

i. applying desensitizing medication or resin

j. fabricating athletic mouthguards

k. changing periodontal dressings

l. administering local anesthetic

m. simple extraction of erupted primary teeth

n. emergency palliative treatment of dental pain limited to the procedures in this section

o. preparation and placement of direct restoration in primary and permanent teeth

p. fabrication and placement of single-tooth temporary crowns

q. preparation and placement of preformed crowns on primary teeth

r. indirect and direct pulp capping on permanent teeth

s. indirect pulp capping on primary teeth

t. suture removal

u. minor adjustments and repairs on removable prostheses

v. removal of space maintainers

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 dental therapy 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 dental therapy responsibilities and other influencing factors. Programs should define overall competency, in order to measure the graduate’s readiness to enter the practice of dental therapy.

Additional Dental Therapy Functions

2-22 Where graduates of a CODA-accredited dental therapy program are authorized to perform additional functions defined by the program’s state-specific dental board or regulatory agency, program curriculum must include content at the level, depth, and scope required by the state. Further, curriculum content must include didactic and laboratory/preclinical/clinical objectives for the additional dental therapy skills and functions. Students must demonstrate laboratory/preclinical/clinical competence in performing these skills.

Intent: Functions allowed by the state dental board or regulatory agency for dental therapists are taught and evaluated at the depth and scope required by the state. The DTEP Standards
inclusion of additional functions cannot compromise the scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.

2-23 Dental therapy program learning experiences must be defined by the program goals and objectives.

2-24 Dental therapy education programs must have students engage in service learning experiences and/or community-based learning experiences.

**Intent:** Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.
STANDARD 3- FACULTY AND STAFF

3-1 The program director must have a full-time administrative appointment as defined by the institution and have primary responsibility for operation, supervision, evaluation and revision of the Dental Therapy educational program.

**Intent:** To allow sufficient time to fulfill administrative responsibilities, teaching contact hours should be limited for the program director and should not take precedent over administrative responsibilities.

3-2 The program director must be a licensed dentist (DDS/DMD) or a licensed dental therapist possessing a master’s or higher degree. The director must be a graduate of a program accredited by the Commission on Dental Accreditation and who has background in education and the professional experience necessary to understand and fulfill the program’s mission and goals.

**Intent:** The program director’s background should include administrative experience, instructional experience, and professional experience in general dentistry. The term of interim/acting program director should not exceed a two year period.

**Examples of evidence to demonstrate compliance may include:**
- bio sketch of program director.

3-3 The program director must have the authority and responsibility necessary to fulfill program goals including:

a) curriculum development, evaluation and revision;
b) faculty recruitment, assignments and supervision;
c) input into faculty evaluation;
d) initiation of program or department in-service and faculty development;
e) assessing, planning and operating program facilities;
f) input into budget preparation and fiscal administration;
g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.

**Examples of evidence to demonstrate compliance may include:**
- program director position description

3-4 The number and distribution of faculty and staff must be sufficient to meet the program’s stated purpose/mission, goals and objectives, at all sites where required educational activity occurs.

**Intent:** Student contact loads should allow the faculty sufficient time for class preparation, student evaluation and counseling, development of subject content and
appropriate evaluation criteria and methods, program development and review, and professional development.

Examples of evidence to demonstrate compliance may include:
- faculty schedules including student contact loads and supplemental responsibilities

3-5 The faculty to student ratio for preclinical, clinical and radiographic clinical and laboratory sessions **must** not exceed one to six. The faculty to student ratio for laboratory sessions in the dental science courses **must** not exceed one to ten to ensure the development of clinical competence and maximum protection of the patient, faculty and students.

**Intent:** *The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and supervised patient care clinics rather than by the total number of full-time equivalent positions for the program. The faculty to student ratios in clinical and radiographic practice should allow for individualized instruction and assessment of students’ progression toward competency. Faculty are also responsible for ensuring that the patient care services delivered by students meet the program’s standard of care.*

Examples of evidence to demonstrate compliance may include:
- faculty teaching commitments
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-6 All faculty of a dental therapy program **must** be educationally qualified for the specific subjects they are teaching.

**Intent:** *Faculty should have current background in education theory and practice, concepts relative to the specific subjects they are teaching, clinical practice experience and, if applicable, distance education techniques and delivery. Dentists, dental therapists, dental hygienists, and expanded function dental assistants who supervise students’ clinical procedures should have qualifications which comply with the state dental practice act. Individuals who teach and supervise students in clinical experiences should have qualifications comparable to faculty who teach in the main program clinic and are familiar with the program’s objectives, content, instructional methods and evaluation procedures.*

Examples of evidence to demonstrate compliance may include:
- faculty curriculum vitae
The program must show evidence of an ongoing faculty development process.

**Intent:** Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession. Effective teaching requires not only content knowledge, but an understanding of pedagogy, including knowledge of curriculum design and development, curriculum evaluation, and teaching methodologies.

**Examples of evidence to demonstrate compliance may include:**
- evidence of participation in workshops, in-service training, self-study courses, on-line and credited courses
- attendance at regional and national meetings that address education
- mentored experiences for new faculty
- scholarly productivity
- maintenance of existing and development of new and/or emerging clinical skills
- records of calibration of faculty

The faculty, as appropriate to meet the program’s purpose/mission, goals and objectives, must engage in scholarly activity.

Faculty must be ensured a form of governance that allows participation in the school’s decision-making processes.

A defined faculty evaluation process must exist that ensures objective measurement of the performance of each faculty member.

**Intent:** An objective evaluation system including student, administration and peer evaluation can identify strengths and weaknesses for each faculty member (to include those at distance sites) including the program administrator. The results of evaluations should be communicated to faculty members on a regular basis to ensure continued improvement.

**Examples of evidence to demonstrate compliance may include:**
- sample evaluation mechanisms addressing teaching, patient care, research, scholarship and service
- faculty evaluation policy, procedures and mechanisms

The dental therapy program faculty must be granted privileges and responsibilities as afforded all other comparable institutional faculty.

**Examples of evidence to demonstrate compliance may include:**
- institution’s promotion/tenure policy
Qualified institutional support personnel **must** be assigned to the program to support both the instructional program and the clinical facilities providing a safe environment for the provision of instruction and patient care.

**Intent:** Maintenance and custodial staff should be sufficient to meet the unique needs of the academic and clinical program facilities. Faculty should have access to instructional specialists, such as those in the areas of curriculum, testing, counseling, computer usage, instructional resources and educational psychology. Secretarial and clerical staff should be assigned to assist the administrator and faculty in preparing course materials, correspondence, maintaining student records, and providing supportive services for student recruitment and admissions activities. Support staff should be assigned to assist with the operation of the clinic facility including the management of appointments, records, billing, insurance, inventory, hazardous waste, and infection control.

**Examples of evidence to demonstrate compliance may include:**
- description of current program support/personnel staffing
- program staffing schedules
- staff job descriptions
- examples of how support staff are used to support students
STANDARD 4-EDUCATIONAL SUPPORT SERVICES

Admissions

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

**Intent:** The dental therapy education curriculum is a postsecondary scientifically-oriented program which is rigorous and intensive. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability should be utilized as criteria in selecting students who have the potential for successfully completing the program. Applicants should be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental therapists.

Because enrollment is limited by facility capacity, special program admissions criteria and procedures are necessary to ensure that students are selected who have the potential for successfully completing the program. The program administrator and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures which are non-discriminatory and ensure the quality of the program.

**Examples of evidence to demonstrate compliance may include:**
- admissions management policies and procedures
- copies of catalogs, program brochures or other written materials
- established ranking procedures or criteria for selection
- minutes from admissions committee
- periodic analysis supporting the validity of established admission criteria and procedures
- results from institutional research used in interpreting admissions data and criteria and/or correlating data with student performance
- advanced standing policies and procedures, if appropriate

4-2 Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.

**Intent:** Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.
Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program. Advanced standing requirements for career laddering into a dental therapy program must meet advanced standing requirements of the college or university offering advanced standing for dental therapy.

**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/residents will not result in an increase of the program’s approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for 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.

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.

**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

The number of students enrolled in the program must be proportionate to the resources available.

**Intent:** In determining the number of dental therapy students enrolled in a program (inclusive of distance sites), careful consideration should be given to ensure that the number of students does not exceed the program’s resources, including patient supply, financial support, scheduling options, facilities, equipment, technology and faculty.

**Examples of evidence to demonstrate compliance may include:**
- sufficient number of clinical and laboratory stations based on enrollment
- clinical schedules demonstrating equitable and sufficient clinical unit assignments
- clinical schedules demonstrating equitable and sufficient radiology unit assignments
- faculty full-time equivalent (FTE) positions relative to enrollment
- budget resources and strategic plan
- equipment maintenance and replacement plan
- patient pool availability analysis
- course schedules for all terms

Facilities and Resources

4-6 The program must provide adequate and appropriately maintained facilities and learning resources to support the purpose/mission of the program and which are in conformance with applicable regulations.

Intent: The classroom facilities should include an appropriate number of student stations with equipment and space for individual student performance in a safe environment.

4-7 The clinical facilities must include the following:

a) sufficient clinical facility with clinical stations for students including conveniently located hand washing sinks and view boxes and/or computer monitors; functional, equipment; an area that accommodates a full range of operator movement and opportunity for proper instructor supervision;

b) a capacity of the clinic that accommodates individual student practice on a regularly scheduled basis throughout all phases of preclinical technique and clinical instruction;

c) a sterilizing area that includes sufficient space for preparing, sterilizing and storing instruments;

d) sterilizing equipment and personal protective equipment/supplies that follow current infection and hazard control protocol;

e) facilities and materials for students, faculty and staff that provide compliance with accepted infection and hazard control protocols;

f) patient records kept in an area assuring safety and confidentiality.

Intent: The facilities should permit the attainment of program goals and objectives. To ensure health and safety for patients, students, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule. This Standard applies to all sites where students receive clinical instruction.
Radiography facilities must be sufficient for development of clinical competence and contain the following:

a) an appropriate number of radiography exposure rooms which include: dental radiography units; teaching manikin(s); and conveniently located hand-washing sinks;
b) processing and/or imaging equipment;
c) an area for viewing radiographs;
d) documentation of compliance with applicable local, state and federal regulations.

Intent: The radiography facilities should allow the attainment of program goals and objectives. Radiography facilities and equipment should effectively accommodate the clinic and/or laboratory schedules, the number of students, faculty and staff, and comply with applicable regulations to ensure effective instruction in a safe environment. This Standard applies to all sites where students receive clinical instruction.

A multipurpose laboratory facility must be provided for effective instruction and allow for required laboratory activities and contain the following:

a) placement and location of equipment that is conducive to efficient and safe utilization;
b) student stations that are designed and equipped for students to work while seated including sufficient ventilation and lighting, necessary utilities, storage space, and an adjustable chair;
c) documentation of compliance with applicable local, state and federal regulations.

Intent: The laboratory facilities should include student stations with equipment and space for individual student performance of laboratory procedures with instructor supervision. This Standard applies to all sites where students receive clinical instruction.

Office space which allows for privacy must be provided for the program administrator and faculty

Intent: Office space for full- and part-time faculty should be allocated to allow for class preparation, student counseling and supportive academic activities. Student and program records should be stored to ensure confidentiality and safety.

Instructional aids, equipment, and library holdings must be provided for student learning.

Intent: The acquisition of knowledge, skills and values for students requires the use of current instructional methods and materials to support learning needs and development. All students, including those receiving education at distance sites, should be assured access to learning resources. Institutional library holdings should include or provide
access to a diversified collection of current dental and medical literature and references necessary to support teaching, student learning needs, service, research and development. There should be a mechanism for program faculty to periodically review, acquire and select current titles and instructional aids.

Examples of evidence to demonstrate compliance may include:
- a list of references on education, medicine, dentistry, dental therapy, dental hygiene, dental assisting and the biomedical sciences
- policies and procedures related to learning resource access
- timely electronic access to a wide variety of professional scientific literature
- skeletal and anatomic models and replicas, sequential samples of laboratory procedures, slides, films, video, and other media which depict current techniques
- a wide range of printed materials and instructional aids and equipment available for utilization by students and faculty
- current and back issues of major scientific and professional journals related to medicine, dentistry, dental therapy, dental hygiene, dental assisting and the biomedical sciences

Student Services

4-12 Student services must include the following:

a. personal, academic and career counseling of students;
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; and
f. maintenance of the integrity of student performance and evaluation records.

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.
Student Financial Aid

4-13 At the time of acceptance, students must be advised of the total expected cost of their education and opportunities for employment.

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

4-14 The institution must be in compliance with all federal and state regulations relating to student financial aid and student privacy.

Health Services

4-15 The dental therapy program must advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental therapy studies.

4-16 There must be a mechanism for ready access to health care for students while they are enrolled in dental therapy school.

4-17 Students must be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.

**Intent:** All individuals who provide patient care or have contact with patients should follow all standards of risk management thus ensuring a safe and healthy environment.

**Examples of evidence to demonstrate compliance may include:**
- policies and procedures regarding infectious disease immunizations
- immunization compliance records
- declinations forms
STANDARD 5 – HEALTH, SAFETY, AND PATIENT CARE PROVISIONS

5-1 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 standard of care.

**Intent:** All radiographic exposure should be integrated with clinical patient care procedures.

5-2 Written policies and procedures must establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste.

**Intent:** Policies and procedures should be in place to provide for a safe environment for students, patients, faculty and staff.

5-3 The school’s policies and procedures must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

5-4 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 healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED), and be able to manage common medical emergencies.

**Examples of evidence to demonstrate compliance may include:**
- accessible and functional emergency equipment, including oxygen
- instructional materials
- written protocol and procedures
- emergency kit(s)
- installed and functional safety devices and equipment
- first aid kit accessible for use in managing clinic and/or laboratory accidents
5-5 The program must conduct a formal system of continuous quality improvement for the patient care program 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: Programs should create and maintain databases for monitoring and improving patient care and serving as a resource for research and evidence-based practice.

5-6 The program must have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs and the scope of dental therapy care available at the dental therapy facilities.

Intent: All patients should receive appropriate care that assures their rights as a patient are protected. Patients should be advised of their treatment needs and the scope of care available at the training facility and appropriately referred for procedures that cannot be provided by the program. This Standard applies to all program sites where clinical education is provided.

Examples of evidence to demonstrate compliance may include:
- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided
- quality assurance policy and procedures
- patient bill of rights

5-7 The program must develop and distribute a written statement of patients’ rights and commitment to patient-centered care to all patients, appropriate students, faculty, and staff.

Intent: The primacy of care for the patient should be well established in the management of the program and clinical facility assuring that the rights of the patient are protected. A written statement of patient rights should include:

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

5-8 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of patient care.

**Intent:** The need for students to satisfactorily complete specific clinical requirements prior to advancement and graduation should not adversely affect the health and care of patients.

**Examples of evidence to demonstrate compliance may include:**
- patient bill of rights
- documentation that patients are informed of their rights
- continuing care (recall) referral policies and procedures

5-9 Patient care must be evidenced-based, integrating the best research evidence and patient values.

**Intent:** The program should use evidence to evaluate new technology and products and to guide treatment decisions.

5-10 The program must ensure that active patients have access to professional services at all times for the management of dental emergencies.
June 22, 2021

Dr. Jeffery Hicks
Chair
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois  60611

Dear Doctor Hicks:

Over the past year, the ADA Council on Dental Education and Licensure has studied ADA House of Delegates Resolution 100H-2020 Special Needs Dentistry, part of which calls for the Council to address actionable strategies to strengthen training in treating patients with special needs at the predoctoral and advanced dental education levels.

In considering the resolution, the Council conducted a survey of the appropriate communities of interest to gather data on the current state of special needs dentistry education. The Council then considered the survey results and strategies that could be considered for enhancing pre-doctoral and advanced dental training via the Accreditation Standards for Dental Education Programs and Accreditation Standards for Advanced Dental Education Programs.

The Council reviewed and supported recently adopted Standard 2-25 of the Accreditation Standards for Dental Education Programs concluding that the Standard appropriately addresses the scope and depth of predoctoral dental education related to special needs dentistry. However, the Council believed that the intent statement which complements Standard 2-25 could be strengthened to ensure consistent interpretation and application of the standard by dental education faculty and accreditation site visitors. Accordingly, the Council urges CODA to consider revision of the Standard 2-25 intent statement to provide further clarification and additional guidance to programs and accreditation site visitors.

The Council also reviewed the Accreditation Standards for Advanced Dental Education Programs in General Dentistry, General Practice Residency, Dental Anesthesiology, Pediatric Dentistry, Periodontics, Orthodontics and Dentofacial Orthopedics, Orofacial Pain, and Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics which call for students to receive training in managing and/or treating patients with special needs. The Council noted that depending on the document, residents may be required to achieve competency in assessing, diagnosing, and planning and/or managing and/or providing, and/or examining and/or treating patients with special needs and/or disabilities. In reviewing these standards, the Council concluded that although the standards in the relevant advanced dental education programs address special needs dentistry education, the Commission should consider further strengthening the standards to require all graduates to be competent in treating patients with special needs. Accordingly, the Council urges the Commission to consider further revision of these Accreditation Standards to require graduates to be competent in treating patients with special needs and to strengthen the standards in other areas such as curriculum, resident evaluation, facilities and patient care to better support the special needs patient population.
The Council will be transmitting its response to Resolution 100H-2020 to the 2021 House of Delegates. The report will note this request to the Commission to amend the Accreditation Standards for Dental Education Programs and Advanced Dental Education Programs as noted above.

On behalf of the Council, I thank you for the opportunity to comment on this important matter.

Sincerely,

Jacqueline Plemons, DDS, MS
Chair
Council on Dental Education and Licensure

JP:ap

cc: Dr. Anthony J. Ziebert, senior vice-president, Education and Professional Affairs
    Dr. Sherin Tookes, director, Commission on Dental Accreditation
    Ms. Karen M. Hart, director, Council on Dental Education and Licensure
CONSIDERATION OF PROPOSED REVISION TO THE ACCREDITATION
STANDARDS FOR DENTAL EDUCATION PROGRAMS RELATED TO
PATIENTS WITH SPECIAL NEEDS

Background: On December 7, 2021, the Commission on Dental Accreditation (CODA) received a request from Dr. Amid Ismail, dean, Temple University The Maurice H. Kornberg School of Dentistry to consider a proposed revision to Standard 2-25 of the Accreditation Standards for Dental Education Programs. The request is found in Appendix 1.

Dr. Ismail believes that Standard 2-25 of the Dental Education Standards should be revised to change the term “special needs” to the term “disabled patients.”

Summary: The Predoctoral Dental Education Review Committee and Commission are requested to consider the proposed revision to Standard 2-25 (Appendix 1) submitted by Dr. Amid Ismail. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks
Sherin

I propose changing the term “special needs” in Standard 2-25 to “disabled patients”.

Amid

Rationale:

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**Reasons to Say Disability instead of Special Needs**

1. Disabled is not a dirty word. Why are we avoiding using the word disabled? Calling my son anything else does not make him any less disabled. To take another quote from the blog post I mentioned earlier: *Disability. It’s a word used with pride. A word reclaimed. Part of an identity. A community. In itself, it’s not a negative or a positive necessarily in terms of describing the person or experience, but something which combines with everything*
else to make you, YOU. It’s part of you and that part is important. I suggest you read the entire essay “We can’t keep using special needs” – we need to listen to disability advocates now.”

2. Disability is a normal part of human diversity. Somewhere around 15-20% of the human population is disabled. Like other forms of diversity, the presence of disability in the world enriches humanity in ways that we probably can’t even imagine. Being disabled is not something to be ashamed of, and it’s not something to be scared of; it’s just a fact of life. Great thoughts from Erin Human.

Most experts and advocates vehemently oppose the term "special needs," and believe we need to
eliminate it from our vernacular. Furthermore, they say avoiding the term "disabled" only leads to stigmatization.

For some, the term "special needs" feels offensive.

"I am disabled by society due to my impairment," says Lisette Torres-Gerald, board secretary for the National Coalition for Latinx with Disabilities. "My needs are not 'special;' they are the same, human needs that everyone else has, and I should be able to fully participate in society just as much as the next person."

It can also be counterproductive.

Researchers from a 2016 study found people who are referred to as having "special needs" are seen more negatively than those referred to as having a disability.

**Reasons to Say Disability instead of Special Needs**

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any less disabled. To take another quote from the blog post I mentioned earlier: *Disability. It’s a word used with pride. A word reclaimed. Part of an identity. A community. In itself, it’s not a negative or a positive necessarily in terms of describing the person or experience, but something which combines with everything else to make you, YOU. It’s part of you and that part is important.* I suggest you read the entire essay *“We can’t keep using “special needs” – we need to listen to disability advocates now.”*

2. **Disability is a normal part of human diversity.** Somewhere around 15-20% of the human population is disabled. Like other forms of diversity, the presence of disability in the world enriches humanity in ways that we probably can’t even imagine. Being disabled is not something to be ashamed of, and it’s not something to be scared of; it's just a fact of life. Great thoughts from Erin Human.
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REPORT OF THE STANDING COMMITTEE ON INTERNATIONAL ACCREDITATION

**Background**: The Standing Committee on International Accreditation (Predoctoral only) has the following charge:

- Provide international consultation fee-based services to international predoctoral dental education programs, upon request.
- Develop and implement international consultation policies and procedures to support the international consultation program.
- Monitor and make recommendations to the Commission regarding changes that may affect its operations related to international issues.


The following members were present for the July 28, 2021 meeting: Dr. Terry Fiddler (ADA, Chair), Dr. Bryan Edgar (ADA), Dr. Carol Anne Murdoch-Kinch (CODA), Dr. Perry Tuneberg (ADA), and Dr. Lawrence Wolinsky (CODA). Dr. Stephen Young, Standing Committee on International Accreditation Consultant was unable to attend. **Ex-Officio Members**: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation. **CODA Commissioner**: Dr. Bruce Rotter, vice chair, Commission on Dental Accreditation. **CODA Staff**: Dr. Sherin Tooks, director, CODA, and Ms. Dawn Herman, manager, Predoctoral Dental Education, CODA. **ADA Staff**: Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, ADA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, as available.

The following members were present for the August 11, 2021 meeting: Dr. Terry Fiddler (ADA, Chair), Dr. Bryan Edgar (ADA), Dr. Carol Anne Murdoch-Kinch (CODA), Dr. Perry Tuneberg (ADA), and Dr. Lawrence Wolinsky (CODA). Dr. Stephen Young, Standing Committee on International Accreditation Consultant was unable to attend. **Ex-Officio Members**: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation. **CODA Staff**: Dr. Sherin Tooks, director, CODA, and Ms. Dawn Herman, manager, Predoctoral Dental Education, CODA. **ADA Staff**: Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, as available.

The Standing Committee considered the following program during its July 28, 2021 meeting:

- Instituto Tecnológico y de Estudios Superiores de Monterrey, Monterrey, Nuevo Leon, Mexico (PACV Survey)

The Standing Committee considered the following program during its August 11, 2021 meeting:

- The Hebrew University of Jerusalem, Jerusalem, Israel (Response to PACV Site Visit Report)
Standing Committee Action: The Standing Committee on International Accreditation directed that formal letters be sent to the programs reviewed at each meeting, as applicable, in accordance with the actions taken by the Committee.

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

Prepared by: Dr. Sherin Tooks