Winter 2022 CODA Meeting

**Agenda Book 1:** Background Materials

**Book 1 Contains:**
- CODA Open Session Agenda with Bookmarks
- All Discipline Specific and p. 1800 Policy Reports
  Considered by Review Committees
Call to Order:  Friday, February 11, 2022
10:00 a.m., Open Session

Dr. Bruce Rotter, presiding

I.  Roll Call:  Dr. Evanthia Anadioti, Dr. Victor Badner, Dr. Keith Beasley, Dr. Joel Berg, Dr. Carolyn Brown, Dr. Linda Casser, Dr. Gary Heir (substitute for Dr. Joseph Cohen), Dr. Scott DeRossi, Dr. Scott DeVito, Dr. Maxine Feinberg, Mr. Marco Gargano, Dr. Joseph Giovannitti, Dr. Kevin Haubrick, Dr. John Hellstein, Dr. Amid Ismail, Dr. Susan Kass, Dr. James Katancik, Dr. Barbara Krieg-Menning, Dr. George Kushner, Dr. Brent Larson, Dr. Frank Licari, Dr. Sanjay Mallya (vice chair), Ms. Martha McCaslin, Dr. Carol Anne Murdoch-Kinch, Dr. Garry Myers, Dr. Miriam Robbins, Dr. Nancy Rosenthal, Dr. Bruce Rotter (chair), Dr. Timmothy Schwartz, Dr. Marybeth Shaffer, Dr. Alan Stein, Ms. Lonni Thompson, and Dr. Marshall Titus.

Commission Staff: Dr. Sherin Tooks, ex-officio (director), Ms. Jamie Asher Hernandez, Ms. Kirsten Nadler, Ms. Jennifer Snow, Ms. Peggy Soeldner, and Ms. Marjorie Hooper. Ms. Cathryn Albrecht, senior associate general counsel, CODA.

Trustee Liaison: Dr. James Stephens, Thirteenth District Trustee, Board of Trustees Liaison to CODA, American Dental Association (ADA).

II.  Adoption of the Agenda

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

IV.  Approve Minutes from Summer 2021 Meeting

V.  Mail Ballots Approved Since Last Commission Meeting
   •  Nomination Committee Ballot Closed, 10/15/2021

VI.  Consent Agenda

VII.  Report of the Review Committee on Predoctoral Dental Education: Dr. Bruce Rotter, Chair, Dr. William Akey, Dr. Charles Berry, Mr. Drew Christianson, Dr. Chester Evans, Dr. Susan Long, Dr. Ana Karina Mascarenhas, Dr. Thomas McConnell, and Dr. Linda Wells.
   A.  Report of the Ad Hoc Committee to Review Accreditation Standards for Dental and Dental Therapy Education Programs (p. 100)
   B.  Consideration of Proposed Revision to the Accreditation Standards for Dental Education Programs Related to Patients with Special Needs (p. 101)
   C.  Report of the Standing Committee on International Accreditation (p. 102)

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VIII. **Report of the Review Committee on Postdoctoral General Dentistry Education:** Dr. Miriam Robbins, Chair, Dr. Gary Fischer, Dr. Neal Henning, Dr. Yasser Khaled, Dr. Sally Placa, Dr. Frank Romano, Dr. Eric Sung, Mr. Glenn Unser, and Dr. Michelle Ziegler.

A. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice Residency Related to Patients with Special Needs (p. 200)

B. Report on Advanced Education in General Dentistry and General Practice Residency Annual Survey Curriculum Section (p. 201)

C. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice Residency (p. 202)

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IX. **Report of the Review Committee on Dental Assisting Education:** Ms. Martha McCaslin, Chair, Ms. Julie Bera, Ms. Kimberly Bland, Ms. Margaret Bowman-Pensel, Ms. Dorothea Cavallucci, Ms. Nichole Finnegan, Ms. Kori Preble-Boeckler, Ms. Christy Ross, Dr. Preeti Sahasi, and Dr. Debra Schneider.

A. Informational Report on Dental Assisting Programs Annual Survey Curriculum Data (p.300)

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X. **Report of the Review Committee on Dental Hygiene Education:** Dr. Susan Kass, Chair, Ms. Tami Grzesikowski, Ms. Carrie Hobbs, Dr. Lorie Holt, Dr. Tariq Javed, Ms. Betty Kabel, Dr. Barbara Krieg-Menning, Dr. Nancy Rosenthal, Ms. Laura Scully, Dr. Suzanne Thomas, and Dr. Sheila Vandenbush.

A. Informational Report on Dental Hygiene Programs Annual Survey Curriculum Data (p.400)

B. Consideration of Proposed Revisions to the Accreditation Standards for Dental Hygiene Education Programs Related to Standards 2-14 and 3-7 (p.401)

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

A. Report on Dental Public Health Programs Annual Survey Curriculum Section (p. 600)

B. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Advanced Dental Education Programs in Dental Public Health (p. 601)
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XII. Report of the Review Committee on Oral and Maxillofacial Surgery Education: Dr. George Kushner, Chair, Dr. Vasiliki Karlis, Dr. Pushkar Mehra, Dr. Faisal Quereshy, Dr. Phillip Rinaudo, and Ms. Cindy Stergar.

A. Report on Oral and Maxillofacial Surgery Programs (Residency and Fellowship) Annual Survey Curriculum Sections (p. 1000)

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Review Committee Minutes and New Business

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

A. Informational Report on Orthodontics and Dentofacial Orthopedics Programs (Residency and Fellowship) Annual Survey Curriculum Sections (p.1100)
B. Consideration of Proposed Revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (p. 1101)

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XIV. Report of the Review Committee on Pediatric Dentistry Education: Dr. Joel Berg, Chair, Dr. James Boynton, Dr. Kevin Haubrick, Dr. Tad Mabry, Dr. Joseph Morales, and Dr. Anupama Rao Tate.

A. Report on Pediatric Dentistry Programs Annual Survey Curriculum Section (p. 1200)
B. Report of the Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards (p. 1201)

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XV. Report of the Review Committee on Periodontics Education: Dr. James Katancik, Chair, Dr. Georgía Johnson, Dr. Paul Luepke, Dr. Angela Palaiologou-Gallis, Dr. Vishal Shah, and Dr. Jaqueline Sobota.

A. Informational Report on Periodontics Programs Annual Survey Curriculum Section (p. 1300)
B. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics (p. 1301)
C. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics Related to Patients with Special Needs (p. 1302)
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XVI. **Report of the Review Committee on Prosthodontics Education**: Dr. Evanthis Anadioti, Chair, Dr. Scott DeVito, Dr. David Felton, Dr. Joseph Hagenbruch, Dr. Kent Knoernschild and Dr. Sang Lee.

A. Report on Prosthodontics Programs Annual Survey Curriculum Section (p. 1400)
B. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Advanced Dental Education Programs in Prosthodontics (p. 1401)

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XVII. **Report of the Review Committee on Dental Anesthesiology Education**: Dr. Joseph Giovannitti, Chair, Dr. Gerard Kugel, Dr. Mana Saraghi, Dr. Shashi Unnithan, and Dr. Philip Yen.

A. Progress Report on the 2021 Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 1500)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology Related to Patients with Special Needs (p. 1501)
C. Report on Dental Anesthesiology Annual Survey Curriculum Section (p. 1502)

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XVIII. **Report of the Review Committee on Advanced Education in Oral Medicine Education**: Dr. Scott DeRossi, Chair, Ms. Jennifer Barber Dr. Michael Brennan, Dr. Michael DeBellis, and Dr. Thomas Sollecito.

A. Consideration of Proposed Revision to Standard 3-1 of the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine (p. 1600)
B. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs in Oral Medicine Related to Patients with Special Needs (p. 1601)
C. Report on Oral Medicine Annual Survey Curriculum Section (p. 1602)

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XIX. **Report of the Review Committee on Advanced Education in Orofacial Pain Education**: Dr. Joseph Cohen, Chair, Dr. Reny de Leeuw, Dr. Gary Heir, Dr. Bessie Katsilometes, and Dr. Robert Windsor.

A. Consideration of Proposed Revision to Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain Related to Patients with Special Needs (p. 1700)
B. Report on Orofacial Pain Annual Survey Curriculum Section (p. 1701)
C. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain (p. 1702)
XX. Miscellaneous Affairs – Consideration of Matters Relating to More than One Review Committee

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

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B. Reminder of Professional Conduct Policy and Prohibition Against Harassment (p. 1801) (All Review Committees)  
  Dr. Feinberg

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C. Consideration of Resolutions Adopted by the ADA House of Delegates and the ADA Board of Trustees Related to the Commission on Dental Accreditation and Dental Education (p. 1802) (All Review Committees)  
  Dr. Schwartz

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

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

  Commission Report  
  Dr. Mallya

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

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  Dr. Rotter


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D. Report of the Standing Committee on Communication and Technology (p. 1903)

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E. Report of the Ad Hoc Committee on Alternative Site Visit Methods (p. 1904)
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G. Consideration of a Request to Establish a Process of Accreditation for Advanced Dental Education Programs in Geriatric Dentistry (p. 1906)

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H. Report of the Standing Committee on International Accreditation (p. 1907)

Commission Report

I. Update on USDE and Higher Education Accreditation Issues

J. Survey of Meeting (verbal)

XXII. New Business

XXIII. Adjourn
CONSENT AGENDA

Review Committee Reports:

I. Report of the Review Committee on Dental Laboratory Technology Education: Ms. Lonnie Thompson, Chair, Mr. Gary Gann, Ms. LaShun James, Ms. Sandra Kotowske, and Dr. Arpana Verma.

   A. Informational Report on Dental Laboratory Technology Programs Annual Survey Curriculum Data (p.500)

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II. Report of the Review Committee on Endodontics Education: Dr. Garry Myers, Chair, Dr. Linda Casser, Dr. Gerald Glickman, Dr. Scott McClanahan, Dr. Josanne O’Dell, and Dr. Ankur Patel.

   A. Report on Endodontics Programs Annual Survey Curriculum Section (p. 700)

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III. Report of the Review Committee on Oral and Maxillofacial Pathology Education: Dr. John Hellstein, Chair, Dr. Ashley Clark, Mr. James Hinds, Dr. Kathryn Korff, and Dr. Renee Reich.

   A. Report on Oral and Maxillofacial Pathology Programs Annual Survey Curriculum Section (p. 800)

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IV. Report of the Review Committee on Oral and Maxillofacial Radiology Education: Dr. Sanjay Mallya, Chair, Dr. Boris Bacanurschi, Dr. KC Chan, Dr. Gene Kelber and Dr. Sindhura Anamali Reddy.

   A. Report on Oral and Maxillofacial Radiology Programs Annual Survey Curriculum Section (p. 900)

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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” accreditation 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 phrasing “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
Commission on Dental Accreditation

Accreditation Standards
For Dental Education Programs
Accreditation Standards for Dental Education Programs

Commission on Dental Accreditation
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Document Revision History

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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 Policy on Accreditation of Off-Campus Sites</td>
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<td>Revision to Policy on Complaints (Anonymous)</td>
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<td>Revision to Standard 4-3 and 5-8</td>
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<td>Areas of Oversight at Sites Where Educational Activity Occurs (new Standards 2-6 and 4-6, revisions to Standards 3-1 and 3-2)</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.
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. 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.

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**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.

**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.

**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 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.*
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.

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.)

The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

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

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

2-15 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**

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

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

**Intent:**

*Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:*

- basic principles of culturally competent health care;
- basic principles of health literacy and effective communication for all patient populations
- recognition of health care disparities and the development of solutions;
- the importance of meeting the health care needs of dentally underserved populations, and;
• the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a 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.
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.
STANDARD 5- PATIENT CARE SERVICES

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.
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.*

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

The dental school **must** ensure that active patients have access to professional services at all times for the management of dental emergencies.

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.

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.

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.

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
6-3 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.
Number of Recipients, Number that Opened Survey, Number of Responses, Unadjusted Response Rate and Abandon Rate by Recipient Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Sent Survey</th>
<th>Opened Survey</th>
<th>Number of Responses</th>
<th>Unadj Resp Rate</th>
<th>Abandon Rate</th>
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<tbody>
<tr>
<td>Predoc Site Visitor</td>
<td>109</td>
<td>81</td>
<td>71</td>
<td>65.1%</td>
<td>12.3%</td>
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<tr>
<td>Dental School Dean</td>
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<td>35</td>
<td>29</td>
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<td>Dentist</td>
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<td>180</td>
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<td>6</td>
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<td>Director</td>
<td></td>
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</tr>
<tr>
<td>State Dental Society President</td>
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<td>12</td>
<td>22.6%</td>
<td>14.3%</td>
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<tr>
<td>State Dental Board Executive Director</td>
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<td>9</td>
<td>3</td>
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<td>66.7%</td>
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<tr>
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<tr>
<td>Clinical Testing Agency Executive Director</td>
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<td>1</td>
<td>20.0%</td>
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<tr>
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<td>570</td>
<td>302</td>
<td>5.7%</td>
<td>47.0%</td>
</tr>
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</table>

The Abandon Rate is calculated by subtracting the Number of Responses from the number that Opened Survey, then dividing that result by the number that Opened Survey. It signifies the percentage of survey recipients who accessed the online survey but did not complete it.

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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(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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(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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(ST1-4) 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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(St1-6) 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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(ST1-7) 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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(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**

(ST2-18) 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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</table>
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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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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(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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</tbody>
</table>
(ST3-2) 38. The dental school must show evidence of an ongoing faculty development process.

<table>
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<th>Dentist</th>
<th>Dean</th>
<th>Site Visitor</th>
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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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<td>29</td>
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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.

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

<table>
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</table>
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.

<table>
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<td>29</td>
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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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Appendix 2

Page 41

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

(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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(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.

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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.

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(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; and
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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(ST5-8) 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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Appendix 2

Ad Hoc Committee to Review
Dental and Dental Therapy Standards
Predoctoral Dental Education RC
CODA Winter 2022

(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.

5-If 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” eventhough 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 haphazzard 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.
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 who 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 educationREDACL... 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 many 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).

Dentist – Standard 1 Comments

All the parameters stated are important to develop a well rounded student.

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.

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.

Dental schools remain "behind the times" despite everyone's efforts. It's a simple fact. How do we change that? It's complicated, but it can be done.

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.

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.

I believe all of the above questions are relevant and need to be sufficiently demanding.

I don't necessarily see how Diversity is relevant under Institutional Effectiveness.

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 "type" of person to fit the diversity mix if they aren't adequately qualified.
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 dental school has done it's best to stay a breast and give the necessary education

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).

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<tr>
<th>Dentist, Questions 10-16 (ST2-1 to 2-7)</th>
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<td>&quot;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.&quot; 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.</td>
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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 will 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.
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 students 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 - most students are not interested in scientific methodology and including this is in the standard requires schools to do something that most students do not enjoy. 20 - it is impossible to accurately assess the student on "self-directed, lifelong learning" 23 - too many things to address in one standard.

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
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.

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.
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"

Graduates 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

Graduates 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).
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
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.

*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 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.
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)

<table>
<thead>
<tr>
<th>Question</th>
<th>Note</th>
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<tbody>
<tr>
<td>#20</td>
<td>&quot;Capacity&quot; is a bit confusing. #33 h - Does not track the same at &quot;f, i &amp; j. Tooth replacement does not specify PRDP or PRCP, so it is unclear why &quot;h&quot; specifies fixed bridge AND implant replacement. Should this just read &quot;tooth replacement or prosthodontics&quot;?</td>
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<tr>
<td>33 a-o</td>
<td>This section is irrelevant and should be one statement related to competency in diagnosis, prevention, and treatment.</td>
</tr>
<tr>
<td>34.</td>
<td>Competent in providing limited care 35 Require at least minimal Community-Based experience</td>
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<tr>
<td>34. Managing yes, treating no. Special needs patients often need referral.</td>
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<tr>
<td>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.</td>
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<tr>
<td>In K, language should change to evaluation and managing oral mucosal, temporomandibular and osseous disorders. There are not enough cases that are part of a dental school patient base to provide adequate experiences for students.</td>
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<tr>
<td>In Q33, agree with the parent statement but a. - o. are unnecessary specificity.</td>
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<tr>
<td>Its time to break out temporomandibular disorders and make it its own category with orofacial pain.</td>
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<tr>
<td>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.</td>
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</table>
Site Visitor, Questions 33-35 (ST2-24 to 2-26)

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 multifactorial 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.

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

No comments

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**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. i.e. 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.
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.

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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.
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 feed back 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.

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).*

### 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.

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 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.
<table>
<thead>
<tr>
<th>Dentist, Questions 42-48 (ST4-1 to 4-7)</th>
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<tbody>
<tr>
<td>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.</td>
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<tr>
<td>I love the concept of diversity. I do not believe that a school should lower standards to admit a diverse culture.</td>
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<tr>
<td>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.</td>
</tr>
<tr>
<td>Metrics and definitions to measure diversity within the system, faculty and students should be defined by either the institution or CODA</td>
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<tr>
<td>Not enough financial courses available. Not enough attention to student's concerns.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Patients should be treated by the most qualified individuals.</td>
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<tr>
<td>Predoctoral students must be upheld to the highest responsibility</td>
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<tr>
<td>PROGRAMS ARE OPEN TO ALL THAT MEET THE STANDARDS DIVERSITY SHOULD NOT BE MANDATED</td>
</tr>
<tr>
<td>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 - &quot;providing information&quot; is not sufficient. When I was in dental school - the information provided to me was &quot;the school has no health insurance, you are required to provide your own insurance.&quot; 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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
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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 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
#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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**Dentist, Questions 49-53 (ST4-8 to 4-12)**

"At the time of acceptance, students must be advised of the total expected cost of their dental education."-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. "There must be a mechanism for ready access to health care for students while they are enrolled in dental school."-This mechanism for ready access to health care needs to be an "easily accessible, on the dental school campus." 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.

#52: Again, way too broad. Providing access to "health care" 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.

49. Formal annual itemized report regarding projected cost and actual cost with explanation

49. Same comment as for 48.

53. Vaccinations should required

53. As responsible health care providers, students should be required to have immunizations.

53: As long a a student does not have a medical or religious exemption they should be required to have the previously mentioned vaccinations.

Governing bodies should not be responsible for making personal decisions for anyone

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.

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.
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).*

**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.

*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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<thead>
<tr>
<th>Dentist, Standard 5 Comments</th>
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<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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<tr>
<td>Far too much time in dental school is spent doing things one will never do again after graduation. More time should be spent providing patient care building confidence and competency.</td>
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<tr>
<td>I would encourage ACLS training along with BLS training with advancement of cardiovascular support skills</td>
</tr>
<tr>
<td>Is any of this enforceable?</td>
</tr>
<tr>
<td>Students should be given more training and optional training in cosmetic and aesthetic dentistry - photography training.</td>
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<th>Dean, Standard 5 Comments</th>
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<th>Site Visitor, Standard 5 Comments</th>
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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.

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 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.
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.

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.

These standards are not rigorous enough.

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

No comments

#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.

I do not feel that research must be a component of a clinical educational experience.

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.
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 SHOULDBE 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.
**Appendix 2**

**Subpage 114**

Ad Hoc Committee to Review Dental and Dental Therapy Standards Predoctoral Dental Education RC CODA Winter 2022

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**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 intent 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
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
Start of Block: STANDARD 1 - Q1-9

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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<td>a. achieve appropriate levels of diversity among its students, faculty and staff;</td>
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<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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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

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.

- 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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No opinion = No opinion on this criterion

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

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**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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No opinion = No opinion on this criterion

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, diagnosis, comprehensive treatment planning, prognosis,</td>
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<td>b. Screening and risk assessment for head and neck cancer;</td>
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<td>c. Recognizing the complexity of patient treatment and identifying when</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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End of Block: STANDARD 2 - Q10-35

Start 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 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.

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 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:
<table>
<thead>
<tr>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Personal, academic and career counseling of students;</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>b. Assuring student participation on appropriate committees;</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>c. Providing appropriate information about the availability of financial aid and health services;</td>
<td>o</td>
<td>o</td>
<td>o</td>
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<tr>
<td>d. Developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>e. Student advocacy</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>f. Maintenance of the integrity of student performance and evaluation records; and</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>g. Instruction on personal debt management and financial planning.</td>
<td></td>
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</tbody>
</table>

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.

*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 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

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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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 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 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.
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

Start of Block: FINISH

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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<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
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<td>February 6, 2015</td>
<td>Accreditation Standards for Dental Therapy Education Programs</td>
<td>Adopted</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Accreditation Standards for Dental Therapy Education Programs</td>
<td>Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
<td>Approved, Implemented</td>
</tr>
<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
</tr>
<tr>
<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>
<td>Implemented</td>
</tr>
<tr>
<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>
<td>Adopted, Implemented</td>
</tr>
<tr>
<td>August 5, 2021</td>
<td>Definition of Terms (Should)</td>
<td>Adopted, Implemented</td>
</tr>
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</table>
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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.
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.
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

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.
Community Resources

1-12 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.

2-5 Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.

**Examples of Evidence to demonstrate compliance may include:**
- On-going faculty training
- Calibration training manuals
- Periodic monitoring for compliance
- Documentation of faculty participation in calibration-related activities

2-6 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.

2-7 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

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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 disease 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
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

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.

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

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 Tooks, 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 Tookes
Sherin

I propose changing the term “special needs” in Standard 2-25 to “disabled patients”.

Amid

Rationale:

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 Latinxs 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

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.
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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.

**July 28, 2021 and August 11, 2021 Meetings:** The Standing Committee on International Accreditation met via conference call on Wednesday, July 28, 2021 and Wednesday, August 11, 2021.

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 on International Accreditation
PREDOC RC / Commission Only
CODA Winter 2022

Standing Committee Actions: 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
CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION
STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ADVANCED
EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY
RELATED TO PATIENTS WITH SPECIAL NEEDS

Background: 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 graduates to be competent in treating patients with special needs. The Council on Dental Education and Licensure’s request is found in Appendix 1.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) considered the request for proposed revision to the Accreditation Standards for Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, and Orofacial Pain submitted by the Council on Dental Education and Licensure. The AGDOO RC believed that the Accreditation Standards for each of the disciplines under its purview should be further studied to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted. At its August 5, 2021 meeting, the Commission agreed and directed the newly reconfigured Postdoctoral General Dentistry Review Committee, which will conduct its meeting in Winter 2022, to further study the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice Residency to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted with a report to the Commission at its Winter 2022 meeting.

Summary: The Postdoctoral General Dentistry Education Review Committee (PGD RC) is requested to further study the proposed revision to the Accreditation Standards (Appendix 1) submitted by the Council on Dental Education and Licensure. If proposed changes are made to the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry and General Practice Residency, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Ms. Peggy Soeldner
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
REPORT ON ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for advanced education in general dentistry and general practice residency programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020.

At its Summer 2020 meeting, the Commission on Dental Accreditation approved revisions to the Annual Survey Curriculum Section for implementation in Fall 2022. The approved Curriculum Section of the Annual Survey for advanced dental education programs in advanced education in general dentistry and general practice residency can be found in **Appendix 1**.

**Summary:** The Review Committee on Postdoctoral General Dentistry (PGD RC) is requested to review the draft Curriculum Section of the Annual Surveys for advanced education programs in general dentistry and general practice residency (**Appendix 1**).

**Recommendation:**

Prepared by: Ms. Peggy Soeldner
Underline indicates addition; Strikethrough indicates deletion

Start of Block: AEGD/GPR Curriculum (Q21-40)

Part II - General Practice Residency/Advanced Education in General Dentistry
(GPR/AEGD) Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

______________________________________________________________________________

21. What percentage of time did FIRST-YEAR students/residents spend in each of the following areas during the 2017-18 2021-22 residency year?

Column must add up to 100%. Do not enter percent signs.

a. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations) : ______
b. Dental inpatient care (management of dental inpatients) : ______
c. Management of dental inpatients or same-day surgery patients in the hospital operating room suite : ______
d. Rotations/Assignments to other services (non-dental) : ______
e. Didactics: courses/lectures/conferences/seminars : ______
f. Responding to consults : ______
g. Other, please specify : ______
Total : ______

______________________________________________________________________________

21 (continued). What percentage of time did SECOND-YEAR students/residents spend in each of the following areas during the 2017-18 residency year?

Column must add up to 100%. Do not enter percent signs.

h. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations) : ______
i. Dental inpatient care (management of dental inpatients) : ______
j. Management of dental inpatients or same-day surgery patients in the hospital operating room suite : ______
k. Rotations/Assignments to other services (non-dental) : ______
l. Didactics: courses/lectures/conferences/seminars : ______
m. Responding to consults : ______
n. Other, please specify : ______
Total : ______
22. Please indicate the total number of clock hours residents spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the 2017-18 2021-22 residency year.
If none, enter zero.
<table>
<thead>
<tr>
<th>Clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Applied pharmacology (Standard 2-2)</td>
</tr>
<tr>
<td>b. Endodontics (Standard 2-2)</td>
</tr>
<tr>
<td>c. Hospital organization and function (Standard 2-10)</td>
</tr>
<tr>
<td>d. Medical risk assessment (Standard 2-6)</td>
</tr>
<tr>
<td>e. Restorative/Operative dentistry (Standard 2-2)</td>
</tr>
<tr>
<td>f. Oral diagnosis/treatment planning (Standard 2-1)</td>
</tr>
<tr>
<td>g. Oral and maxillofacial pathology (Standard 2-4)</td>
</tr>
</tbody>
</table>
h. Oral and maxillofacial radiology/imaging
   (Standard 2-1)

i. Oral and maxillofacial surgery
   (Standard 2-2)

j. Orthodontics and dentofacial orthopedics

k. Pain and anxiety control
   (Standard 2-2)

l. Pediatric dentistry

m. Patients with special needs
   (Standard 2-1)

n. Periodontics
   (Standard 2-2)

o. Physical evaluation
   (Standards 2-6, 2-7)
23. Indicate all rotations/assignments to non-dental services in either the sponsoring or affiliated institution(s) required of the residents. Give the length in weeks and hours per week for each assignment.

<table>
<thead>
<tr>
<th>Length of rotation/assignment</th>
<th>Average hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>a. Anesthesia</strong>&lt;br&gt;(GPR Standard 2-5)</td>
<td></td>
</tr>
<tr>
<td><strong>b. Medicine</strong>&lt;br&gt;(GPR Standard 2-6)</td>
<td></td>
</tr>
<tr>
<td><strong>c. Emergency Department</strong>&lt;br&gt;(Standard 2-6)</td>
<td></td>
</tr>
<tr>
<td><strong>d. Other, please specify</strong>&lt;br&gt;(GPR Standard 2-8; AEGD Standard 2-5)</td>
<td></td>
</tr>
</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.

________________________________________________________________
________________________________________________________________
________________________________________________________________

Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)
Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

24. Provide the following dental clinic statistics related to outpatient visits for the 2017-18 2021-22 residency year. Include statistics for both sponsoring and affiliated institution(s).

<table>
<thead>
<tr>
<th>Number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Total number of outpatient visits to the dental clinic (include screening/consultative visits) (Standard 2-1)</td>
</tr>
<tr>
<td>b. Total number of outpatient visits managed by the residents (Standard 2-1)</td>
</tr>
</tbody>
</table>

25. How many patients with special needs did the residents treat during the 2017-18 2021-22 residency year?

These are defined as patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations. (Standard 2-1)
26. How many patients did residents provide comprehensive care to, from treatment plan to completion (as opposed to episodic or emergency care), during the 2017-18 2021-22 residency year? *(Standard 2-1)*

27. Provide the following emergency care statistics for the 2017-18 2021-22 residency year identifying the activity level(s) at both the sponsoring and affiliated institution(s).

<table>
<thead>
<tr>
<th></th>
<th>Sponsoring institution</th>
<th>Affiliated institution(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The number of dental emergencies treated in the dental clinic by residents</td>
<td><em>(Standard 2-1)</em></td>
<td></td>
</tr>
<tr>
<td>b. The number of dental emergencies treated in the hospital emergency department by all residents</td>
<td><em>(Standard 2-1)</em></td>
<td></td>
</tr>
</tbody>
</table>
28. How was emergency care experience provided to the residents during the 2017-18 residency year? (Standard 2-1)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Block assignment to the Emergency Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. On-going/on-call, with resident on premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. On-going/on-call with resident off premises</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. In which of the following conscious sedation techniques did residents receive instruction and clinical experience during the 2017-18 2021-22 residency year? (Standard 2-2g)

<table>
<thead>
<tr>
<th></th>
<th>Instruction provided?</th>
<th>Clinical experience provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a. Oral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Inhalation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Intravenous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Intranasal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Other, please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)  (Standard 5-1) OR (Standard 2-2)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

NOTE: The procedures listed in Questions 30-33 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students’/residents’ total experience or to imply that all listed procedures are required for accreditation.
30. Indicate the total number of each of the following procedures in **Preventive Dentistry** completed by residents during the 2017-18 2021-22 residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prophylaxis (D1110, D1120, D4346, D4355)</td>
</tr>
<tr>
<td>b. Topical fluoride treatments (D1203 – D1208)</td>
</tr>
<tr>
<td>c. Sealants (D1351)</td>
</tr>
</tbody>
</table>
31. Indicate the total number of each of the following procedures in **Restorative/Operative Dentistry** completed by residents during the **2017-18 2021-22** residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Amalgam Restorations (D2140, D2150, D2160, D2161)</td>
</tr>
<tr>
<td>b. Anterior composites (D2330, D2331, D2332 and D2335)</td>
</tr>
<tr>
<td>c. Posterior composites (D2391, D2392, D2393, &amp; D2394)</td>
</tr>
<tr>
<td>d. Single unit crowns (D2710, D2712, D2720-D2722, D2740, D2750-D2752, D2780-D2783, D2790-D2792, D2794)</td>
</tr>
<tr>
<td>e. Crown cores (cast or prefabricated) (D2952-D2954, D2957)</td>
</tr>
<tr>
<td>f. Crown core build-up, including pins (preparatory work before crown) (D2950)</td>
</tr>
<tr>
<td>g. Inlay/Onlay (D2510-D2664)</td>
</tr>
</tbody>
</table>
32. Indicate the total number of each of the following procedures in **Endodontics** completed by residents during the **2017-18 2021-22** residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Single canals (anterior) (D3310, D3346)</td>
</tr>
<tr>
<td>b. Double canals (bicuspide) (D3320, D3347)</td>
</tr>
<tr>
<td>c. Molars (D3330, D3348)</td>
</tr>
<tr>
<td>d. Apicoectomies (D3410, D3421, D3425, D3426)</td>
</tr>
</tbody>
</table>
33. Indicate the total number of each of the following procedures in **Periodontics** completed by residents during the 2017-18 **2021-22** residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Scaling, root planing and curettage (D4341, D4342, D4910)</td>
</tr>
<tr>
<td>b. Gingivectomies (D4210-D4211, D4212)</td>
</tr>
<tr>
<td>c. Soft tissue grafts/gingival flap procedures (D4240, D4241, D4270, D4273, D4275, D4276)</td>
</tr>
<tr>
<td>d. Crown lengthening/Bone grafts/osseous surgery/guided tissue regeneration (D4249, D4260, D4261, D4266, D4267)</td>
</tr>
<tr>
<td>e. Apically repositioned flap (D4245)</td>
</tr>
<tr>
<td>f. Bone graft replacement graft – first site in quadrant (D4263)</td>
</tr>
<tr>
<td>g. Bone replacement graft – each additional site in quadrant (D4264)</td>
</tr>
</tbody>
</table>
h. Biologic materials to aid in soft tissue and osseous tissue regeneration (D4265)

Use this space to enter comments or clarifications for your answers on this page.

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

NOTE: The procedures listed in Questions 34-37 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students'/residents' total experience or to imply that all listed procedures are required for accreditation.

34. Indicate the total number of each of the following procedures in Removable Prosthodontics completed by residents during the 2017-18 2021-22 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Units/complete dentures (D5110-D5120)</td>
</tr>
<tr>
<td>b. Units/immediate dentures (D5130-D5140)</td>
</tr>
<tr>
<td>c. Units/overdentures (D5863-D5866)</td>
</tr>
<tr>
<td>d. Interim complete dentures (D5810, D5811)</td>
</tr>
<tr>
<td>e. Adjustment to dentures and partials (D5410-D5422)</td>
</tr>
<tr>
<td>f. Complete denture repairs (D5511, D5512, D5520)</td>
</tr>
<tr>
<td>g. Repairs to partials (D5511-D5671)</td>
</tr>
<tr>
<td>h. Acrylic partial dentures (D5211-D5212, D5221, D5222, D5225, D5226, D5820-D5821)</td>
</tr>
</tbody>
</table>
i. Conventional cast frame partial frame dentures (D5213-D5214, D5223, D5224)

j. Precision or semi-precision partial dentures attachments (D5862)
35. Indicate the total number of each of the following procedures in **Implant Services**
completed by residents during the **2017-18 2021-22** residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Surgical placement of implant body (D6010, D6013)</td>
</tr>
<tr>
<td>b. Prefabricated abutment (including placement) (D6056)</td>
</tr>
<tr>
<td>c. Custom abutment (including placement) (D6057)</td>
</tr>
<tr>
<td>d. Implant retained Removable Prosthodontics (D6110-D6113)</td>
</tr>
<tr>
<td>e. Implant retained Fixed Prosthodontics (D6058–D6077, D6114-D6117)</td>
</tr>
</tbody>
</table>
36. Indicate the total number of each of the following procedures in **Fixed Prosthodontics** completed by residents during the 2017-18 2021-22 residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units/fixed bridgework (D6205-D6794)</td>
</tr>
</tbody>
</table>

37. Indicate the total number of each of the following procedures in Oral and Maxillofacial Surgery completed by residents during the 2017-18 2021-22 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Uncomplicated extractions (D7111, D7140, D7210, D7250)</td>
</tr>
<tr>
<td>b. Extractions of impacted teeth (D7220, D7230, D7240, D7241)</td>
</tr>
<tr>
<td>c. Oral Tissue biopsy (D7285, D7286)</td>
</tr>
<tr>
<td>d. Brush biopsy (D7288)</td>
</tr>
<tr>
<td>e. Surgical removal of lateral exostosis (maxilla or mandible) (D7471)</td>
</tr>
<tr>
<td>f. Surgical reduction of osseous tuberosity (D7485)</td>
</tr>
<tr>
<td>g. Surgical reduction of fibrous tuberosity (D7972)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>h. Incision and drainage (D7510, D7511, D7520, D7521)</td>
</tr>
<tr>
<td>i. Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth (D7270)</td>
</tr>
<tr>
<td>j. Alveoplasties (D7310, 7311, 7320, 7321)</td>
</tr>
<tr>
<td>k. Removal of torus palatinus (D7472)</td>
</tr>
<tr>
<td>l. Removal of torus mandibularis (D7473)</td>
</tr>
<tr>
<td>m. Suture of recent small wounds up to 5 cm (D7910)</td>
</tr>
<tr>
<td>n. Complicated suture, up to 5 cm (D7911)</td>
</tr>
<tr>
<td>o. Complicated suture, greater than 5 cm (D7912)</td>
</tr>
<tr>
<td>p. Frenectomy (D7960)</td>
</tr>
</tbody>
</table>
q. Excision of hyperplastic tissue – per arch (D7970)

r. Excision of pericoronal gingiva (D7971)

Use this space to enter comments or clarifications for your answers on this page.
Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

NOTE: The procedures listed in Question 38 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students'/residents’ total experience or to imply that all listed procedures are required for accreditation.

38. Indicate the total number of each of the following procedures in Pediatric Dentistry and Orthodontics completed by residents during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Resin-based Composite posterior (D2391-D2394)</td>
</tr>
<tr>
<td>b. Resin-based Composite anterior (D2330-D2335)</td>
</tr>
<tr>
<td>c. Amalgam restoration (primary or permanent) (D2140-D2161)</td>
</tr>
<tr>
<td>d. Limited ortho treatment of adult dentition (Upright tilted teeth) (D8040)</td>
</tr>
<tr>
<td>e. Limited treatment of primary dentition (Moyer’s or equivalent space analysis) (D8040)</td>
</tr>
<tr>
<td>f. Space maintenance (D1510, D1515, D1520, D1525, D1550, D1555)</td>
</tr>
<tr>
<td>g. Comprehensive ortho treatment (space closures) (D8070, D8080, D8090)</td>
</tr>
</tbody>
</table>
h. Interceptive ortho treatment/crossbite corrections (D8050, D8060)

i. Occlusal orthotic device (TMJ) (D7880)

j. Stainless steel crowns (D2930, D2931, D2933, D2934)

k. Prefabricated resin crowns/polycarbonate crowns (D2932)

l. Pulpotomies (D3220)

39. How many times during the 2017-18 2021-22 residency year were formal documented evaluations of resident performance conducted? (Standard 2-15)

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

- Goals and objectives
- Competencies and proficiencies
Use this space to enter comments or clarifications for your answers on this page.

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

End of Block: AEGD/GPR Curriculum (Q21-40)
INFORMATIONAL REPORT ON THE CONDUCT OF A VALIDITY AND RELIABILITY STUDY FOR THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY

Background: The Accreditation Standards for Advanced Education Programs in Advanced Education in General Dentistry (AEGD) and General Practice Residency (GPR) were adopted by the Commission on Dental Accreditation at its August 3, 2018 for immediate implementation.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1), the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula:

\[ \text{The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.} \]

Thus, the validity and reliability of the new standards for a one-year program will be assessed after four years, while standards applying to programs two years in length will be assessed five years after implementation.

According to the Commission’s timetable for validity and reliability studies the study for Advanced Education in General Dentistry (AEGD) and General Practice Residency (GPR) will be initiated in the spring of 2022. Survey results will be considered at the Summer 2022 meetings of the PGD RC and the Commission on Dental Accreditation. The communities will be surveyed to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

Methodology and Survey Design: In cooperation with the ADA’s HPI, a timetable will be developed, surveys will be distributed to the audiences, and responses will be due to the HPI within two weeks of receipt of the survey. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2022. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2022 meeting.
A survey instrument will be developed to obtain evaluations of each of the requirements in the current standards. Respondents will be asked to indicate the relevance of each criterion to the AEGD and GPR curricula:

- Relevant/ Too demanding: Criterion relevant but too demanding
- Retain as is: Retain criterion as is
- Relevant/ Not demanding: Criterion relevant but not sufficiently demanding
- Not relevant: Criterion not relevant
- No opinion. No opinion on this criterion

In addition, they will be asked to add and provide a rationale for any issues that they believe should be added to the standards. A sample format of the survey is presented in Appendix 2.

The following alternatives might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

If it is determined that revisions to the accreditation standards is warranted, further analysis of the data obtained in the validity and reliability study would be conducted to provide more in-depth information for the revision process. In addition, other resources could provide further information, including:

- The annual Frequency of Citings Reports of Accreditation Standards for Advanced Education Programs in General Dentistry and Accreditation Standards for Advanced Education Programs in General Practice Residency.
- Data identifying trends in accredited advanced education programs in dentistry and general practice residency.
- Issues related to advanced general dentistry education programs in general dentistry and general practice residency.
- Requests for standards revisions received but postponed until the regular validity and reliability study.
- Relevant reports from the higher education and practice communities, e.g., Institute of Medicine Report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce.”

When a comprehensive revision of an accreditation standards document is required, the new document is developed with input from the communities of interest in accordance with Commission policies. The document is drafted using resources such as those noted above.
When the document is finalized, it is shared with the communities of interest and hearings are held, as appropriate. Written and oral comments from the hearings and written comments received during the comment period are reviewed when considering the document for adoption. An implementation date is specified when the document is adopted.

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

Prepared by: Ms. Peggy Soeldner
POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of standards are made to reflect significant changes in disease and practice patterns, scientific or technological advances, or in response to changing professional needs for which the Commission has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year after the validity and reliability of the standards has been assessed, the Commission will conduct a study to determine whether the accreditation standards continue to be appropriate to the discipline. This study will include input from the broad communities of interest. The communities will be surveyed and invited to participate in some national forum, such as an
invitational conference, to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

The following alternatives, resulting in a set of new standards, might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with Commission policies. An implementation date is specified and copyright privileges are sought when the document is adopted. Assessment of the validity and reliability of these new standards will be scheduled in accord with the policy specified above. Exceptions to the prescribed schedule may be approved to ensure a consistent timetable for similar disciplines (e.g. advanced dental education programs and/or allied dental education programs).

Revised: 8/18; 7/07, 07/00; Reaffirmed: 8/12, 8/10, 7/06; Adopted: 12/88
SAMPLE ADVANCED DENTAL EDUCATION PROGRAMS IN ADVANCED EDUCATION IN GENERAL DENTISTRY AND ADVANCED DENTAL EDUCATION PROGRAMS IN GENERAL PRACTICE RESIDENCY VALIDITY AND RELIABILITY SURVEY

Listed below are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Advanced Education in General Dentistry (AEGD) and Advanced Dental Education Programs in General Practice Residency (GPR) for accreditation purposes. For each standard, please circle the appropriate number that corresponds to your rating in terms of its relevance of the criterion to the curriculum. Please note that certain standards have multiple items to be rated.

<table>
<thead>
<tr>
<th>DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced Education in General Dentistry (AEGD)</strong> - a postgraduate general dentistry education program providing advanced training in providing comprehensive patient care for all population groups.</td>
</tr>
<tr>
<td><strong>General Practice Residency (GPR)</strong> - a postgraduate general dentistry education program conducted in a hospital setting that includes substantial experience in managing medically compromised patients.</td>
</tr>
<tr>
<td>For each of the five-point rating scales use:</td>
</tr>
<tr>
<td>1 = criterion relevant but too demanding</td>
</tr>
<tr>
<td>2 = retain criterion as is</td>
</tr>
<tr>
<td>3 = criterion relevant but not sufficiently demanding</td>
</tr>
<tr>
<td>4 = criterion not relevant</td>
</tr>
<tr>
<td>5 = no opinion</td>
</tr>
</tbody>
</table>

**STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS**

1. List Standards in this column

List comments related to Standard 1 – Institutional and Program Effectiveness.

**STANDARD 2 – EDUCATIONAL PROGRAM**

1. List Standards in this column

List comments related to Standard 2 – Educational Program.

**STANDARD 3 – FACULTY AND STAFF**

1. List Standards in this column

List comments related to Standard 3 – Faculty and Staff.
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

1. List Standards in this column


STANDARD 5 – PATIENT CARE SERVICES

1. List Standards in this column

List comments related to Standard 5 – Patient Care Services.
INFORMATIONAL REPORT ON DENTAL ASSISTING PROGRAMS ANNUAL SURVEY CURRICULUM DATA

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

The Curriculum Section of the Commission’s Annual Survey is conducted for dental assisting education in alternate years. The most recent Curriculum Section was conducted in September/October 2021. Aggregate data of the most recent Curriculum Section for review by the Review Committee on Dental Assisting Education is provided as an informational report in Appendix 1.

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

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

Prepared by: Dr. Sherin Tooks
Q51. What are the number of hours each student typically spends in the following over the course of the full program?

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Formal clinical practice seminar - Hours</td>
<td>1.0</td>
<td>996.0</td>
<td>109.3</td>
<td>215</td>
</tr>
<tr>
<td>b. Clinical practice experience - Hours</td>
<td>7.0</td>
<td>2059.0</td>
<td>347.0</td>
<td>240</td>
</tr>
</tbody>
</table>

Q52. What types of settings are utilized for students' clinical practice experience?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. On-campus comprehensive dental clinic</td>
<td>35.8%</td>
<td>64.2%</td>
<td>154</td>
</tr>
<tr>
<td>b. Private dental office, general</td>
<td>98.8%</td>
<td>1.3%</td>
<td>3</td>
</tr>
<tr>
<td>c. Private Dental office, specialty</td>
<td>94.6%</td>
<td>5.4%</td>
<td>13</td>
</tr>
<tr>
<td>d. Dental school clinic</td>
<td>28.7%</td>
<td>71.3%</td>
<td>171</td>
</tr>
<tr>
<td>e. Public health / non-profit clinic</td>
<td>68.8%</td>
<td>31.3%</td>
<td>75</td>
</tr>
<tr>
<td>f. Other, please specify (see below)</td>
<td>13.8%</td>
<td>86.3%</td>
<td>207</td>
</tr>
</tbody>
</table>

f. Other, please specify - Text

[City] Veteran Administration Dental Clinic

[…] Hospital, VA […] Healthcare System, University Pediatric Hospital and [abbreviation] Dental Clinic

Children's hospital dental clinic

Community Volunteer dental event

Corporation dental office

DDS Residency clinic

DSO/Corporate Offices

Dental school specialty clinics

General Residency Program- Hospital

Hospital Dental Clinic

Hospital- Veteran's
f. Other, please specify - Text

Indian Health Services Dental Clinics

Local dental hygiene school clinic and restorative clinic

[Abbreviation] Dental facility houses 3 functioning dental chairs. 3 x-ray units using digital and traditional technique- Instrument processing are and a dental laboratory. Our facility does not conduct any patient care.

Military Base Clinics

Military base clinic

Non-ambulatory

Non-profit clinics and […] Health Clinic

On campus dental hygiene clinic

On site dental hygiene clinic

On-campus coronal polish and pit & fissure sealant

On-campus dental hygiene clinic (3)

Pediatric-general

[Sponsoring Institution Name] Dental Hygiene Clinic

Students' clinical practice experience is conducted in the [government unit] dental treatment facilities.

campus non-patient care full dental clinic

on-campus radiography patient care experience (12 hours)

on-campus, non-comprehensive dental clinic

ortho, oral surg

program is on hold
Q53. What are the minimum and maximum number of sites to which each student is assigned?

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Minimum - Number of sites</td>
<td>1.0</td>
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<tr>
<td>b. Maximum - Number of sites</td>
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</table>

Q54. During the off-campus clinical practice experience, do any of the following individuals:

**plan [lessons for] dental assisting students?**

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>a. Dental assisting faculty</td>
<td>95.8%</td>
<td>4.2%</td>
<td>240</td>
</tr>
<tr>
<td>b. Dentists/dental office personnel</td>
<td>29.6%</td>
<td>70.4%</td>
<td>240</td>
</tr>
<tr>
<td>c. Other, please specify</td>
<td>4.6%</td>
<td>95.4%</td>
<td>240</td>
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</table>

**supervise dental assisting students?**

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<td>a. Dental assisting faculty</td>
<td>82.1%</td>
<td>17.9%</td>
<td>240</td>
</tr>
<tr>
<td>b. Dentists/dental office personnel</td>
<td>92.5%</td>
<td>7.5%</td>
<td>240</td>
</tr>
<tr>
<td>c. Other, please specify</td>
<td>4.6%</td>
<td>95.4%</td>
<td>240</td>
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</table>

**evaluate dental assisting students?**

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</thead>
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<tr>
<td>a. Dental assisting faculty</td>
<td>94.2%</td>
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<td>240</td>
</tr>
<tr>
<td>b. Dentists/dental office personnel</td>
<td>89.2%</td>
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<td>c. Other, please specify (see below)</td>
<td>7.1%</td>
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</table>
Q54c. Other, please specify - Text

CDA
CFA
DHG
Dental Lab Coordinator
Dental Student
Hygienist and [name] Health Clinic
Lab/Clinic Coordinator
Lead Assistants In the office

[Sponsoring institution name] Dental School Students and [another sponsoring institution name] Hygiene Students

Our program employs a Cooperative Education Coordinator who assists the dental assisting faculty in planning clinical rotations in area dental practices

Program Administrator
Program Director (2)
RDA
RDA and DDS supervise and evaluate. Program Director evaluates and visits offices every ten working days.

Staff, Ex Program graduates

Supervising Dental Assistants
The offices only evaluate professionalism. All other evals come from the faculty but clinical rotations are for enhancement. On-campus students are evaluated.

[Sponsoring institution name] School of Dentistry Dental Assisting Staff and Faculty

clinical coordinator
dental assistants

program is on hold

student self assessment
Q55. Clock hours for all dental assisting content areas

<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Mean</th>
<th>Max</th>
<th>Min</th>
<th>Count</th>
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<tr>
<td>a. Interpersonal communications</td>
<td>23.8</td>
<td>96</td>
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<td>230</td>
</tr>
<tr>
<td>b. Psychology of patient management</td>
<td>17.0</td>
<td>64</td>
<td>1</td>
<td>227</td>
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<tr>
<td>c. Anatomy and physiology</td>
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<td>229</td>
</tr>
<tr>
<td>d. Microbiology</td>
<td>10.1</td>
<td>73</td>
<td>1</td>
<td>227</td>
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<tr>
<td>e. Oral anatomy</td>
<td>23.9</td>
<td>90</td>
<td>1</td>
<td>233</td>
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<tr>
<td>f. Oral histology</td>
<td>6.1</td>
<td>40</td>
<td>1</td>
<td>230</td>
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<tr>
<td>g. Oral embryology</td>
<td>5.7</td>
<td>40</td>
<td>1</td>
<td>230</td>
</tr>
<tr>
<td>h. Legal and ethical aspects of dental assisting</td>
<td>10.7</td>
<td>60</td>
<td>1</td>
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<table>
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<tr>
<th>Laboratory instruction clock hours</th>
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<tr>
<td>b. Psychology of patient management</td>
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<td>53</td>
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<tr>
<td>c. Anatomy and physiology</td>
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<td>1</td>
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<td>d. Microbiology</td>
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<td>1</td>
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<td>94</td>
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<td>f. Oral histology</td>
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Q55. Clock hours for all dental assisting content areas (continued)

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<td>j. Dental materials</td>
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<td>108</td>
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<td>k. Dental radiography</td>
<td>40.5</td>
<td>160</td>
<td>6</td>
<td>237</td>
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<tr>
<td>l. Oral and maxillofacial pathology</td>
<td>11.6</td>
<td>48</td>
<td>1</td>
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<tr>
<td>m. General dentistry procedures</td>
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<td>382</td>
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<td>n. Specialty procedures</td>
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<td>150</td>
<td>2</td>
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<tr>
<td>o. Practice management</td>
<td>27.6</td>
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<td>2</td>
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<td>p. Preventive dentistry</td>
<td>17.0</td>
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<td>k. Dental radiography</td>
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<td>150</td>
<td>6</td>
<td>233</td>
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<td>l. Oral and maxillofacial pathology</td>
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<td>o. Practice management</td>
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<td>2</td>
<td>129</td>
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<td>p. Preventive dentistry</td>
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<td>r. Medical emergencies</td>
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<td>1</td>
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<td>180</td>
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### Clinical instruction clock hours

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<th>Min</th>
<th>Count</th>
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<td>84</td>
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<td>k. Dental radiography</td>
<td>31.6</td>
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<td>2</td>
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<td>2</td>
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<td>100</td>
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<td>q. Dental emergencies</td>
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<td>20</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>r. Medical emergencies</td>
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<td>24</td>
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</table>
Q56. Are any of the following functions, not required with the Dental Assisting Standards, taught in the dental assisting program? If so, please indicate the level of instruction provided in that function.

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<th>Function</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Total</th>
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<tbody>
<tr>
<td>a. Placing periodontal and other surgical dressings</td>
<td>83.3%</td>
<td>16.7%</td>
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<tr>
<td>b. Removing periodontal and other surgical dressings</td>
<td>85.0%</td>
<td>15.0%</td>
<td>36</td>
</tr>
<tr>
<td>c. Removing sutures</td>
<td>95.4%</td>
<td>4.6%</td>
<td>11</td>
</tr>
<tr>
<td>d. Inspecting the oral cavity</td>
<td>94.6%</td>
<td>5.4%</td>
<td>13</td>
</tr>
<tr>
<td>e. Polishing coronal surfaces of teeth</td>
<td>93.8%</td>
<td>6.3%</td>
<td>15</td>
</tr>
<tr>
<td>f. Scaling coronal surfaces of teeth</td>
<td>6.3%</td>
<td>93.8%</td>
<td>225</td>
</tr>
<tr>
<td>g. Placing matrices</td>
<td>97.5%</td>
<td>2.5%</td>
<td>6</td>
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<tr>
<td>h. Removing matrices</td>
<td>97.1%</td>
<td>2.9%</td>
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<tr>
<td>i. Placing temporary restorations</td>
<td>90.4%</td>
<td>9.6%</td>
<td>23</td>
</tr>
<tr>
<td>j. Removing temporary restorations</td>
<td>78.8%</td>
<td>21.3%</td>
<td>51</td>
</tr>
<tr>
<td>k. Placing amalgam restorations</td>
<td>35.8%</td>
<td>64.2%</td>
<td>154</td>
</tr>
<tr>
<td>l. Carving amalgam restorations</td>
<td>30.0%</td>
<td>70.0%</td>
<td>168</td>
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<tr>
<td>m. Polishing restorations</td>
<td>50.4%</td>
<td>49.6%</td>
<td>119</td>
</tr>
<tr>
<td>n. Placing and finishing composite restorations</td>
<td>31.7%</td>
<td>68.3%</td>
<td>164</td>
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<tr>
<td>o. Removing excess cement from coronal surfaces of teeth</td>
<td>87.1%</td>
<td>12.9%</td>
<td>31</td>
</tr>
<tr>
<td>p. Applying pit and fissure sealants</td>
<td>88.8%</td>
<td>11.3%</td>
<td>27</td>
</tr>
<tr>
<td>q. Applying cavity liners and bases</td>
<td>82.5%</td>
<td>17.5%</td>
<td>42</td>
</tr>
<tr>
<td>r. Monitoring nitrous oxide analgesia</td>
<td>67.1%</td>
<td>32.9%</td>
<td>79</td>
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<td>s. Other 1, not specified in Standards 2-7 and 2-8 (see pages 9-10)</td>
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<td>82.5%</td>
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</table>
Q56. If [function is taught in the dental assisting program], please indicate the level of instruction provided in that function.

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<th>Laboratory/ Pre-clinical</th>
<th>Clinical competence</th>
<th>Total</th>
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</thead>
<tbody>
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<td>87.0% 174</td>
<td>13.0% 26</td>
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<tr>
<td>b. Removing periodontal and other surgical dressings</td>
<td>85.3% 174</td>
<td>14.7% 30</td>
<td>204</td>
</tr>
<tr>
<td>c. Removing sutures</td>
<td>84.3% 193</td>
<td>15.7% 36</td>
<td>229</td>
</tr>
<tr>
<td>d. Inspecting the oral cavity</td>
<td>44.5% 101</td>
<td>55.5% 126</td>
<td>227</td>
</tr>
<tr>
<td>e. Polishing coronal surfaces of teeth</td>
<td>24.0% 54</td>
<td>76.0% 171</td>
<td>225</td>
</tr>
<tr>
<td>f. Scaling coronal surfaces of teeth</td>
<td>46.7% 7</td>
<td>53.3% 8</td>
<td>15</td>
</tr>
<tr>
<td>g. Placing matrices</td>
<td>71.8% 168</td>
<td>28.2% 66</td>
<td>234</td>
</tr>
<tr>
<td>h. Removing matrices</td>
<td>73.0% 170</td>
<td>27.0% 63</td>
<td>233</td>
</tr>
<tr>
<td>i. Placing temporary restorations</td>
<td>78.3% 170</td>
<td>21.7% 47</td>
<td>217</td>
</tr>
<tr>
<td>j. Removing temporary restorations</td>
<td>81.0% 153</td>
<td>19.0% 36</td>
<td>189</td>
</tr>
<tr>
<td>k. Placing amalgam restorations</td>
<td>84.9% 73</td>
<td>15.1% 13</td>
<td>86</td>
</tr>
<tr>
<td>l. Carving amalgam restorations</td>
<td>86.1% 62</td>
<td>13.9% 10</td>
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<tr>
<td>m. Polishing restorations</td>
<td>76.9% 93</td>
<td>23.1% 28</td>
<td>121</td>
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<tr>
<td>n. Placing and finishing composite restorations</td>
<td>88.2% 67</td>
<td>11.8% 9</td>
<td>76</td>
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<td>o. Removing excess cement from coronal surfaces of teeth</td>
<td>73.2% 153</td>
<td>26.8% 56</td>
<td>209</td>
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<tr>
<td>p. Applying pit and fissure sealants</td>
<td>40.4% 86</td>
<td>59.6% 127</td>
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<tr>
<td>q. Applying cavity liners and bases</td>
<td>81.3% 161</td>
<td>18.7% 37</td>
<td>198</td>
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<tr>
<td>r. Monitoring nitrous oxide analgesia</td>
<td>64.0% 103</td>
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<td>161</td>
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<td>s. Other 1, not specified in Standards 2-7 and 2-8 (see pages 9-10)</td>
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Q56s-t. Other functions, not specified in Standards 2-7 and 2-8 - Text

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<th>Function Description</th>
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<tbody>
<tr>
<td>2-10-j Preliminary impressions</td>
</tr>
<tr>
<td>2-9-b Take &amp; record vital signs</td>
</tr>
<tr>
<td>Administering Nitrous Oxide Analgesia</td>
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<tr>
<td>Administering Nitrous Oxide Inhalation Sedation</td>
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<tr>
<td>Administration of Nitrous Oxide</td>
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<tr>
<td>Administration/Induction of N20/02</td>
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<tr>
<td>All Orthodontic Procedures</td>
</tr>
<tr>
<td>Application of desensitizing agents</td>
</tr>
<tr>
<td>Apply acid etch material</td>
</tr>
<tr>
<td>Apply Acid Etch, Flushing, drying and closing root canal, Orthodontic: tying or unttying wires, inserting interdental spacers, fitting bands or brackets, sizing ortho wires, loading amalgam carrier</td>
</tr>
<tr>
<td>Automated caries detection</td>
</tr>
<tr>
<td>CAD/CAM Image Acquisition</td>
</tr>
<tr>
<td>caries detection, CAD/CAM</td>
</tr>
<tr>
<td>Dental Dam</td>
</tr>
<tr>
<td>Dry root canals with paper points and place cotton pellet into endodontic opening; Place non-surgical retraction materials for gingival displacement; Cement temporary crowns; Orthodontic functions; Take intraoral and extraoral photographs</td>
</tr>
<tr>
<td>Drying endo canals (2)</td>
</tr>
<tr>
<td>Exposing radiographs and cone beam images</td>
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<tr>
<td>Fab. &amp; Cem. of temps</td>
</tr>
<tr>
<td>Fabricate and cement provisional restorations</td>
</tr>
<tr>
<td>fabricate and deliver whitening tray</td>
</tr>
<tr>
<td>Fabricate bleach tray and mouthguard</td>
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<tr>
<td>Fabricate Provisionals (2)</td>
</tr>
<tr>
<td>Fabricate Whitening Trays</td>
</tr>
<tr>
<td>Fabricating and cementing provisional coverage</td>
</tr>
<tr>
<td>Fabricating provisional, mouthguard and bleaching trays</td>
</tr>
<tr>
<td>Fabricating stainless crowns</td>
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<tr>
<td>Fabricating temporary crowns</td>
</tr>
<tr>
<td>Fabrication of dental models and custom trays</td>
</tr>
<tr>
<td>Facebow transfer</td>
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<tr>
<td>Facebow transfer, caries detection, intra-oral and extra-oral photography</td>
</tr>
<tr>
<td>Facebow, Redressing of Alveolitis</td>
</tr>
<tr>
<td>fit orthodontic bands</td>
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<tr>
<td>Fluoride application (2)</td>
</tr>
<tr>
<td>Gingival Displacement (3)</td>
</tr>
<tr>
<td>Gingival Retraction</td>
</tr>
</tbody>
</table>
Q56s-t. Other functions, not specified in Standards 2-7 and 2-8 - Text

- gingival retraction cord packing
- Impressions and Study Models
  - Impressions for fabricating study models, surgical stents, & passive ortho appliances
  - impressions for study models
- Induce Nitrous
- Induction/Administration of N2O/O2
- [Redacted] Orthodontic Expanded Function skills
- Orthodontic duties
- Orthodontic Expanded Functions (2)
- Orthodontic Functions (3)
- Packing/removing retraction cord
- Perform facebow transfer
- Place and Remove Gingival Retraction Cord
- Place and remove orthodontic separators
- Place and remove retraction cord
- Place Non Surgical Gingival Retraction
- Place retraction cord
- Place/Remove Orthodontic Arch Wires, Ligature ties, elastomeric ties, select/fit molar bands and arch wires
- Placement & Removal of Socket Dressing
- Placement and removal of gingival retraction material
- Placement and removal of orthodontic brackets and bands
- Placement and removal of retraction cord
- Placing & removing dental dams
  - placing and removing dressing for alveolitis
- Placing and removing gingival retraction cord (2)
- Placing and removing retraction cord
- Placing gingival retraction cord
- Polish and contouring sealants with a slow speed rotary handpiece immediately following the procedure for the purpose of occlusal adjustment
- Pre- & Post-op instructions
- Preliminary examination including performing pulp vitality testing.
- Provisional Crowns
- Pulp Vitality Testing
- Remove Excess bonding
- Removing Ortho Resin with non-tissue cutting instruments
- Retraction Cord
- Retraction cord placement
- Soft denture relines
Q56s-t. Other functions, not specified in Standards 2-7 and 2-8 - Text

<table>
<thead>
<tr>
<th>Function</th>
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<tbody>
<tr>
<td>Soft Reline</td>
</tr>
<tr>
<td>Take vital signs; Preliminary charting; Obtain informed consent; Take radiographs; Place and remove rubber dam; Administer and monitor nitrous oxide; Take impressions and bite registrations; Applying topical medications; Apply topical fluorides</td>
</tr>
<tr>
<td>Taking &amp; processing conventional &amp; Digital X-rays</td>
</tr>
<tr>
<td>Taking alginate impressions</td>
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<tr>
<td>Taking Final Impressions for direct and indirect restorations and prosthesis including bite registration</td>
</tr>
<tr>
<td>Taking impressions; fabricating whitening trays</td>
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<tr>
<td>Taking Preliminary Impressions (2)</td>
</tr>
<tr>
<td>testing pulp vitality</td>
</tr>
<tr>
<td>Topical Anesthetic</td>
</tr>
<tr>
<td>Topical Fluoride</td>
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<tr>
<td>Topical Fluoride Application (2)</td>
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<tr>
<td>Vital Signs</td>
</tr>
</tbody>
</table>
APPENDIX – Responses to open-ended questions

Questions 51-54 comments

54a. The [sponsoring institution] has established a [redacted]. Each student has a supervisor who will evaluate and discuss with the student and the dentist in regards to their clinical practice experience. The information that is obtained from the student and dentist will be relayed from the supervisor to the dental treatment facility’s training manager. The training manager will validate and update the student’s [redacted] to make sure that the student is adhering to CODA standards and [sponsoring institution] policies.

53. The students normal assignment is two clinical sites; however, if for some reason they are not able to complete all hours within these two sites due to site vacations or other reasons, then a third site will be assigned to fulfill the requirements of the program.

54c. The Program Director works with the Executive Dean to coordinate externship sites and respective affiliation agreements.

All formal evaluations are completed by the DA faculty during the office visit. Informal evaluations, completed by the dentist/dental office personnel, are used for student feedback and growth.

All students rotate through all dental specialties during their clinical experience at the [sponsoring institution] School of Dental Medicine.

At the dental school we ask the dental student to evaluate the assisting student at the end of the chair side time. In the private office student is evaluated at the end of the rotation. Sometimes the dentist wants to do the evaluation, sometime the assistant who has worked with the student will do the evaluation.

At this time program faculty is not sure how many sites will be utilized due to the temporary program suspension.

DA faculty and [sponsoring institution] SOD faculty plan the clinical experience for DA students for the fall semester. Planning includes- HIPAA, OSHA training, clinical rotation orientation, team assignments, locker assignments, Uniform and Personal protective equipment requirements, ID badges and immunization requirements.

Dental Assisting faculty observe students in their clinical practice experience and provide coaching, but they are not consistently supervising them.

Dental School clinic: Due to the COVID pandemic, the [affiliated institution], has put a temporary restriction on [sponsoring institution] students utilizing their facility for clinical rotations.

Dental assisting faculty do not directly supervise students during clinical externships while they are performing skill sets. However, they do check in with the clinical site preceptors to make sure students are performing and completing competencies at acceptable levels on required skill sets.

Dentists evaluate employability and professionalism

During our student internships, our students have their schedules/days, supervision and evaluations to be performed by the internship clinic sites. The dental assistants and dentists are who will be guiding and mentoring them, and then evaluating the students throughout their internship. Dental assisting faculty do help guide and advise students during this timeframe, but faculty are fairly hands-off during the internships, unless we are asked to jump in for any reason.

Faculty visit each student a minimum of 4 times to supervise and evaluate.

Fall Semester: No off campus clinical rotations Spring Semester: At all times students are supervised by Dental Assisting Faculty during clinical rotations. Summer Term: Supervising Dental Assistants and Dentists do provide feedback to students concerning their clinical performance; each student receives one visit per week from a dental assisting faculty member.

For 51, the numbers exclude 1 holiday and Spring Break.

For questions #51, Seminar is an additional 16 hours above clinical time. In other courses, an approximate 9 hours is also done for debriefing and reflection.

In the Clinical Affiliations course (clinical practice experience) The dentist and the supervising dental assistant both complete an overall assessment/evaluation of the student, in each clinical site.
Questions 51-54 comments

No engagement with dental hygienists.

**ONLY THE DENTIST EVALUATE THE OFF CAMPUS PORTION OF EXTERNSHIP**

Off Campus experience is limited only to shadowing, observation, Q/A, interaction with the specialty dentist and staff. All teaching and evaluations are done on site.

Program Administrator actively participates with, planning, supervise, and evaluates the dental assisting students?

Program Director and Dental Office coordinate a time to discuss the potential student completing their externship hours at their office. The office signs an agreement and reviews the externship packet details. Program Director is actively in contact with the dental office from beginning to end of externship completion. Program Director visits the office every ten working days to check on student and office.

Regarding 52 f, the on-campus dental hygiene clinic is not a comprehensive care clinic, however, DA students provide dental imaging and preventive services (sealants, fluoride treatments).

Students are assigned to a minimum of 2 clinical sites or clinics. The students may be assigned to a third or fourth site if they are unable to complete their necessary requirements.

Students are tested to competence prior to attending clinical externships.

Students evaluated by dentist/dental personnel on clinical skills. Calibration is accomplished each Fall before rotations begin in Spring.

The dental assisting faculty schedule patient clinical rotations and visit on a routine basis. The dental assistants and dentists of the rotation sites supervise and evaluate student skills.

Unsure what Formal Clinical Practice Seminar means. The number of hours listed under Clinical Practice Experience includes both on-campus and externship experience. If you need further explanation, feel free to contact me.

We use an online clinical monitoring system too, where students log all their hours and skills.

program is currently on stop-out/hold
Q55. Please complete the following chart for all other content areas required in the accredited dental assisting program.

<table>
<thead>
<tr>
<th>w - z. Other, please specify: Text</th>
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<tbody>
<tr>
<td>Abrasive agents/coronal polishing; sealants</td>
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<tr>
<td>ACA</td>
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<tr>
<td>Administration of N2O/O2</td>
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<tr>
<td>Anatomy &amp; Physiology</td>
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<tr>
<td>Anatomy and physiology</td>
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<tr>
<td>Anesthesia - general</td>
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<td>Annual Employability Workshop</td>
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<td>Applied Communications</td>
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<tr>
<td>Basic Anatomy and Physiology</td>
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<td>Basic Computer Skills</td>
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<td>Board Review</td>
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<td>CAD/CAM image acquisition</td>
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<td>Career Management</td>
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<td>Career Readiness</td>
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<tr>
<td>Caries Prevention</td>
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<tr>
<td>Chairsides Assisting (4)</td>
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<tr>
<td>Clinical Practicum</td>
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<tr>
<td>College Experience</td>
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<tr>
<td>College Transfer Success</td>
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<td>Communication</td>
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<td>Community Dentistry</td>
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<td>Composition I</td>
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<tr>
<td>Computer Literacy</td>
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<tr>
<td>Computers for dental assistants</td>
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<tr>
<td>Confidentiality</td>
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<td>Coronal Polish (3)</td>
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<td>Coronal Polishing and Caries Prevention (2)</td>
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<td>Coronal Scaling</td>
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<td>DANB</td>
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<td>DANB Review (3)</td>
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Q55. Please complete the following chart for all other content areas required in the accredited dental assisting program.

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<tbody>
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<td>w - z. Other, please specify: Text</td>
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<td>Dental Asst. Professionalism</td>
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<td>Dental Computing</td>
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<td>Dental Dam Workshop</td>
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<tr>
<td>Dental Equipment</td>
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<tr>
<td>Dental Practice Management</td>
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<tr>
<td>Dental Profession (2)</td>
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<tr>
<td>Dental Related Environmental Hazards</td>
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<tr>
<td>Dental Sealants</td>
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<tr>
<td>Dental Seminar</td>
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<tr>
<td>Dental Terminology (2)</td>
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<td>Drug prescriptions, agencies, regulations, common drugs used in dentistry; drugs used in dentistry including anesthetics</td>
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<tr>
<td>Employability Skills (2)</td>
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<td>Employment Strategies</td>
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<td>Environmental Hazards</td>
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<td>Ergonomics</td>
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<td>Essential Dental Assisting Skills</td>
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<td>Expanded Functions (3)</td>
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<td>Expanded Functions I</td>
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<tr>
<td>Expanded Functions II</td>
</tr>
<tr>
<td>Expectations, Computer Literacy, Math, HOSA, and Job Search Prep</td>
</tr>
<tr>
<td>Extraoral Functions</td>
</tr>
<tr>
<td>Face Bow Transfer</td>
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<td>Fluoride application</td>
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<tr>
<td>Foundation of Clinical Dentistry</td>
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<tr>
<td>Foundations of Mathematics</td>
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<td>Gingival Displacement (3)</td>
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<tr>
<td>Head &amp; Neck Anatomy (2)</td>
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<tr>
<td>Histology &amp; Embryology</td>
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<td>HSC Safety</td>
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</table>
Q55. Please complete the following chart for all other content areas required in the accredited dental assisting program.

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<td>Implicit Bias</td>
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<td>Infection Control (8)</td>
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<td>Infection Control in Dentistry</td>
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<td>Internship Seminar</td>
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<td>Intro to Computers (2)</td>
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<td>Intro to Dental Assisting (2)</td>
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<td>Intro to Psychology</td>
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<td>Introduction to dentistry</td>
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<td>Introduction to Oral Health Professions</td>
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<td>Introduction to Psychology</td>
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<td>Laboratory Procedures</td>
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<td>LAP System</td>
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<td>Legal &amp; Ethical Issues</td>
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<td>Math</td>
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<td>Medical Anatomy &amp; Physiology</td>
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<td>Medical Terminology (2)</td>
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<td>Medically compromised patients</td>
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<tr>
<td>Module I - Core Sciences</td>
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<tr>
<td>Module II - Preclinical Dental Sciences</td>
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<td>Module III - Radiation Safety</td>
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<td>Module IV - Coronal Polish and Dental Sealants</td>
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<td>Multiculturalism in Dental Practice</td>
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<td>Nitrous Oxide Administration (2)</td>
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Q55. Please complete the following chart for all other content areas required in the accredited dental assisting program.

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<td>Orthodontic Expanded Functions</td>
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<td>Patient Information &amp; Assessment</td>
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<td>Patients with special needs</td>
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<td>Periodontal Pack Placement</td>
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<td>Practice Management</td>
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<td>Preclinic</td>
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<td>Professional Orientation (2)</td>
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<td>Professionalism</td>
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<td>Pulp Vitality Testing</td>
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<td>RDA Procedures</td>
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<td>Restorative Expanded Functions</td>
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<td>Review for clinical portion of state board exam</td>
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<tr>
<td>Review for written portion of state board exam and national exam</td>
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<td>Review of Dental Assisting</td>
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<td>Seminar</td>
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<td>Service Learning</td>
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<td>Sociology</td>
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<td>Special need and medically compromised</td>
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<td>Special Needs</td>
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<td>Sterilization/Infection Control</td>
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<td>Study skills lab B</td>
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<tr>
<td>Test Taking Skills</td>
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<td>The College Experience</td>
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<td>Tooth Morphology (2)</td>
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<tr>
<td>Ultrasonic scaling for cement</td>
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<tr>
<td>Written Communications</td>
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</tbody>
</table>
Question 55 comments

#55. (A, B, C, D = GEN ED Courses required within the Program of Study) a. COM 120: Interpersonal Communications; b. PSY 118: Interpersonal Psychology; c. and d BIO 106: Intro to Anatomy/Physiology/Microbiology v. Clinical Externships: Students are receiving clinical instruction in dental materials, dental specialties, general dentistry, office emergencies, dental health education, radiology, infection control, hazard communication, office emergencies, dental emergencies, preventive dentistry, advanced functions during the clinical sessions in DEN 106 and DEN 107 clinical courses. During Clinical Externships (DEN 106/DEN 107 there is a 1:6 faculty:student ratio. w. ENG 111 Writing and Inquiry is also required GEN ED course within the Program of Study

#55. a. j, m, s are also covered in prerequisite courses. #55. b - h & r are covered in prerequisite courses. Medical Emergencies (#55r.) is now taught in a prerequisite course.

#55u. All Expanded Functions included in above 8 hours seminar but students also required to journal while attending clinical.

55(q-r). The Dental and Medical Emergencies curriculum is combined. 55. (w). includes standard 2-9 didactic and skills; (x). includes standard 2-12.

55. Didactic instruction during the seminar course included with externship. Extra- and Intraoral functions are as outlined in the state licensing examination requirements. Chairsite assisting is the clinical externship where the student is in the dental office working directly with the dental team. A clinical instructor visits each student and meets with them in a 1:1 ratio. 55s. More emphasis is placed on not only blood borne pathogens and hazard communication but also with disease transmission due to the COVID crisis.

55. The students do not earn any type of restorative functions or preventative functions certificate although it is in the curriculum but do earn Monitoring Nitrous Oxide and Coronal Polishing certificates.

55. (a & b): One course allocated into 2 topics. a. Didactic Hours=16; Laboratory Clock hours=24; Faculty/Student Ratio=1:12 b. Didactic Hours=16; Laboratory Clock hours=24; Faculty/Student Ratio=1:12 55. (c, e, & l): One Course allocated into 3 topics. c. Didactic Hours=11; Laboratory Clock hours=16; Faculty/Student Ratio=1:10 e. Didactic Hours=11; Laboratory Clock hours=16; Faculty/Student Ratio=1:10 l. Didactic Hours=11; Laboratory Clock hours=16; Faculty/Student Ratio=1:10

55. c. Should read Anatomy and Physiology.

55a. & 55b. Content is combined in the DTA1130 Psychology & Communication course.; 55c. Content is course DTA1020 Anatomy & Physiology.; 55d. & 55w. Content combined in course DTA1060 Microbiology & Sterilization.; 55e. Content is course DTA1030 Dental Anatomy.; 55f. & 55g. Content is combined in DTA1050 Embryology & Histology.; 55h. Content is course DTA2070 Ethics & Jurisprudence.; 55i. & 55p. Content combined in course DTA1090 Prevention & Nutrition.; 55j. Content broken down into courses DTA2010 Dental Materials I and DTA2020 Dental Materials II.; 55k. Content broken down into courses DTA2030 Radiology I, DTA2040 Radiology II, and DTA3030 Radiology III.; 55l. Content is course DTA 1070 Pathology.; 55m. Content is broken down into DTA1120 Operative I, DTA2050 Operative II, and DTA2060 Operative III.; 55n. Content has broken down into courses DTA3040 Endodontics, DTA3050 Periodontics, DTA3060 Orthodontics, DTA3070 Oral Surgery, and DTA3080 Pedodontics, however our program is currently working to combine these 5 courses into 1 course named DTA3035 Dental Specialties. A report notifying the Commission about this change is forthcoming when final approval by TBR has been received. 55o. Content is course DTA3010 Practice Management.; 55q. & 55r. Content is combined as course DTA1100 Office Emergencies.; 55t. Content is course DTA 1110 Pharmacology.; 55v. Content is course DTA3020 Clinical Externship. This is a 380 hour course consisting of 320 clinical hours and 60 externship conference hours.; 55x. Content is course DTA1010 Professional Orientation.; 55y. Content is course DTA1040 Head & Neck Anatomy.; 55z. Content is course DTA1080 Oral Diagnosis.

55k. Students expose two full mouth series of radiographs and two panoramic radiographs on live work patients under the supervision of local licensed dentists.
Question 55 comments

55u. Hours are combined with 55n. 55v. These lab hours are reported in other courses.

55v. The clinical instruction clock hours are the hours obtained during the student's clinical phase of on-the-job training conducted at the military dental treatment facility.

Above number are approximate calculations because we have many of these topics covered under specific course titles.

All students must achieve a minimum of 300 clinical hours per CODA requirements.

Any 'advanced/expanded dental assisting functions' learning clock hours were counted in the hours entered for general dentistry or specialty procedures.

As a new director, I discovered that previous curriculum changes are not reflected on previous Annual Curriculum Report.

College Success 22 hours, English 55 hours, Math 33 hours,

College student success course

Content areas are delivered to the students in course outline. Eight courses are presented with the students requiring 1080 clock hours for graduation requirements. All lab and clinic skills are rigorously evaluated before and during clinical rotation.

Coronal Polishing and Pit and Fissure Sealant was included in Preventive Dentistry. In addition to the 32 didactic hours, they complete required hours for CODA and the state at dental offices/clinics.

Everything was tallied into question 55 example: sealants was included in preventative dentistry and dental material

Expanded functions include rubber dam placement and removal, suture removal, coronal polishing, sealant placement, and fluoride varnishes. Skill sets are practiced during clinical externship.

For clinical instruction hours I included clinical externship

In addition to the hours listed, students are required to get the following PRIOR to entry of the program: 55a Interpersonal Communications: 30-40 hours of didactic instruction  55c Anatomy and Physiology: 30-60 hours of didactic instruction  55u. Expanded function instruction is included in General and Preventive Dentistry Procedures information

R: Six hours of the eight indicated for didactic are for review of medical history as it relates to pathology for DAST 1550 Dental Science 2.

Strictly Lab experience student faculty ration is 1:12 Pre-clinical instruction (in our clinic) working with typodonts, faculty ratio is 1:6 Clinical instruction (in our clinic) working with patients, faculty ration is 1:6 Radiology Lab, considered "pre clinical" working with typodonts, faculty ration is 1:6

Students are tested to competence prior to going on clinical externship rotations. the 384 hours are dedicated to practicing clinical skills, and completing assisting tasks and chairside assisting procedures in a dental office setting.

The College Experience course is required by the Institution as a general education requirement.
Question 55 comments

The change in our lab ratio is due to the COVID social distancing restrictions, which are mandated by [sponsoring institution] protocol.

These topics are included as outlined by the Public Health Code and Administrative Rules of the Board of Dentistry.

This is completed to the best of my knowledge by referring to each course's weekly schedule.

We also ask that students attend the annual [redacted] Dental Meeting for workshops. (not required)

v. Clinical Hours are divided like this: a. 144 in Chairside Assisting b. 108 in Restorative Clinic c. 72 in Preventive Dentistry d. 144 in Private Dental Offices (Extramural)
Question 56 comments

56. J. Removal of provisional crown or bridge, O. Soft cement may be removed by dental assistants

56. 56. Additional Expanded Functions: (Laboratory/Pre-Clinical)-Dry root canals, place temporary restorations in canal openings, pre-select orthodontic bands, Etch enamel surfaces prior to bonding, remove excess bond with hand instruments, remove and replace ligature ties, attach pre-adjusted orthodontic appliances, remove fixed orthodontic bands and brackets, remove loose bands and brackets. (Clinical competence) - Take intra-oral and extra-oral photographs, obtain informed consent, place and remove separators, preliminary charting of the oral cavity.

Clinical competence column is what student may have the opportunity to perform during their clinical rotation...

For K, L, M, and N students practice these functions only typodonts to understand the concept of the procedures. Students are not allowed to perform these functions on a patient.

Orthodontic assisting functions are taught to a Lab/Pre-clinical, Dental Dam placement and removal are taught to Lab/Pre-clinical, Retraction cord placement and removal are taught to Lab/Pre-clinical, Creating Provisionals are taught to Lab/Pre-clinical competence.

Other #1; preselection of orthodontic bands, cement removal with rotary instruments, placing and removing ligature ties, placing and removing ortho separators etc. Other #2; placing gingival retraction cord

Packing retraction cord to a laboratory setting.

Placement of restorations is taught in DENT 132 and is an optional course that may or may not be take, if a student is on seeking a TC (Technical Certificate) Most offices do not polish their restorations anymore, thus the level taught is just to pre-clinical.

Previous expanded functions are no longer a State of Idaho requirement. Students will perform nitrous oxide in their externship sites. Coronal Polish and Sealants are performed on manikins

Questions 56 g.h,i,k,l,m,n,o.p,& q- These functions are taught to clinical competency in the optional upper level dental assisting courses during their patient care clinics on campus and taught to laboratory/pre-clinical competency in the accredited certificate courses. Question 56 R The topic of monitoring nitrous oxide analgesia is delegated to only didactic instruction and therefore is not taught to laboratory/pre-clinical competency.

Shade selection - clinical competence Place retraction cord - clinical competence Diagnostic testing (pulp tester) - clinical competence Fabricating temporary crowns & restorations - lab competence

Students are tested for competence on all skills prior to going out on externship rotations in dental offices.

There are a number of other duties assigned to the RDA in [state redacted]. Those duties are taught to the level of competency outlined in the Administrative Rules of the Board of Dentistry. [website redacted]

We teach clinical competence level skills in NM Dental Board approved EFDA certificate program which includes skills in Restorative Functions. Graduates have to take and pass the CRDTS or WREB board exams in Restorative Functions.

all legal functions are first evaluated at the lab/pre-clinical level and then at the clinical competency level

b. After a survey of local offices, including oral surgery and periodontal offices, we found that periodontal dressings are not being used in our area; thus, we discontinued the teaching of periodontal dressing removal. 56 additional other #3: placing and removing orthodontic ligatures and arch wires - taught to preclinical other Other #2 and #3: if a student has one of their clinical externships in an ortho practice, these skills are taught to clinical level #4: denture soft reline placement - taught to preclinical

items j,k,l,n,p, are all EFDA 2 functions, completed after the student leaves the program, items q and r and EFDA and EFDA 1 functions competed after the student leaves the program.
INFORMATIONAL REPORT ON DENTAL HYGIENE PROGRAMS ANNUAL SURVEY CURRICULUM DATA

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

The Curriculum Section of the Commission’s Annual Survey is conducted for dental hygiene education in alternate years. The most recent Curriculum Section was conducted in September/October 2021. Aggregate data of the most recent Curriculum Section for review by the Review Committee on Dental Hygiene Education is provided as an informational report in Appendix 1.

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

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

Prepared by: Dr. Sherin Tooks
Q53. Clock hours for all dental hygiene content areas

**Didactic instruction clock hours**

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**Laboratory instruction clock hours**

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### Q53. Clock hours for all dental hygiene content areas (continued)

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Q53. Clock hours for all dental hygiene content areas (continued)

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Q54. Clock hours per term per year dental hygiene students are scheduled for pre-clinical and clinical practice:

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Q55. Are students taught to perform the service? | Yes | No | Total |
---|---|---|---|
a. Clinical infection control procedures | 99.7% | 0.3% | 1 327 |
b. Medical and dental histories | 99.7% | 0.3% | 1 327 |
c. Vital signs | 99.7% | 0.3% | 1 327 |
d. Intraoral inspection (including charting carious lesions, periodontal diseases, existing and missing teeth) | 99.7% | 0.3% | 1 327 |
e. Extraoral inspection | 99.7% | 0.3% | 1 327 |
f. Dental hygiene assessment/dental hygiene treatment planning | 99.7% | 0.3% | 1 327 |
g. Evaluation of dental hygiene services | 99.7% | 0.3% | 1 327 |
h. Radiographs | 99.7% | 0.3% | 1 327 |
i. Indices | 99.7% | 0.3% | 1 327 |
j. Risk management (i.e., tobacco, systemic, caries) | 99.7% | 0.3% | 1 327 |
k. Impressions for study casts | 99.4% | 0.6% | 2 327 |
l. Occlusal registration for mounting study casts | 76.5% | 23.5% | 77 327 |
m. Pulp vitality testing | 60.9% | 39.1% | 128 327 |
n. Oral health education including health promotion, disease prevention and behavior modification | 99.7% | 0.3% | 1 327 |
o. Clean removable appliances and prostheses | 99.4% | 0.6% | 2 327 |
p. Nutritional counseling | 99.7% | 0.3% | 1 327 |
q. Supragingival scaling | 99.7% | 0.3% | 1 327 |
r. Subgingival scaling | 99.7% | 0.3% | 1 327 |
s. Root planing | 96.9% | 3.1% | 10 327 |
t. Coronal polishing | 99.7% | 0.3% | 1 327 |
u. Application of chemotherapeutic agents | 99.4% | 0.6% | 2 327 |
v. Application of anticariogenic agents | 99.4% | 0.6% | 2 327 |
w. Polish restorations | 77.1% | 22.9% | 75 327 |
x. Pit and fissure sealants | 99.7% | 0.3% | 1 327 |
y. Application of topical anesthetic agents | 99.4% | 0.6% | 2 327 |
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APPENDIX – Responses to open-ended questions

Q53. Other content areas specified:
ACA 111
ADHA, Ethics, DH Profession
Adjunctive periodontolgy
Administration and monitoring of Nitrous Oxide
Adv Topics
Advanced Clinical
Advanced Clinical Topics (2)
Advanced Dental Hygiene Theory for Special Needs Patient
Advanced Periodontics and Topics in Dental Hygiene
Advanced Procedures
Advanced technology
Advocacy and Ethics
Alternative DH Practice
American Govt.
Analysis of Dental Literature (2)
Application of dental hygiene care through case studies
Applied Community Dentistry
Apply Sealants
Basic Instrumentation
Behavioral Foundations (2)
behavioral sciences
Biostatistics
Biostatistics/Statistics
Board Exam Prep
Board Review (3)
Business Practice Management
Capstone II Seminar
Capstone Leadership
Capstone Methods
Capstone Seminar I
Career Development
Career Exploration
Career/Life Planning
Cariology (5)
Case Studies (2)
Child, Elder, Domestic Abuse clinic
Clinic I
Clinic I Seminar
Clinic II
Clinic II Seminar
Clinic III
Clinic III Seminar
Q53. Other content areas specified:
Clinical assessment
Clinical externship
Clinical Teaching
College Algebra
College Algebra/Statistics
College Math
College Success Skills
College Transfer Success
Community Clinic
Community Enrichment site   xternal Rotation
Comp Case Studies
Computer Literacy
Computer Technology (2)
Contemporary Issues in Dental Hygiene
Critical Thinking (3)
Cultural Competency/Competence (3)
Cultural Diversity (4)
Cultural Diversity in Dental Hygiene
Cultural Perspective in Health and Healing
Current Concepts, Practice Management
Current Issues
current issues in dental hygiene
Dental Health Education (2)
Dental Health Safety
Dental Hygiene Practice
Dental Hygiene Practice/Ethics
Dental Hygiene Research
Dental Hygiene Restorative
Dental Hygiene Review (2)
Dental Hygiene Seminar
Dental Implants
Dental Office Management (2)
Dental Office Practice
Dental Practice Management
Dental Public Health
Dental research
Dental Specialties (10)
Dental Team Communication
DH Care Plan
DH Pre-Clinical Teaching
DH Seminar
DH Theory I
DH Theory II
DH Theory III
Q53. Other content areas specified:

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<td>Evidence-Based Practice for the Dental Hygienist</td>
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<td>Foundations of Physiology, Pathophysiology and Pharmacology</td>
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Healthcare Ethics
HIPAA (2)
History (2)
HUM ELECTIVE
Humanities (6)
Humanities Course
Humanities Elective (2)
Humanities/Fine Arts
Implantology
Information Literacy
Instructional Methods
Instrumentation (2)
INTERDISCIPLINARY
Internal Med
Interprofessional collaboration (2)
Inter-professional Collaborative Practice Field Experience
Interviewing Techniques
Intraoral Photography
Intraprofessional Education
Intro to Computers
Intro to Dentistry
Intro to DH Practice
Intro to Healthcare
Intro. to Dentistry
Introduction to DH
Introduction to Research Methods
IPE
IPE didactic course
Laser/pulp vitality
Leadership
Leadership and Group Dynamics
Leadership and Professional Development
Leadership in Admin.
Leadership in Dental Hygiene
Leadership roles and
Licensure Board Preparation
Local Anesthesia
Local Anesthesia and Nitrous Oxide Sedation
Management/Marketing
Math - Stats
Math of Business
Math/Algebra
Mathematics (4)
Microcomputer Concepts
Q53. Other content areas specified:
National Board Review
Nitrous Oxide (3)
Nitrous Oxide Analgesia
Nitrous Oxide Monitoring (2)
Nitrous Oxide Sedation (2)
Office Management (2)
Office procedures, practice management
or Statistics
Oral Biology
Oral Communication
Oral diagnosis
Oral Health Research
Oral Health Worldview
Oral Hist./Embryology
oral maxillofacial
organic chemistry
Orthodontics
Orthodontic band, arch wires
Patient management-medical
Patient Records/EHR procedures
Pediatric Dentistry
Pediatric Dentistry/Ortho
pedodontics
Philosophy
Placement of sealants
Placing Medicaments
Placing, carving, and finishing restorations
POC I
POC II
POC III
portfolio capstone
Practicum and Financial Management
Practice Administration
Practice Management (16)
Practice management for the dental hygienist
Practicum (2)
preclinic
Pre-Clinic I
Pre-Clinic II
Preclinical Instruction
Preclinical Theory
Pre-preclinical
Principles of Dental Hygiene
Principles of Practice
Q53. Other content areas specified:
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  Professional Dental Hygiene
  Professional Development (5)
  Professional Issues (2)
  Professionalism (2)
  prosthodontics
  Provision of Amalgam Restorations
  Provision of Composite Restorations
  Public Health
  Quality Assurance
  RDH 226 Review of DH
  Regulatory Health Care Policy
  Religion
  Research (9)
  research analysis and writing
  research design
  Research in Dental Hygiene
  Research Methodology (4)
  Research Methods (5)
  Research Methods, Perio, and Community Health
  Research, Evidence-Based Decision Making
  Research/ EBD
  Research/EbDH
  Research/Statistics
  Research/Study skills; Professional seminars
  Restorative
  Restorative Clinic
  Restorative Dental Hygiene
  Restorative Dentistry (7)
  Restorative dentistry for the dental hygienist
  Restorative Lab I
  Restorative Lab II
  Resume Writing (2)
  Review of Dental Hygiene
  Risk and Practice Management
  Rubber dam, matrix, and base and liner placement
  Scientific Communication
  Scientific Method and Writing
  Scientific Methods (2)
  SDV 101: orientation to healthcare
  Senior Hygiene Seminar
  Senior Project
  Service Learning
  Skills for Patient & Family Centered Care
Q53. Other content areas specified:
Smoking Cessation
Spanish
Statistical evaluation of dental hygiene literature
Statistics (6)
Statistics and Research Methods
Stats/ Research/Analysis
Substance Abuse
Suicide Prevention CE
Taking Impressions
Technology/documentation
Test and Board Review
Transition to the Dental Profession
Treatment & Evaluation in Dental Hygiene
Trends and Issues in Dental Hygiene
Upper Division GE (3)
Written communication
Question 53, items a – n comments

53 a-i are part of the prerequisites prior to the dental hygiene program.

53. Note: The following credits/content areas are taken as prerequisites to DH Program entry a. 9 cr Written Communications (English Composition I & I and English Technical Writing); b. an additional 3 cr Speech course in addition to the DH program’s 1 credit Oral Health Literacy/2 cr DHYG 612 Communicative Health Literacy and Advocacy course for dual degree BS/MS dental hygiene track; c. 3 credits Introduction to Psychology; d. 3 credits Introduction to Sociology; e. and f. 8 credits Anatomy & Physiology with labs; g. and h. 4 credits General/Inorganic Chemistry with lab and 4 credits Organic & Biochemistry with lab; i. an additional 4 credits General Microbiology and Immunology course with lab.

53.j. Is included in 53.i.

53a and 53b: Hours include content from pre-requisite courses and clinical courses with a ratio of 1:4 in clinic. 53i 5 hours of this course content are shown in immunology. 53j includes 5 hours of microbiology, 1 hour of DHYG 4034, medically compromised and 1 hour of periodontology. 53l Content in DHYG 3022, Dental Anatomy is included in this course.

53a-j: These courses are pre-requisites at [sponsoring institution name]. 53k: General and oral pathology are taught together as a core Dental Hygiene course. 53l: Includes 30 hours of Head and Neck Anatomy (DH 1330) and 15 hours of Dental Anatomy (DH 1340). 53n: Aspects of Ethics is taught beginning in Theory I (DH 1100), then Theory II (DH 1400), in Theory III and IV (DH 2200 and DH 2600), Community Dental Health (DH 2220), and Practice Management (DH 2800).

A & B are covered in CCM 145; E & F in BIO 115; I & J in Bio 145; M in RDH 186; N in RDH 291 and several other courses; and K in RDH 220

A dedicated lab section is not included for these courses, however hands-on learning is used in almost every course in the curriculum.

A-K are prerequisites and total approx 450 clock hours instruction

Above g, h, j and k are topics embedded in the Bio courses required for the program as well as DNH 145 and 146.

Anatomy and Physiology are taken as three course sequence (A & P I, II, III) with 24 lecture hours per course and 48 lab hours per course. Totaling 72 didactic (lecture) and 144 lab hours. This was split evenly between line items e. and f. Chemistry and Biochemistry are taken as two co-registered courses, with 54 hours of didactic (lecture) and 36 hours of lab. This was split evening between line items g. and h.

Anatomy, Chemistry and Microbiology all consists of 2 classes I and II.

Biochemistry is taught in CHEM1310 - Chemistry and DH110 - Oral Embryology and Histology. General and pathophysiology is taught in DH228 - Oral Pathology. Immunology is taught in DH110 - Oral Embryology, DH203 - Periodontology and Histology and DH228 - Oral Pathology. (2)

Calculated using ICCB rules: Theory: 1 credit for every 15 clock hours. Lab: 1 credit for every 30 clock hours Biochemistry is embedded in CHM 110 and in Nutrition courses.
Question 53, items a – n comments

Chemistry and Biochemistry are taught in one course. Both lab and lecture encompass concepts from general, organic, and biochemistry principles. Immunology is taught didactically in LS194 Microbiology (3 hours) and in DH210 General, Oral, and Maxillofacial Pathology (3 hours). Further, Immunology is taught in the LS194 Microbiology Lab for one session (2 hours). Dental Anatomy, Histology, and Embryology are taught in one course. Students are exposed to 5 hours per week of instruction over a 15-week semester.

Chemistry is considered pre-requisite. Biochemistry, Immunology, and Pathophysiology are incorporated throughout the curriculum but are not stand alone courses.

Chemistry; biochemistry; immunology are combined into several courses to total the above hours. The program does not have a separate chemistry, biochemistry and immunology course. Ethics and Legal aspects of dental hygiene are a part of DHYG 2201 didactic portion of the clinical.

Clinics has a ratio of 1:4.8 Preclinic (DHY 119) has a ratio of 1:4.8 Radiography lab (DHY 113) has a ratio of 1:4 Dental Materials lab (DHY 240) has a ratio of 1:8

Content areas A-J are pre-requisite courses. Content areas I and J are taught in the same pre-requisite class, BIOL 220C. For labs associated with E-I, there is one faculty per lab with lab techs available to help as needed.

E and F: Combined: 192 G and H:Combined: 96

Immunology is included in microbiology. General pathology is included in oral pathology

It was noted from our last accreditation that we were deficient in biochemistry. Two hours and 4 objectives were added to Oral Pathology to increase the lack of biochemistry.

Line E & F are combined on Line E because Anatomy and Physiology are taken as one course for two semesters. BIO 211 and BIO 212

Lab (Dental Anatomy, dental materials, etc.) faculty to student ratios are 1:10. Radiology lab faculty to student ratio is 1:5. Preclinic and clinic faculty to student ratio is 1:5

Lab ratios for general education courses are no more than 1:10. Many students transfer out of general education courses and class size is typically less than 15 students.

NUT210 Nutrition + CHE130 Chemistry [14 hours] + [Didactic 6] + [6 Lab - 2 Labs] = 12 hours

On July 1, 2015, the [sponsoring institution] course credit hour:contact hour ratio of the curriculum changed from 1:15 (didactic)/1 :30 (science laboratory)/ 1:45 (laboratory/clinical) to 1:12.5 (didactic)/1 :25 (science laboratory)/ 1:37.5 (laboratory/clinical). The [state committee] 2012 -2015, which was in effect at the time of the previous CODA review of the [sponsoring institution] dental assisting program in 2013, defined contact time as "the actual time instructor spends with students in an instructional method." The [sponsoring institution] Day Contract that was executed July 1, 2015 -June 30, 2018, and went into effect July 1, 2015 defines contact time as "the actual time is the actual time instructor spends with students in an instructional method. For laboratory -like and clinical courses, every 50 min of class time shall be calculated as one contact hour." (Article 12.03 B.5.b.) Before the change, the credit/contact hour ratio of the curriculum was 1:15 (didactic), 1:30 (laboratory) and 1:45 (clinical). Since the change, the credit contact
Question 53, items a – n comments

hour ratio of the curriculum is 1:12.5 (didactic), 1:25 (laboratory), 1:37.5 (laboratory/clinical). This change was reported to the Commission and will be reviewed at the Winter 2022 meeting.

Oral embryology, histology and tooth morphology are taught in the same course 49.5 lecture hours and 13.5 lab hours. Immunology and General and/or Pathology are taught in the same course 36 hours.

Our Physiology class is combined with Anatomy. The total lecture hours for that class is 60.

Pre requisites include: sociology, psychology, anatomy, physiology, chemistry, biochemistry, microbiology, nutrition, health care ethics

Prerequisite courses are not included.

Prerequisite courses include: BIOL 1314 - Essentials of Anatomy and Physiology, CHEM 1134 - General, Organic and Biological Chemistry, BIOL 1324 - Basic Microbiology, ENGL 1113 - Composition I. General education courses include: COMM 1113 - Public Speaking, PSYC 1113 - Introduction to Psychology, SOCI 1113 - Introduction to Sociology; these courses are required to graduate with an Associate of Applied Science degree, the student can take these courses in addition to dental hygiene courses; however, these courses are not required "in" the accredited dental hygiene program as part of the dental hygiene program curriculum. General and/or pathophysiology is included in the Basic Microbiology prerequisite course. Oral anatomy is included in the Oral embryology and histology clock hours for this dental hygiene program.

Question # 53 e, f, g, h, i: These are not dental hygiene courses and these courses can accept 24 students at on time in a lab with one professor. 1:24

Ratios were provided for lab faculty to student ratios only. 0:0 was used to indicate when there is no lab associated with a didactic topic.

Sociology is a topic in DEH 2701 (2),1000 (2),2804 (2),1800 (4),2806 (2),1720 (2),1200 (5). Dental Materials DES 2100 and Biochemistry and Applied Nutrition DEH 1710 have topics on Biochemistry. Microbiology and Immunology combine for 47 hours didactic and 45 lab hours. Orofacial Anatomy DES 1020 with 14 hours and tooth morphology with 18 hours combine for 32 hours. Orofacial Anatomy with 21 hours and tooth morphology with 24 hours combine for 45 hours of lab.

Students may take general education and prerequisite courses at other institutions where the faculty to student ratio is unknown.

The prerequisite courses were not included on the previous report (2019) as per the instructions.

There are 2 Anatomy & Physiology courses: Anatomy & Physiology I @ 5 credits / 2 lab hours Anatomy & Physiology II @ 5 credits / 2 lab hours

This includes courses taken prior to entrance into the program and information pertaining to dental hygiene coursework. All are required to complete the degree.

This includes prerequisites as well as program courses

This is not applicable due to the program closure.

This is not including prerequisites hours.
### Question 53, items a – n comments

Written and Oral Communications is not a stand alone course. It is embedded throughout our course curriculum. Biochemistry is incorporated in Anatomy and Physiology I (BIO 1141/1147) and in Nutrition and Oral Health (DEH 1206). Immunology is taught within General and Oral Pathology (DEH 1306) and Microbiology (BIO 2205). Program specific requirement is completion of high school chemistry within the last 5 years with a grade of "C" or better or completion of Intro to Chemistry I (CHE 1111) within the last five years. Legal and Ethical Aspects of Dental Hygiene is introduced in Introduction to Dental Hygiene (DEH 1102), Reviewed in Preclinical Dental Hygiene I (DEH 1204), enforced throughout the entire program and mastered in DEH Dental Hygiene Practice (DEH 2604).

Written and oral communications are a small component of many courses within the curriculum. Student’s orally present the following items to the peers/faculty while in the program: perio presentation, pico question presentation, storyboard presentation, behavior modification presentation, dental anomaly presentation, oral path presentation, motivational interviewing videos, mind map presentation. Written communication occurs in the form of journals, discussion groups via CANVAS, and papers. In addition, there are pre-reqs that focus particularly on those two skills.

Written communications, psychology, sociology, anatomy, physiology, chemistry and microbiology are required prerequisites.

- a - i are program pre-requisites--see questions 20b and 20c for required credit hours for graduation with BS degree

- a. DHYG Theory courses have written projects incorporated; estimated 5 hrs.  
  - b. DHYG Theory courses have public speaking presentation projects incorporated; estimated 5 hrs.  
  - c. Pre-clinic lecture discusses general psychometric skills of patients and behavior.  
  - d. Clinic I or II lecture discusses general social environmental skills of patients in connected to diseases.  
  - e. ad f. All DHYG courses incorporate general anatomy (not dental, head, neck, anatomy) in relation to the body mechanical systems.  
  - g and h. Biochemistry and Nutrition course includes hours of instruction  
  - i. Microbiology is discussed in periodontology lecture.  
  - j. Immunology is discussed in periodontology lecture.  
  - k. All DHYG courses incorporate general pathology (not dental, head, neck, anatomy) in relation to the body mechanical systems.  
  - l. Head neck and oral anatomy minimum hours are 30.  
  - m. Oral embryology and histology minimum hours are 15.  
  - n. Legal and ethics aspects are included in all theories, but primarily pre-clinic lecture and Clinic IV theory. The minimum hours are 16.

- a. Written Communications is Eng 101 and 102 total hours  
  - k. Med Emer and Gen Diseases/oral Path total hours  
  - l. Tooth morph, oral anatomy and Head and Neck total hours

- a.b; written and oral communication is spread throughout the curriculum, specifically in clinical where written and oral is a daily communication. Classroom will require written papers/research and oral presentations. Hours represent clinical and classroom. c and d are included in clinical classes didactic portion; these are pre-requisites.  
  - e. Students have 8 credits prereq anatomy/physiology. Here they have a specific oral anatomy, pathophysiology class. The anatomy in e is based on their Local Anesthesia semester class and clinical instruction.  
  - f is included with oral and pathophysiology i. Microbiology is a pre-requisite; students will study dental micro in their 1st year clinical hygiene class and in pathology j is included in oral pathology.  
  - n. is included throughout the curriculum and specific didactic classes as part of their ADHA code of ethics at the start of the program and again in the last semester of their program
Question 53, items a – n comments

ccontent related to Histology and Embryology is embedded with our 3 clock hour Orofacial Anatomy course. Legal and ethical aspects of dental hygiene is embedded within our Dental Hygiene Theory I-IV course (DHYG 1010,01020,2010,2020)
g. Chemistry is taught throughout the curriculum as follows: A total of 45 hours of lecture: CHE105, DNT200, and DH220. A total of 45 hours of laboratory: DH130, DH220, and DS110. *Faculty:student radios for lab are 1:10 for DH130, 1:1 for DH220, and 1:5 for DS110.
h. Biochemistry units (16 hours) offered Chemistry course. j. Immunology (10 hours) offered within Microbiology course.

head & neck anatomy has a lab section associated but is not a traditional lab, it is didactic in nature to allow for more learning activities. Immunology/pathophysiology taught as modules within other courses (physiology)

some of these hours are a sum of hours/times from several different classes
Question 53, items o – jj and Question 54 comments

#53: Often the content is included in the clinical instruction hours and ratios--ie patient management is part of clinical dental hygiene

#54. 3RD year: Clinical Term 1 = 180, Clinical Term 2 = 180

(x) and (dd) are incorporated into other courses.

(y) is composed of preclinic and clinical instruction (bb) medical and dental emergencies are taught in (ee) Process of Care I (z) Provision of services for and management of patients with special needs are taught in (ee) Process of care I

* Clinical instruction in these areas is an integral part of, and is included in hours indicated for clinical dental hygiene. They are evaluated on every patient.

1st year clinical Term 2 (Summer Semester) is 8 weeks

1st year preclinical DH 123, first year clinical DH 124

1st year preclinical= one semester of 6 hours per week for 16 weeks =96 hours
1st year clinical = one semester of 12 hours of clinical for 16 weeks =192 hours
1st year clinical = one semester of 12 hours of clinical for 8 weeks = 96 hours
2nd year clinical = two semesters of 12 hours of clinical for 16 weeks =384 hours

1st year preclinical term 1= 9 hours x 16 weeks, 1st year clinical term 2= 8 hours x 16 weeks, 1st year clinical term 3= 16 hours x 10 weeks, 2nd year clinical term 3= 16 hours x 16 weeks, 2nd year clinical term 4 = 12 hours x 16 weeks

1st year: Term 1 Fall Semester, Term 2 Spring Semester, Term 3 Summer Semester 2nd year: Term 1 Fall Semester, Term 2 Spring Semester

2020-21 academic year 3 hour lab/clinic sessions were scheduled to meet COVID temporary flexibility resulting in slight increase in lab 2%; clinic hours 6%  (lab 194/198 hrs; clinic 836/891 hrs)

28 hours are completed in the summer. 3.5 weeks, 2 days per week for 4 hours each

2nd year: Clinical, Term 5: 60 clock hours.

2nd year: Term 1 (also 20 hrs pre-clinical local anesthesia + 30 hrs pre-clinical restorative dentistry) 2nd year: Term 2 (also 30 hrs pre-clinical restorative dentistry) 2nd year: Term 3 (also 48 hrs pre-clinical restorative dentistry)
Question 53, items o – jj and Question 54 comments

53 cc&dd: Subject matter for Infection and hazard control management and Provision of oral health services . . . are covered in DHYG 301/Sterilization & Disinfection; Infection Control and Transmissible Diseases (3 hours); DHYG 309/Asepsis (3 clock hours); and are areas covered in College of Dentistry Annual Clinic Compliance/Safety Training (mandatory)

53 ee. Elements of Research

53. Note: 3 credits Nutrition is prerequisite before entering program and is an additional 45 didactic clock hours not tallied in o. w. Oral Health Literacy in addition to didactic and clinical applications was applied in aa. Two community Oral Health Service-learning courses at a total of 3 credits (135 total service-learning hours) plus the 3 credit didactic Community Oral Health course were tallied together since the didactic and two service-learning courses complement each other.

53. Most courses in 53 include clinical courses in which application of didactic material occurs. Content hours are sometimes split between courses when content is shared. 54. There is a summer term between the 1st and 2nd years in which there is is a clinical course with 45 clock hours.

53.u. clinical instruction for pain management utilizes student partners

53o-Besides the Nutrition course of 30 clock hours of instruction, there are components of nutrition as linked to oral health embedded in the Dental Hygiene theory courses (approximately 10 clock hours), totaling 40 hours. 53y-lab hours based on Pre-Clinic lab instructional clock hours of 6 hours for 15 weeks & clinical lab instructional clock hours are based on 15 weeks. All other course clock hours are based on 16 weeks (students attend for 16 weeks). 54-Clock hours are based on 15 weeks.

53o-dd are also integrated throughout all clinical experiences. 53x links directly to clinical dental hygiene. 53ff is new since last year. It can be completed post graduation, but we added it as a required Continuing Education course. It is WA State required within six months of graduation. 53gg is maximum 1:5 ratio, generally less.

53o: Nutrition is a pre-requisite course. 53q: Tooth morphology is initially taught in DH 1340 Dental Anatomy for 15 hours. At least 5 hours are spent on this subject in DH 2450 Periodontology. Clinically, tooth morphology is taught and reinforced in Clinic III and IV (DH 2210 Clinical Dental Hygiene III and DH 2610 Clinical Dental Hygiene IV). 53r: General and Oral pathology are taught together as a Dental Hygiene core course. 54c: Includes minor activity enrichment rotation sites.

53s Radiography 1:6 ratio is completed during the Dental Assisting program.

54. In addition, winter and summer sessions are offered for students interested in the extra clinical hours. For first-year pre-clinical session is 54 hours. For second-year clinical session is 108 hours.

54. Term 3 reflects a summer session (8 weeks)

54: There are five semesters in our program
Question 53, items o – jj and Question 54 comments

90 hours included in term includes 10-week summer session

Biochemistry (8) + Nutrition (24) = 32, Orofacial Anatomy (14) + Tooth Morphology = 32, Oral and Maxillofacial Pathology (22) + Anatomy I & II (8) + Immunology (10) = 32, Periodontology (I & II) = 63, Pain Management includes Pharmacology (6) + Histology (2) + 1800L (1) + 2803L (3) + 2802L (15) + 2804L (6) + 2805L (3) = 36, Dental Materials (26) + Chemistry (60) = 32, Patient Management includes 2300 (3) + 2802L (2) + 1800 (2) + 1200L (3) = 10. All terms noted are Pre COVID and will return to these clock hours Post COVID. Term 3 = 2802L (135) + 2804L (180) = 315

Clinical Dental Hygiene has a MINIMUM of 560 clinical hours, actuals are scheduled for 920, with 744 hours of direct patient care available. 3 year program. Year 1 = 2 terms pre-clinic, 1 term clinic. Year 2 = 3 terms clinic. Year 3 = 3 terms clinic

Clinical Dental Hygiene hours have not changed. The method of counting these hours has changed in order to count patient treatment in courses other than the courses that are named Clinical Dental Hygiene.

Clinical instruction clock hours are recorded on the clinical practice line in question #54.

Clinical skill evals are conducted in clinic I, II, III, IV to assess for competency related to didactic instruction identified above with radiology, pain management, dental materials, oral health ed, patient management, special needs, medical and dental emergencies, infection control and bloodborne infections. I have them identified with lab hours.....the clinical component of these areas are included in our clinic I, II, III, and IV courses.

Correction on 53V: we do not have a clinical portion to dental materials (biomaterials) course. Only a laboratory portion. Dental materials clinical portions is incorporated in semester 6 with restorative clinic, RDH 285. Correction on 53w. referring to oral health education and prevention being taught throughout the program in all clinical dental hygiene experiences at minimum. Correction on 53x. Patient management is in reference only to our Patient/Pain management course, not to patient management training in general. 53cc Infection and hazard control management is covered and practiced throughout the program in each lab and clinic experience. 53dd Provision of oral health services to patients with infectious diseases- these concepts are woven through various courses including RDH 218 Periodontology and RDH 259 Community & Public Dental Health.

During 2nd year DH2 students are also on clinical rotations 105 hours both terms. Clinical hours were reduced due to provision of care in pairs during fall 2020 and part of spring 2021 due to restrictions associated with aerosol control during COVID19 pandemic.

For 1st year pre-clinical we have 12 [x 16] = 192 lab periods for a semester of 16 weeks. For the 1st year clinical we have 15 [x 16] = 240 lab periods + 12 [x 16] = 192 clinical periods for a semester of 16 weeks. For 2nd year clinical Term 1 we have 16 [x 16] = 256 clinical periods. For 2nd year clinical Term 2 we have 19 [x 16] = 304 clinical periods.

I = 12 hours x 14 weeks II = 8 hours x 14 weeks III = 12 hours x 14 weeks IV = 14 hours x 14 weeks
Question 53, items o – j j and Question 54 comments

If a student is repeating a clinical course, in the 3rd term they would do the normal hours for the clinical course they are repeating.

In the above curricular categories, patient management, special needs, infection control and blood-borne pathogens are taught in the Pre-Clinic, Clinic II, III, and IV courses.

In the above responses, it is difficult to tally the time students spend on clinical items related to each content area as it varies as the needs arise for patients (ex nutritional counseling, radiographs, etc). The time in Clinical Dental Hygiene incorporates several of the other topic areas.

In the previous curriculum report, preclinical/clinical hours were duplicated in some content areas. This report includes the required corrections.

Local Anesthetic will be added to the curriculum in the clinical content over the next year due to the [state] Legislature now mandating that registered dental hygienists can now administer local anesthetic.

Note: 1st year pre-clinical includes Fall semester (135 hours) and winter intersession (54 hours) =189; 1st year clinical Term 2 - includes Spring semester (162 hours) and Summer session (72 hours) = 234. 2nd year clinical term 1 Fall semester (192 hours) and winter intersession (72 hours) = 264 and Spring semester (216 hours). Total Clinical hours 903. Oral embryology, histology and tooth morphology are taught in the same course 49.5 lecture hours and 13.5 lab hours. Immunology and General and/or Pathology are taught in the same course 36 hours. Patient Management is covered in Principle's of Dental Hygiene and Seminar 90 hours. Community Oral Health has 36 lecture hours and 72 hours implementing service learning over the two year program.

Our bachelor degree curriculum begins with fundamental classes in the first term with no pre-clinical clock hours. Pre-clinical hours begin in term 2, with clinical hours beginning their junior year, term 1 through the senior year term 2.

Our seminar courses include patient management, medical emergencies, special needs care. Our curriculum is 5 semesters long. For this question, we included the first three semesters as the first-year curriculum.

Pain management was listed twice. We do not have a specific course for pain management so hours are established in the 3rd and 4th year clinical courses along with administering and monitoring delivery of nitrous oxide. We do not have a specific course on infection control or BBP. Information is incorporated into pre-clinic course and self-study practicum provided by the Safety and Health Coordinator.

Patient management is introduced in DH 10/100.1. Introduction to Clinical Dental Hygiene and reinforced in DH 20.1, Clinical Dental Hygiene Seminar, DH 30 Advanced Clinical Dental Hygiene Seminar and DH 40 Advanced Clinical Dental Hygiene Seminar. In the laboratory component of DH100.1 instructor ratios are 1:5 as students are supervised reviewing health histories and risk factors. (2)

Pre-clinic = 6 hrs x 15 weeks 1st yr clinic /Term 2 = 9 hrs x 15 weeks Term 3 (summer session)= 12 hrs x 5 weeks 2nd yr clinic = 12 hrs x 15 weeks
Question 53, items o – jj and Question 54 comments

Program sessions are semesters. Semesters 1-3 are considered first year which includes pre-clinic for a total of 210 clinic hours. Semesters 4-6 are considered second year for a total of 510 clinic hours.

Q is in RDH 186; R in RDH 220; FF in RDH 209; EE is a board prep review course. Total 720 hours of clinic including 90 hours of pre-clinic.

Q.53. Clinical Instruction hours were calculated based on sum of all clinical based courses that incorporate that topic/area instruction throughout the curriculum.

Radiology Interpretation - 15 didactic/lab instruction clock hours 2 yr: Term 1 = 0; term 2 Preclinical: 30 lec/120 lab/clinic; term 3 (summer) clinical = 72 3 yr: Term 1 = 30 lec/90 clinical; term 2 = 3 lec/90 clinical; term 3 (summer) = 250 clinical 4 yr: Term 1 = 15 lec/180 clinical; term 2 = 30 lec/135-180 clinical

Ratios different than previous years due to reduced number of students due to reduction in class size during reporting year as required by social distancing in pandemic situation. Terms are semesters.

Same as ‘y’ clinical Dental Hygiene.

Second year clinical term 3 was extended by four weeks due to COVID 19 mandatory lock down.

Students also have a required summer semester with 108 clinical hours (between 2nd and 3rd term).

Students do have clinical hours over the summer between their junior and senior year. They are in clinic for three weeks and treat patients for a total of 80 hours.

Summer Term - 96 hours clinical

Term 3 = summer

Term 3 for the Class of 2022 class was extended from 80 clock hours to 95 hours this year to be proactive against closures due to COVID-19.

Term 3 in Question 54 is the Summer semester (8 weeks).

Term 3 includes clinical hours at the [name] Clinic during the Summer course. Second year clinical hours are counted over the entire year and divided in 2 for this question.

Term = quarter

Term III is a 4 week "summer" term though it falls within our Fall semester.
Question 53, items o – jj and Question 54 comments

Terms are semesters. Enrollment begins fall semester and continues for 5 semesters with graduation at end of term 2 of 2nd year.

The DH program made and reported a few curriculum changes which reduced the overall DH program by 2 credits. You'll note a reduction in hours for (O.) Nutrition, and (W.) Oral Health Education and Preventative Counseling as a result of this change.

The [sponsoring institution name] Dental Hygiene program is in its second year and many of the courses are combined including in the clinic and preclinic settings. The students will have 96 hours of pre-clinic along (hands-on) instructions and 32 hours (hands-on) instruction in radiology lab the first semester. The second semester students begin clinicals and will complete 128 hours and will begin seeing live patients during this clinical. The third semester and fourth semesters (Summer and Autumn) consists of 192 hours each semester of hands-on instruction and see live patients.(During clinical hours students do receive instruction in all aspects of dental hygiene throughout the program).

The clinic hours have been reduced to not include remediation and screening clinics. The hours for didactic courses and labs were reduced to a 15 week schedule and do not include the 16th week which is finals week.

The dental hygiene students in their DH3 year do not have preclinical courses in the first semester. Second semester of the DH3 year, preclinical courses occur. Then the students matriculate into their DH4 year in the Summer Semester of the DH4 year. This is why we have three clinical terms listed in the 2nd year: clinical section (#54, letter C). Additionally, we are reporting the data for the Class graduating in Spring of 2022. There has been a curriculum change that will be reported on next year's survey.

The lab hours for Community Oral Health are required outreach hours where students are engaged in service-learning opportunities throughout the local area.

The pre-clinical and/or clinical components of u, w, x, z, cc and dd are included in y: Clinical Dental Hygiene.

There are three Pre Clinical courses and 8 Clinical sections.

This is the first semester of a new dental hygiene program. Currently, students are only enrolled in the pre-clinical portion of the program.

Tooth morphology (14 didactic instruction clock hours) is included in the Oral embryology and histology clock hours for this dental hygiene program.
Question 53, items o – jj and Question 54 comments

Tooth morphology is taught within Head, Neck, and Oral Anatomy. The course is Head, Neck and Dental Anatomy (DEH 1202). Oral and Maxillofacial Pathology is combined with the course General and Oral Pathology (DEH 1306). Periodontology is embedded in Clinical Dental Hygiene I (DEH 2402) and continues in Clinical Dental Hygiene II (DEH 2506). s through dd are subjects that are taught within their distinct course but is carried into the clinical situation. Hours were difficult to determine and vary per student. All students are directly observed when they administer local anesthesia in clinic. Students must master competency in pain control before they administer.

[Sponsoring institution name] admits one class every other academic year.

aa: Community dental - lab hours are completed in the community with a sponsor - no faculty are present. ratio is NA

h. & o: taught together in DHYG 2110 p. & u: taught in DHYG 1206 together y. includes: DHYG 1040, 1111, 2010 didactic hours DHYG 1050, 1111, 2020, 2090, 2140 clinic hours [u, v, w, x, z, bb, cc, & dd are taught in the courses listed in y.]

kk. sleep apnea 2 hrs didactic/0 lab/0 clinic/NA lab/clinical faculty:student ratio II. Child Abuse continuing education certification for pre-licensure 3 hrs independent HW requirement

o. DH212 Nutrition: 3 hours of clinical instruction constitutes chairside nutritional counseling in three parts and is taught to clinical competency. t. Periodontology is taught in DH225 Clinic II and Periodontology Seminar (30 hours), and in DH235 Clinic III and Advanced Periodontology Seminar (30 hours). Periodontology is also covered at the introductory level in class and clinic in LS194 Microbiology. X. Patient Management is introduced in DH100 - Introduction to Dental Hygiene through the ADPIED method of the Process of Care, put into practice in DH105 - Preclinic and Infection Control and refined in all clinics: DH215 Clinic I, DH225 Clinic II, DH235 Clinic III. Z. Provision of services for and management of patients with special needs: 3 hours in DH100 Introduction to Dental Hygiene, 3 hours in DH215 Seminar, 3 hours in DH240 Oral Health Education and Promotion. Students are also required to work with 3 special needs patients in clinic, equalling 12 hours of clinic time. bb. Medical Emergencies: Students take DH102 Medical Emergencies as a stand-alone course. Additionally, students are trained in CPR and Basic Life Support on-site upon matriculation (6 hours). cc. Infection and hazard control management: Didactic instruction takes place in the following courses: 1 hour is taught in DH100 Introduction to Dental Hygiene at an introductory level, 18 hours are taught in DH105 Preclinic and Infection Control. Infection Control measures are taught to competency and practiced in DH105 lab, finally, every patient encounter in all clinics are taught to competency and graded. dd. Provision of oral health services to patients with bloodborne infectious diseases: Didactic instruction is handled in the following courses: 6 hours in DH210 General, Oral, and Maxillofacial Pathology, 3 hours in LS194 Microbiology, and 2 hours in Periodontology. Students are introduced to infection control procedures in LS197 Microbiology lab (6 hours), and finally, infection control procedures are taught to clinical competency in DH215 Clinic I.
Question 53, items o – jj and Question 54 comments

o. Nutrition-45 hrs minimum is provided. p. Pharmacology-45 hrs minimum is provided. q. Tooth Morphology-15 hrs of lecture and 30 hrs of lab. r. Oral and pathology-45 hrs minimum is provided. s. Radiology-30 hrs of lecture and 45 hrs of lab t. Periodontology-45 hrs minimum is provided. u. Pain management-8 hrs of lecture in Pharmacology, Dental Materials, and theory courses. 8 hrs of clinic for hands on non inject-able anesthetics on patient use. v. Dental materials: 15 hrs lecture and 30 hrs of laboratory w. Oral Health education and preventative counseling: 20 hrs for theory courses such as Preclinical lecture, Clinic I, II, and III. There were 80 hours calculated from 2 hrs each week x 40 weeks. x. Patient management: There were 80 hours calculated from 2 hrs each week x 40 weeks. y. Clinical Dental Hygiene: 120 hr minimum (Preclinical, Clinic I, II, III, IV) z. Provision of services for and management of patients with special needs: 30 hrs minimum aa. Community dental oral health: 15 hrs of lecture and 60 hrs of laboratory. bb. 16 hrs (CPR course, PC lab, and Pharmacology) cc. Infection and hazard control management: 172 hrs calculating 1 hr per day for estimated clinical days. dd. Provisions of OH services to patients with bloodborne infectious diseases: provided an estimate of 10 hrs of lecture. There are 45 hrs estimated for BB infectious disease. All patients are treated as if they have a bloodborne disease regardless.

s. radiology is a 3 credit class didactic taught 1st year fall. Along with this class are labs in fall and spring. Students in their 2nd year have to assess and take quizzes as part of their clinical requirements. v. dental materials is didactic/lab class. In clinic they are required to complete aspects of this class also. y. clinical dental hygiene is taught all 4 semesters, in class, clinic and lab. Lab portions for the 1st year fall semester are their clinical dental hygiene experiences, then patient care begins spring semester. 2nd years are involved in clinical practice both semesters. z and aa combined as a in community public health students will experience this. They also have experiences in the clinical portion. 54 Hours in the 2nd year based at 12 hrs/week, however they can range from 12-18 hours per week.

the program is a 1-plus-3 program. The first year in the program the students learn the foundations to practice, including periodontology. No preclinical courses are taught. Junior year, students enter preclinical in fall (8 hours per week) in the spring they are in clinical 8 hours minimum per week. Senior year consists of a summer semester and a fall and spring semester. In the summer students are scheduled for 24 hours a week for the 6 week semester. They are scheduled at least 13 hours a week for fall and spring.

y. Total clinical hours=656. Per instructions, "clinical instruction" hours where students were evaluated on specific content areas in any way (formative or summative) were deducted from the total clinical dental hygiene hours (656-204 = 452).
Question 55 comments

#mm. In [state name], Dental hygienists are able to place Interim Therapeutic Restoration (ITR). Students are exposed to this skill, however, due to the COVID-19 pandemic and limited clinic access by the public, the ITR certification for clinical competency is not offered.

Administration of local anesthesia by an RDH was recently passed into law in the state but has not been implemented in the program as of yet.

Although administration of local anesthesia is currently not a delegable procedure according to the dental practice act, the dental hygiene students at [sponsoring institution abbreviation] are participants in a pilot project between the School of Dentistry and the [state name] Board of Dental Examiners where the dental hygiene students are administering infiltration and block local anesthesia to patients of record in the dental hygiene clinic.

Amalgam restorations and composite resin restorations are placed for the experience and understanding of the material only- not taught at the level for actual clinical placement.

COVID impacted sophomores, juniors and seniors by delaying clinical experiences. All sophomores and juniors were able to make up time missed due to COVID and have achieved minimum competency. The end of the Spring semester 2020 was extended for a May diploma (through June 30), based on the status of the pandemic in the United States. This has enabled a small number or remaining fourth year graduating seniors to complete their clinical competencies through direct patient care without negatively affecting their graduation timeline.

Clarification ff: we discuss and teach the students the different types of suture placement in theory courses and we remove sutures. It is not within our scope of practice to place sutures.

Dental Materials course has many competencies that are only taught to lab competency (ie: place and carve restorations, remove sutures, periodontal dressings)

[Sponsoring institution] Dental Hygiene Program does not provide Expanded Functions Dental Assisting criteria. The program does complete Anesthesia and pain control that includes nitrous oxide training.

If students take the elective restorative course, they are taught to perform the services in Items ii-uu to a clinical competence level.

In most instances where students are taught to perform a service (but not to clinical competence), they do so to laboratory competence if applicable.

In regards to hh: The students learn about the procedure, but we do not teach the students to perform it. Students learn about this procedure in the didactic setting, basically as a previously practiced treatment procedure and why it isn’t a main treatment procedure in today’s practice due to the continued research that has been gathered. Research shows that this particular periodontal therapy procedure has moved into the failure to support its efficacy column.

Instead of root planing, current standard of care is taught, which is periodontal therapy (includes ultrasonic scaling).
Question 55 comments

Nitrous oxide administration and monitoring requires certification through a state board approved course. This is a requirement as part of the curriculum.

Note: Answers marked "no" are taught during the lecture portion but the students do not do the perform the marked "no" procedures.

Root planning was marked as "yes" as taught to clinical and laboratory competency based on the revised definition of the term.

Select dental biomaterials are taught to laboratory competency and include the following: temporary restoration placement, rubber dam placement and removal, materials placement and removal, suture placement and removal and periodontal dressing placement and removal.

Some are demonstration only and completed on typodont only.

Students are taught to perform some of the services listed above in laboratory settings, but they are not taught to perform the services to clinical competency.

Students receive a lecture over the following services for foundation knowledge; however, they are not taught to perform the services: m, dd, ee, ff, gg, hh, ii, jj, kk, ll, nn, oo, pp, qq, rr, ss, tt, uu.

[State name] scope of practice limits LA and N2Os activities; these are completed on manikins.

The state of […] does not permit certain functions.

We teach gingival curettage to the level of competence required to safely remove necrotic tissue.

bb and cc. Did not teach to competence as could not use equipment available due to pandemic conditions.

periodontal dressings and suture removal are done to lab competency only.

s- We teach scaling and root debridement (i.e, removal of calculus) versus root planing (i.e, removal of rough cementum) which is contraindicated according to research. w- We only polish restorations with non-abrasive prophy paste.
CONSIDERATION OF PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR DENTAL HYGIENE EDUCATION PROGRAMS RELATED TO STANDARDS 2-14 AND 3-7

**Background:** On November 12, 2021, the Commission on Dental Accreditation (CODA) received a request from Ms. Margaret Lemaster, adjunct professor, Virginia Commonwealth University, to consider proposed revisions to Standards 2-14 and 3-7 of the Accreditation Standards for Dental Hygiene Education Programs. The request for revision of the Standards is found in Appendix 1.

The proposed revision to Dental Hygiene Standard 2-14 suggests the Commission modify the requirement that graduates “be competent in providing dental hygiene care for all types of classifications of periodontal diseases including patients who exhibit moderate to severe periodontal disease.” The proposed change requests that the language be modified to require graduates “be competent in providing dental hygiene care for all stages and grades of periodontal disease.”

The proposed revision to Dental Hygiene Standard 3-7 suggests that the Commission require all full-time faculty to possess a master’s degree or be in the process of obtaining a master’s degree. Currently, Standard 3-7 requires that “full time faculty of a dental hygiene program must possess a baccalaureate or higher degree.”

**Summary:** The Dental Hygiene Review Committee and Commission are requested to consider the proposed revisions to Standards 2-14 and 3-7 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 1) submitted by Ms. Margaret Lemaster. 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
To the CODA Dental Hygiene Review Committee:

I would like to submit two recommended revisions to the Accreditation Standards for Dental Hygiene Education Programs for consideration at the January 11-12, 2022, Dental Hygiene Review Committee meeting and the February 10, 2022 Commission meeting.

1. **Standard 2-14 states:**

Graduates must be competent in providing dental hygiene care for all types of classifications of periodontal diseases including patients who exhibit moderate to severe periodontal disease.

Consider the following changes to Standard 2-14:

Graduates must be competent in providing dental hygiene care for all stages and grades of periodontal disease.

**Rationale:**

The American Academy of Periodontology (AAP) published the official proceedings from the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions. These proceedings provide a comprehensive update to the previous disease classification established at the 1999 International Workshop for a Classification of Periodontal Diseases and Conditions.

From the AAP website:


The multi-dimensional staging and grading framework for periodontitis classification is among the 2017 Workshop’s major features. Staging levels indicate the severity of the disease and the complexity of disease management, while the grading structure considers supplemental biologic characteristics of the patient in estimating the rate and likelihood of periodontitis progression. This framework builds upon a notable change: Forms of periodontal disease are now defined as one of three distinct forms which include periodontitis (formerly aggressive and chronic), necrotizing periodontitis, and periodontitis as a manifestation of systemic conditions. The four categories of periodontitis staging are determined by a number of variables and range from the least severe Stage I to most severe Stage IV. The three levels of periodontitis grading—which consider a patient’s overall health status and risk factors such as smoking and metabolic control of diabetes—indicate low risk of progression (Grade A), moderate risk of progression (Grade B), and high risk of progression (Grade C).
2.

**Standard 3-7 states:**

The full-time faculty of a dental hygiene program possesses a baccalaureate or higher degree.

Consider the following changes to Standard 3-7:

Full-time dental hygiene faculty possesses a minimum of a master’s degree or should be in the process of obtaining a master’s degree.

Rationale: This statement aligns with the American Dental Educator’s Association policy statement on faculty qualifications for dental education programs.

According to ADEA:


**All dental education institutions and programs** should:

1. **Faculty Qualifications.** Recruit faculty who have backgrounds in and current knowledge of the subject areas they are teaching and, where appropriate, educational theory and methodology, curriculum development, and test construction, measurement, and evaluation. Full-time dental assisting and dental laboratory technology faculty should hold a minimum of a baccalaureate degree. Full-time dental hygiene faculty should hold a minimum of a master’s degree or should be in the process of obtaining a master’s degree. Full-time dental faculty should hold a degree that is consistent with their teaching and research responsibilities.

Thank you for your consideration.

Margaret Lemaster, RDH, MS
Adjunct Professor, Virginia Commonwealth University
Commission on Dental Accreditation Site Visitor
Virginia Board of Dentistry Member
Executive Board Member and Examiner, Council of Interstate Testing Agencies (CITA)
INFORMATIONAL REPORT ON DENTAL LABORATORY TECHNOLOGY PROGRAMS ANNUAL SURVEY CURRICULUM DATA

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

The Curriculum Section of the Commission’s Annual Survey is conducted for dental laboratory technology education in alternate years. The most recent Curriculum Section was conducted in September/October 2021. Aggregate data of the most recent Curriculum Section for review by the Review Committee on Dental Laboratory Technology Education is provided as an informational report in **Appendix 1**.

**Summary:** The Review Committee on Dental Laboratory Technology Education is requested to review the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Section (**Appendix 1**).

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

Prepared by: Dr. Sherin Tooks
### Q51. Clock hours for all DLT content areas

#### Didactic instruction clock hours

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<thead>
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<td>c. Business principles</td>
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<td>e. Physics</td>
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<td>f. Dental materials</td>
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<td>j. Legal, ethical, and historical aspects of dentistry and dental laboratory technology</td>
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<td>s. Practical experience</td>
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<td>t-w. Other (see page 2)</td>
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<td>153</td>
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#### Laboratory instruction clock hours

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<tr>
<td>b. Mathematics</td>
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<td>c. Business principles</td>
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<td>d. Chemistry</td>
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<td>f. Dental materials</td>
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<td>g. Tooth morphology</td>
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<td>h. Oral anatomy</td>
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<td>i. Occlusion</td>
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<td>j. Legal, ethical, and historical aspects of dentistry and dental laboratory technology</td>
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<td>l. Hazard control</td>
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<td>m. General laboratory techniques</td>
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<td>q. Dental ceramics</td>
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<td>r. Orthodontic appliances</td>
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Q51. Please complete the following chart for all other content areas required in the accredited dental laboratory technology program.

**t - x. Other, please specify - Text**

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<th>Course</th>
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<th>Semester III</th>
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<tr>
<td>Implant Prosthodontics</td>
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**Question 51 comments**

51. Faculty/student ratios are dependent upon if one, two, or three services are participating in certain content areas. (Example: If didactic faculty/student ratio is 1:7 ([student type] only); 1:14 ([2 student types]); 1:20 ([3 student types]) all participate. 51f. Dental materials is taught throughout various content areas for both didactic and laboratory clock hours. 51i. Occlusion is taught throughout various content areas for both didactic and laboratory clock hours.
Q52. Clock hours for advanced dentistry content areas

<table>
<thead>
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<th>Didactic instruction clock hours</th>
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<th>Min</th>
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<td>b. Removable partial denture prosthodontics</td>
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<td>64</td>
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<tr>
<td>c. Fixed prosthodontics (crown and bridge)</td>
<td>27.4</td>
<td>72</td>
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<tr>
<td>d. Dental ceramics</td>
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<td>e. Orthodontic appliances</td>
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<table>
<thead>
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</table>

Question 52 comments

52a.- 52e. [Sponsoring institution] students continue [redacted comment] [Sponsoring institution] to enhance skill set and proficiency.

Depending on the student's academic track, they will select up to 3 specialty areas to focus on for 7 weeks. Each specialty area requires a minimum of 98 hours of laboratory time to be completed in 7 weeks.

Implants = 18/Didactic  54/Laboratory

Low numbers of students opt for optional denture courses one advanced course did not run last year because of low enrollment. Students are opting more for implants and ceramics.
REPORT ON DENTAL PUBLIC HEALTH PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for dental public health programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in Appendix 1 for review by the Review Committee on Dental Public Health.

**Summary:** The Review Committee on Dental Public Health is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (Appendix 1).

**Recommendation:**

Prepared by: Ms. Kirsten Nadler
## Part II - Dental Public Health Curriculum Section

*Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.*

Please identify the percentage of time devoted by all students/residents combined to each of the 15 educational objectives in the advanced dental public health program.

Column must add up to 100%. Do not enter percent signs.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage oral health programs for population health</td>
<td></td>
</tr>
<tr>
<td>Evaluate systems of care that impact oral health</td>
<td></td>
</tr>
<tr>
<td>Demonstrate ethical decision-making in the practice of dental public health</td>
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<tr>
<td>Design surveillance systems to measure oral health status and its determinants</td>
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<tr>
<td>Communicate on oral and public health issues</td>
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</tr>
<tr>
<td>Lead collaborations on oral and public health issues</td>
<td></td>
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<tr>
<td>Advocate for public health policy, legislation, and regulations to protect and promote the public's oral health, and overall health</td>
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<tr>
<td>Critically appraise evidence to address oral health issues for individuals and populations</td>
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<tr>
<td>Conduct research to address oral and public health problems</td>
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<tr>
<td>Integrate the social determinants of health into dental public health practice</td>
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<tr>
<td>Biostatistics</td>
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<tr>
<td>Epidemiology</td>
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<tr>
<td>Behavior science</td>
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<tr>
<td>Environmental health</td>
<td></td>
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<tr>
<td>Healthcare policy and management</td>
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</table>
36. Other, please specify

Total
INFORMATIONAL REPORT ON THE CONDUCT OF A VALIDITY AND RELIABILITY STUDY FOR THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN DENTAL PUBLIC HEALTH

Background: The Accreditation Standards for Advanced Dental Education Programs in Dental Public Health were adopted by the Commission on Dental Accreditation at its August 3, 2018 meeting with immediate implementation.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1), the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula:

*The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.*

Thus, the validity and reliability of the standards for a one-year program will be assessed after four years.

According to the Commission’s timetable for validity and reliability studies the study for dental public health will be initiated in the spring of 2022. Survey results will be considered at the Summer 2022 meetings of the DPH RC and the Commission on Dental Accreditation. The communities will be surveyed to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

Methodology and Survey Design: In cooperation with the ADA’s HPI, a timetable will be developed, surveys will be distributed to the audiences, and responses will be due to the HPI within two weeks of receipt of the survey. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2022. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2022 meeting.

A survey instrument will be developed to obtain evaluations of each of the requirements in the current standards. Respondents will be asked to indicate the relevance of each criterion to the dental public health curricula:

- Relevant/ Too demanding: Criterion relevant but too demanding
In addition, they will be asked to add and provide a rationale for any issues that they believe should be added to the standards. A sample format of the survey is presented in Appendix 2.

The following alternatives might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

If it is determined that revisions to the accreditation standards is warranted, further analysis of the data obtained in the validity and reliability study would be conducted to provide more in-depth information for the revision process. In addition, other resources could provide further information, including:

- The annual Frequency of Citings Report of Accreditation Standards for Advanced Dental Education Programs in Dental Public Health.
- Data identifying trends in accredited advanced dental education programs in dental public health.
- Issues related to advanced dental education programs in dental public health.
- Requests for standards revisions received but postponed until the regular validity and reliability study.
- Relevant reports from the higher education and practice communities, e.g., Institute of Medicine Report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce.”

When a comprehensive revision of an accreditation standards document is required, the new document is developed with input from the communities of interest in accordance with Commission policies. The document is drafted using resources such as those noted above. When the document is finalized, it is shared with the communities of interest and hearings are held, as appropriate. Written and oral comments from the hearings and written comments received during the comment period are reviewed when considering the document for adoption. An implementation date is specified when the document is adopted.

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

Prepared by: Ms. Kirsten Nadler
POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of standards are made to reflect significant changes in disease and practice patterns, scientific or technological advances, or in response to changing professional needs for which the Commission has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year after the validity and reliability of the standards has been assessed, the Commission will conduct a study to determine whether the accreditation standards continue to be appropriate to the discipline. This study will include input from the broad communities of interest. The communities will be surveyed and invited to participate in some national forum, such as an
invitational conference, to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

The following alternatives, resulting in a set of new standards, might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with Commission policies. An implementation date is specified and copyright privileges are sought when the document is adopted. Assessment of the validity and reliability of these new standards will be scheduled in accord with the policy specified above. Exceptions to the prescribed schedule may be approved to ensure a consistent timetable for similar disciplines (e.g. advanced dental education programs and/or allied dental education programs).

Revised: 8/18; 7/07, 07/00; Reaffirmed: 8/12, 8/10, 7/06; Adopted: 12/88
SAMPLE ADVANCED DENTAL EDUCATION PROGRAMS IN DENTAL PUBLIC HEALTH
VALIDITY AND RELIABILITY SURVEY

Listed below are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Dental Public Health for accreditation purposes. For each standard, please circle the appropriate number that corresponds to your rating in terms of its relevance of the criterion to the curriculum. Please note that certain standards have multiple items to be rated.

<table>
<thead>
<tr>
<th>STANDARD 1 – INSTITUTIONAL COMMITMENT / PROGRAM EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. List Standards in this column</td>
</tr>
</tbody>
</table>

List comments related to Standard 1 – Institutional and Program Effectiveness.

<table>
<thead>
<tr>
<th>STANDARD 2 – PROGRAM DIRECTOR AND TEACHING STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. List Standards in this column</td>
</tr>
</tbody>
</table>

List comments related to Standard 2 – Educational Program.

<table>
<thead>
<tr>
<th>STANDARD 3 – FACILITIES AND RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. List Standards in this column</td>
</tr>
</tbody>
</table>

List comments related to Standard 3 – Faculty and Staff.
# STANDARD 4 – CURRICULUM AND PROGRAM DURATION

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
1. List Standards in this column


# STANDARD 5 – ADVANCED DENTAL EDUCATION STUDENTS / RESIDENTS

<table>
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<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
1. List Standards in this column

List comments related to Standard 5 – Patient Care Services.

# STANDARD 6 – RESEARCH

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
1. List Standards in this column

List comments related to Standard 5 – Patient Care Services.
REPORT ON ENDOdontics PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for endodontics programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in Appendix 1 for review by the Review Committee on Endodontics Education.

Summary: The Review Committee on Endodontics Education is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (Appendix 1).

Recommendation:

Prepared by: Ms. Jennifer E. Snow
Annual Survey Curriculum Section for Endodontics Programs

Part II - Endodontics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?
Column must add up to 100%. Do not enter percent signs.

a. Clinical (include related laboratory activity) %

b. Didactic (include assigned laboratory activity) %

c. Research %

d. Teaching %

e. Other, please specify %

Total %

22. Basic science instruction in advanced endodontics can be provided in a variety of settings. Identify the number of clock hours students/residents spend in formal courses, lectures or seminars, and on rotation to other
services to receive instruction in the following subject areas during the entire program.

a. Head and neck anatomy (gross and micro)
b. Embryology
c. Infectious and immunologic processes in oral health and disease
d. Pathophysiology of pulpal/periradicular disease
e. Wound healing
f. Oral medicine and oral pathology
g. Pharmacotherapeutics
h. Research methodology and statistics
i. Neuroscience
j. Biomaterials

Total

23. Identify the number of endodontic diagnostic and treatment planning conferences/seminars conducted by the program during the past 24-month period.

24. On average, how many endodontic cases per student/resident have been completed in the past 24-month period?

Make sure to enter the number of cases divided by the number of students/residents, NOT the total number of cases for the entire program.

Cases per student/resident

a. Non-surgical
b. Surgical
c. Non-surgical retreatment
Part II - Endodontics Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

25. How many patients were managed on average per student/resident as a result of traumatic injuries in the past 24-month period?
Make sure to enter the number of patients divided by the number of students/residents, NOT the total number of patients for the entire program.

26. In which of the following interdisciplinary approaches did students/residents receive instruction or gain clinical consultation experience during the past 24-month period for the management of dental patients?

<table>
<thead>
<tr>
<th></th>
<th>Instruction provided?</th>
<th>Clinical experience provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Endodontics / periodontics</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>b. Endodontics / pediatric dentistry</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>c. Endodontics / oral and maxillofacial surgery</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>d. Endodontics / prosthodontics</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
</tbody>
</table>
27. How often does the program conduct formal documented evaluations of student/resident clinical performance?

- Daily
- Weekly
- Monthly
- Quarterly
- Biannually
- Annually
- Other, please specify

28. How often does the program conduct formal documented evaluations of faculty?

- Weekly
- Monthly
- Quarterly
- Biannually
- Annually
- Other, please specify

Use this space to enter comments or clarifications for your answers on this page.

[Blank space for comments]
REPORT ON ORAL AND MAXILLOFACIAL PATHOLOGY PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for oral and maxillofacial pathology programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in Appendix 1 for review by the Review Committee on Oral and Maxillofacial Pathology.

Summary: The Review Committee on Oral and Maxillofacial Pathology is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (Appendix 1).

Recommendation:

Prepared by: Ms. Kirsten Nadler
### Part II - Oral and Maxillofacial Pathology Curriculum Section

*Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.*

21. Instruction in advanced oral and maxillofacial pathology programs can be provided in a variety of settings. Please indicate the total number of clock hours each student/resident spends in formal courses, lectures or seminars, and on rotation to other services receiving instruction in the following subject areas during the entire program.

<table>
<thead>
<tr>
<th></th>
<th>Formal Courses</th>
<th>Lectures &amp; Seminars</th>
<th>Rotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Anatomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Microbiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Physiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Biochemistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Clinical oral and maxillofacial pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

22. What is the average number of hours devoted by students/residents to each of the following areas during the entire program?

<table>
<thead>
<tr>
<th></th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Surgical oral pathology</td>
<td></td>
</tr>
<tr>
<td>b. Oral exfoliative cytology</td>
<td></td>
</tr>
</tbody>
</table>
23. How many autopsies were performed by all students/residents enrolled in the program during the 2019-20 academic year?


24. How many oral pathology specimens were accessioned for histopathologic diagnosis during the 2019-20 academic year?


25. How many patients were seen and managed in the clinical oral and maxillofacial pathology practice during the 2019-20 academic year?


26. How many oral exfoliative cytology specimens were accessioned by the oral pathology diagnostic services during the 2019-20 academic year?

☐

27. How often are conferences/seminars with the oral pathology diagnostic laboratory service conducted?

☐ Daily
☐ Weekly
☐ Biweekly
☐ Monthly
☐ Bimonthly
☐ Quarterly
☐ Other, please specify

Use this space to enter comments or clarifications for your answers on this page.

☐
Part II - Oral and Maxillofacial Pathology Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

28. Below are hospital service rotations. Please indicate whether the rotation is required, elective, or a combined assignment (including both required and elective components). Also, identify the total length of the rotation (in weeks) and the number of hours per week spent by students/residents on the rotation.

If Type of assignment is Not applicable, leave the Length of rotation and Hours per week columns blank.

<table>
<thead>
<tr>
<th>Type of assignment</th>
<th>Length of rotation</th>
<th>Hours</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>Elective</td>
<td>Combined</td>
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<td>----------</td>
</tr>
<tr>
<td>a. General anatomic pathology</td>
<td></td>
<td></td>
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<tr>
<td>b. Clinical laboratory</td>
<td></td>
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<tr>
<td>c. Radiology</td>
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<tr>
<td>d. Autopsy</td>
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<tr>
<td>e. Dermatology</td>
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<tr>
<td>f. Dermatopathology</td>
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<td>g. Microbiology / infectious diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Immunopathology</td>
<td></td>
<td></td>
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<tr>
<td>i. Oncology: surgical</td>
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<tr>
<td>j. Oncology: medical</td>
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<td></td>
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<tr>
<td>k. Oncology: radiation</td>
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<tr>
<td>l. Cyopathology</td>
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<tr>
<td>m. Hematopathology</td>
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<tr>
<td>n. Otorhinolaryngology</td>
<td></td>
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<tr>
<td>o. Medicine</td>
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</table>

28 (continued). Please identify hospital rotations not listed in lines a-o above and indicate whether the rotation is required, elective, or a combined assignment (including both required and elective components). Also, identify the total length of the rotation (in weeks) and the number of hours per week spent by students/residents on the rotation.
If any lines do not apply, leave the entire row(s) blank.

<table>
<thead>
<tr>
<th>Other rotation</th>
<th>Type of assignment</th>
<th>Length of rotation</th>
<th>Hours</th>
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</tbody>
</table>
29. Is the director of the diagnostic laboratory services board certified by the American Board of Oral and Maxillofacial Pathology?

- Yes
- No

30. How many formal documented student/resident evaluations are completed per year by the program director and/or his or her designee?

Use this space to enter comments or clarifications for your answers on this page.
REPORT ON ORAL AND MAXILLOFACIAL RADIOLOGY PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for oral and maxillofacial radiology programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in Appendix 1 for review by the Review Committee on Oral and Maxillofacial Radiology.

**Summary:** The Review Committee on Oral and Maxillofacial Radiology is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (Appendix 1).

**Recommendation:**

Prepared by: Ms. Kirsten Nadler
Part II - Oral and Maxillofacial Radiology Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. Please indicate the total number of clock hours each student/resident spends in didactic courses (lectures, seminars, or labs) and clinical courses in the following subject areas during the entire program.

Note that clinical courses includes time spent by students/residents performing and/or interpreting the findings of these techniques.

<table>
<thead>
<tr>
<th>Didactic courses</th>
<th>Clinical courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Head and neck anatomy</td>
<td>[ ]</td>
</tr>
<tr>
<td>b. Oral pathology</td>
<td>[ ]</td>
</tr>
<tr>
<td>c. Radiation physics</td>
<td>[ ]</td>
</tr>
<tr>
<td>d. Radiation biology</td>
<td>[ ]</td>
</tr>
<tr>
<td>e. Radiation protection</td>
<td>[ ]</td>
</tr>
<tr>
<td>f. Intraoral imaging (physics, technique, interpretation)</td>
<td>[ ]</td>
</tr>
<tr>
<td>g. Panoramic imaging (physics, technique, interpretation)</td>
<td>[ ]</td>
</tr>
<tr>
<td>h. Cephalometric imaging (physics, technique, interpretation)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
i. Cone-beam computed tomographic imaging (physics, technique, interpretation)
j. Multi-detector computed tomography (physics, technique, interpretation)

k. Magnetic resonance imaging (physics, technique, interpretation)

l. Ultrasonography (physics, technique, interpretation)

m. Nuclear medicine (physics, technique, interpretation)

22. What is the average number of written interpretations and consultative reports performed by each student/resident in which the student/resident assumed major responsibility in the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Program year 1</th>
<th>Program year 2</th>
<th>Program year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Intraoral imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Panoramic imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Cephalometric imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Cone-beam computed tomographic imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Multi-detector computed tomography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Magnetic resonance imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Ultrasonography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Nuclear medicine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.
Part II - Oral and Maxillofacial Radiology Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

23. How frequently do students/residents attend the head and neck tumor board, or a similar interdisciplinary conference?

- Daily
- Weekly
- Biweekly
- Monthly
- Bimonthly
- Quarterly
- Other, please specify

24. How often are clinical oral and maxillofacial radiology case conferences conducted and presented with:

- Daily
- Weekly
- Biweekly
- Monthly
- Bimonthly
- Quarterly
- At least once...

Faculty leading the discussion?

- Yes
- No

Students/residents leading the discussion?

- Yes
- No

25. How frequently do students/residents participate in literature review?

- Daily
- Weekly
- Biweekly
Monthly
Bimonthly
Quarterly
Part II - Oral and Maxillofacial Radiology Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

26. Below are service rotations/experiences. Please indicate whether the rotation is required, elective or a combined assignment (including both required and elective components). Also, identify the total length of the rotation (in weeks or equivalent weeks) and the number of hours per week spent by students/residents on the rotation.

<table>
<thead>
<tr>
<th>Type of assignment</th>
<th>Required</th>
<th>Elective</th>
<th>Combined</th>
<th>Not applicable</th>
<th>Length of rotation (in weeks or equivalent weeks)</th>
<th>Average hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Rotation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Screening/Emergency clinic/Treatment planning clinics

b. OMR didactic teaching
c. OMR clinical teaching

d. OMR clinical rotation

e. Medical radiology clinical rotation
<table>
<thead>
<tr>
<th>Type of assignment</th>
<th>Length of rotation</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. How many formal documented student/resident evaluations are completed per year?

Use this space to enter comments or clarifications for your answers on this page.
REPORT ON ORAL AND MAXILLOFACIAL SURGERY PROGRAMS (RESIDENCY AND FELLOWSHIP) ANNUAL SURVEY CURRICULUM SECTIONS

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

The Curriculum Section of the Commission’s Annual Survey is conducted for both oral and maxillofacial surgery residency programs and clinical fellowship training programs in oral and maxillofacial surgery annually. The most recent Curriculum Section was conducted in August/September 2021. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Sections are provided in Appendix 1 and Appendix 2 for review by the Review Committee on Oral and Maxillofacial Surgery Education.

Summary: The Review Committee on Oral and Maxillofacial Surgery Education is requested to review the draft Curriculum Sections of its discipline-specific Annual Surveys (Appendix 1 and Appendix 2).

Recommendation:

Prepared by: Ms. Jennifer E. Snow
Part II - Oral and Maxillofacial Surgery Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

☐ 21. Do residents from this program rotate to another educational site that has its own accredited oral and maxillofacial surgery program?

☐ Yes (Specify institution)

☐ No

Please note that submission of a supplemental report to CODA is not required for this annual survey, unless specifically requested by the Commission.
22. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member in each of the following major oral and maxillofacial surgery categories. If none or not applicable, enter 0. Note that open treatment of bilateral mandibular fractures may be counted as separate procedures. Bilateral mandibular osteotomies may be counted as separate procedures. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Trauma (must agree with Q23 total)</td>
<td></td>
</tr>
<tr>
<td>b. Pathology (must agree with Q24 total)</td>
<td></td>
</tr>
<tr>
<td>c. Orthognathic and Craniofacial (must agree with Q25 total)</td>
<td></td>
</tr>
<tr>
<td>d. Reconstructive / Cosmetic (must agree with Q26 total)</td>
<td></td>
</tr>
<tr>
<td>e. Other, please describe</td>
<td></td>
</tr>
</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.
In calculating the program responses to Questions 23 and 24, same day admission and discharge patients are to be counted as inpatients.

23. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of trauma procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member. Open treatment of bilateral mandibular fractures may be counted as separate procedures. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22a.

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>CPT Codes</th>
<th>Checkmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Alveolus and Mandible Fractures</td>
<td>21441-21449, 21451-21470</td>
<td></td>
</tr>
<tr>
<td>b. Midface Fractures: Le Fort I</td>
<td>21421-21423</td>
<td></td>
</tr>
<tr>
<td>c. Midface Fractures: Le Fort II</td>
<td>21345-21348</td>
<td></td>
</tr>
<tr>
<td>d. Midface Fractures: Le Fort III</td>
<td>21431-21436</td>
<td></td>
</tr>
<tr>
<td>e. Malar</td>
<td>21355-21366</td>
<td></td>
</tr>
<tr>
<td>f. Nasoethmoid</td>
<td>21338-21340</td>
<td></td>
</tr>
<tr>
<td>g. Orbital</td>
<td>21385-21399, 21401-21408</td>
<td></td>
</tr>
<tr>
<td>h. Nasal</td>
<td>21315-21337</td>
<td></td>
</tr>
<tr>
<td>i. Frontal Sinus</td>
<td>21343-21344</td>
<td></td>
</tr>
<tr>
<td>j. Repair of Lacerations</td>
<td>12031-12057, 13120-13153, 13160, 40830-40839, 41250-41252, 42180-42182</td>
<td></td>
</tr>
<tr>
<td>k. Additional Trauma / TMJ codes</td>
<td>20690, 20692, 20693, 20694, 21100, 21480, 21485, 21490, 21495</td>
<td></td>
</tr>
</tbody>
</table>

Total | |
24. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of pathology procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member.

A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22b.

a. Sinus (31020, 31030, 31032, 31040, 31233, 31235, 31237-31240, 31254-31256, 31267, 31276, 31287, 31288, 31290-31297)


c. Malignant Neoplasms of Bone and Soft Tissue (11620-11624, 11626, 11640-11644, 11646, 21015, 21016, 21034, 21044-21045, 21557, 21558, 30150, 30160, 31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31420, 38700, 38720, 38724, 40500-40530, 41110, 41112-41114, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 41825-41827, 42107, 42120, 42140, 42808, 42842, 42844, 42845, 42870, 42890, 42892, 42894)

d. Temporomandibular Joint Surgery (21010, 21050, 21060, 21070, 29800, 29804)

e. Salivary Gland and Duct Procedures (42300-42450, 42509, 42551-42665)

f. Tracheostomy (31600-31603, 31605, 31610)

g. Infections (40801, 41000, 41006-41009, 41015-41018, 42000, 42700, 42720, 42725)

Total

Use this space to enter comments or clarifications for your answers on this page.
25. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of orthognathic and craniofacial procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member.

Bilateral mandibular osteotomies may be counted as separate procedures. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22c.

- a. Mandible (21193-21199)
- b. Genioplasty (21121-21123)
- c. Maxilla (21141-21147, 21206)
- d. Orbit (21172-21180, 21182-21184, 21256, 21260-21268, 21275)
- e. Midface (21150, 21151, 21154, 21155, 21159, 21160, 21188)
- f. Cranial Vault / Transcranial (61550, 61552, 61556, 61557-61559, 61563, 61564, 62120, 62121, 62140-62143, 62145-62148)

Total
26. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of reconstructive procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member.

A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22d.

- Nerve (64600, 64605, 64610, 64716, 64722, 64727, 64732-64744, 64864, 64885-64886, 64902, 64910, 64911)
- Cleft Lip (40700-40761)
- Cleft Palate / Pharyngoplasty (42200-42260, 42950)
- Flaps and Grafts (11960, 11971, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 14302, 14350, 15040, 15100, 15110, 15111, 15115, 15116, 15120, 15121, 15130, 15131, 15135, 15136, 15156, 15157, 15220, 15221, 15240, 15241, 15260, 15261, 15271-15278, 15572, 15740, 15750, 15756, 15758, 15760, 15770, 30580, 30600, 42145)
- Flaps and Grafts: Vestibuloplasty (15574-15576, 15610, 15620-15630, 15650, 15731, 15732, 15757)
- Flaps and Grafts: Soft Tissue Flaps (40500, 40525-40527, 42894)
- Bone, Cartilage and Tissue Grafts (20900, 20902, 20910, 20912, 20920, 20922, 20926, 21210-21235, 21247, 21255)
- Free Flaps (20955-20957, 20962, 20969, 20970, 20972, 21208-21209)
- Temporomandibular Joint (21240-21243)
- Vestibuloplasty (40840-40845)
- Lip Repair (40650, 40652, 40654)
- Salivary Gland and Duct (42500, 42505, 42507, 42509, 42510)
- Correction of Facial Nerve Paralysis (15840-15842, 15845)
- Blepharoplasty / Eyelid Procedures (15820-15823, 21280, 21282, 67901-67906, 67908, 67909, 67911, 67912, 67914-67917, 67921-67924, 67930, 67935, 67950, 67961, 67966, 67971, 67973-67975)
- Brow / Forehead (15824, 15826, 67900)

q. Otoplasty (69300, 69310, 69320)

r. Rhinoplasty (30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30520, 30540, 30545, 30560, 30620, 30630)

s. Rhytidectomy & lipectomy (15819, 15825, 15828, 15829, 15838, 15876)

t. Hair transplant (15775, 15776)

u. Dermabrasion & peels (15870, 15781, 15783, 30120)

v. Implants (21244, d6010)

Total

Use this space to enter comments or clarifications for your answers on this page.
27. For each member of the program's most recent graduating class, please provide their cumulative anesthetic experience.

Note that Total General Anesthesia/Deep Sedation includes all on and off-service general anesthesia/deep sedation.

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

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a. Graduate 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Graduate 2</td>
<td></td>
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<tr>
<td>c. Graduate 3</td>
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<tr>
<td>d. Graduate 4</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>e. Graduate 5</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>f. Graduate 6</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. Graduate 7</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>h. Graduate 8</td>
<td></td>
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</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.
28. Indicate the type of assignment and length of each rotation (in WEEKS) included in the residents' off-service program.

<table>
<thead>
<tr>
<th>Type of Assignment</th>
<th>Elective</th>
<th>Required</th>
<th>Not applicable</th>
<th>Length of Rotation (in WEEKS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Adult anesthesia</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>b. Pediatric anesthesia</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>c. Medicine</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>d. Other medical rotations</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>e. General surgery</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>f. Plastic surgery</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>g. Ear, nose and throat surgery</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>h. Other surgical rotations</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.
29. Does each resident devote a minimum of 120 weeks to clinical oral and maxillofacial surgery over the course of their training?

☐ Yes
☐ No

30a. Is each resident assigned to anesthesia service for at least 20 weeks?

☐ Yes
☐ No

30b. Of the total amount of time spent in anesthesia service, how many weeks is the resident assigned to pediatric anesthesia?

If no separate assignment is made to pediatric anesthesia, enter 0.
31a. Is each resident assigned to a clinical surgical experience for at least 16 weeks?

- Yes
- No

31b. Of the total amount of time spent in clinical surgery, how many weeks is the resident assigned to a surgical service (not to include oral and maxillofacial surgery)?

32. Is each resident assigned to a clinical medical experience for at least eight (8) weeks?

- Yes
- No

33. Is each resident assigned to a clinical surgical or medical education experience, exclusive of all oral and maxillofacial surgery service assignments, for at least eight (8) additional weeks?

- Yes
- No

Use this space to enter comments or clarifications for your answers on this page.
Annual Survey Curriculum Section for Oral and Maxillofacial Surgery Fellowship Programs

CF-OMS Curriculum (Q21-28)

Part II - Oral and Maxillofacial Surgery Clinical Fellowships

Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.
21. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of esthetic procedures performed by fellows.

<table>
<thead>
<tr>
<th>Category</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Blepharoplasty / Eyelid</td>
<td>15820-15823, 21280, 21282, 67901-67904, 67906, 67908, 67909, 67911, 67912, 67914-67917, 67921-67924, 67930, 67935, 67950, 67961, 67966, 67971, 67973-67975, 67999</td>
</tr>
<tr>
<td>b. Brow / Forehead</td>
<td>15824, 15826, 67900</td>
</tr>
<tr>
<td>c. Dermabrasion &amp; Peels / Treatment of Skin Lesions</td>
<td>15780-15781, 15783, 15786-15793, 30120</td>
</tr>
<tr>
<td>d. Injections / Augmentation</td>
<td>11950-11954, 64612, 64615, 64616</td>
</tr>
<tr>
<td>e. Genioplasty / Hard &amp; Soft Tissue Recontouring / Facial Implants</td>
<td>21120, 21125, 21127, 21137-21139, 21181, 21208, 21209, 21270, 21295, 21296</td>
</tr>
<tr>
<td>f. Otoplasty</td>
<td>69300, 69310, 69320, 69399</td>
</tr>
<tr>
<td>g. Rhinoplasty</td>
<td>30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30520, 30540, 30545, 30560, 30620, 30630</td>
</tr>
<tr>
<td>h. Rhytidectomy</td>
<td>15819, 15825, 15828, 15829, 15838, 15876</td>
</tr>
<tr>
<td>i. Hair Transplant</td>
<td>15775, 15776</td>
</tr>
<tr>
<td>j. Scar Revision</td>
<td>13120-13122, 13131-13133, 13151-13153, 13160, 14020, 14021, 14040, 14041, 14060, 14061, 14300-14302, 14350, 15115, 15116, 15120, 15121, 15240, 15241, 15260, 15261, 15574, 15610, 15620, 15630</td>
</tr>
<tr>
<td>k. Destruction of Lesions</td>
<td>17000, 17003, 17004, 17106-17108, 17110, 17111</td>
</tr>
</tbody>
</table>

Total: □ □
22. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of oncology procedures performed by fellows.

a. Excisions for Malignant Tumors (11620-11624, 11626, 11640-11644, 11646, 17270-17276, 17280-17286, 21015, 21016, 21034, 21044, 21045, 21557, 21558, 30150, 30160)

b. Major Soft Tissue Excisions for Benign or Malignant Tumors (e.g., Hemiglossectomy, Floor of Mouth Excision, Parotidectomy, Submandibular Gland Incision) (11420-11424, 11426, 11440-11446, 21552, 21554-21556)

c. Lip (40500-40530, 41110-41114, 41116, 41120-41150, 41825-41827, 42104, 42106, 42107, 42120, 42160, 42410, 42415, 42420, 42425, 42426, 42440, 42450, 42808, 42810, 42815, 42842, 42844, 42845, 42870, 42890, 42892, 42894)

d. Jaw Excisions for Benign and Malignant Disease (e.g., Marginal or Segmental Mandibulectomy, Partial Maxillectomy) (21025-21030, 21040-21050, 31225, 31230, 42280)

e. Neck Dissections which must include Radical and Limited (e.g., Supramohyoid) Neck Dissections (38700, 38720, 38724, 41135, 41145, 41153, 41155)

f. Tracheostomy (31600, 31601, 31603, 31605, 31610)

Total oncology procedures

Total
23. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of pediatric craniomaxillofacial surgery (cleft and craniofacial surgery) procedures performed by fellows.

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Code Range</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Orthognathic, Cleft-Related and Craniofacial: Mandible</td>
<td>21193-21196, 21198, 21199</td>
<td></td>
</tr>
<tr>
<td>b. Orthognathic, Cleft-Related and Craniofacial: Genioplasty</td>
<td>21121-21123</td>
<td></td>
</tr>
<tr>
<td>c. Orthognathic, Cleft-Related and Craniofacial: Maxilla</td>
<td>21141-21143, 21145-21147, 21206</td>
<td></td>
</tr>
<tr>
<td>d. Orthognathic, Cleft-Related and Craniofacial: Midface</td>
<td>21150, 21151, 21154, 21155, 21159, 21160, 21188</td>
<td></td>
</tr>
<tr>
<td>e. Orthognathic, Cleft-Related and Craniofacial: Orbit</td>
<td>21172, 21175, 21179, 21180, 21182-21184, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21275</td>
<td></td>
</tr>
<tr>
<td>f. Cranial Vault / Transcranial</td>
<td>61550, 61552, 61556-61559, 61563, 61564, 62120, 62121, 62140-62148</td>
<td></td>
</tr>
<tr>
<td>g. Cleft Lip</td>
<td>40700-40702, 40720, 40761</td>
<td></td>
</tr>
<tr>
<td>h. Cleft palate / Pharyngoplasty</td>
<td>30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 42200, 42205, 42210, 42215, 42220, 42225-42227, 42235, 42260, 42950</td>
<td></td>
</tr>
</tbody>
</table>

Total pediatric craniomaxillofacial surgery procedures: [ ]

Use this space to enter comments or clarifications for your answers on this page.
24. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of trauma procedures performed by fellows.

Note that open treatment of bilateral fractures may be counted as separate procedures.

<table>
<thead>
<tr>
<th>Total trauma procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Alveolus and Mandible Fractures (21441-21449, 21451-21470)</td>
</tr>
<tr>
<td>b. Midface Fractures: Le Fort I (21421-21423)</td>
</tr>
<tr>
<td>c. Midface Fractures: Le Fort II (21345-21348)</td>
</tr>
<tr>
<td>d. Midface Fractures: Le Fort III (21431-21436)</td>
</tr>
<tr>
<td>e. Malar (21355-21366)</td>
</tr>
<tr>
<td>f. Nasoethmoid (21338-21340)</td>
</tr>
<tr>
<td>g. Orbital (21385-21399, 21401-21408)</td>
</tr>
<tr>
<td>h. Nasal (21315-21337)</td>
</tr>
<tr>
<td>i. Frontal Sinus (21343-21344)</td>
</tr>
<tr>
<td>j. Repair of Lacerations (12031-12057, 13120-13153, 13160, 40830-40839, 41250-41252, 42180-42182)</td>
</tr>
<tr>
<td>k. Vestibuloplasty Procedures (40840-40845)</td>
</tr>
<tr>
<td>l. Additional Trauma / TMJ codes (11960, 11971, 20690, 20692, 20693, 20694, 21100, 21480, 21485, 21490, 21495)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
25. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of oral and maxillofacial pathology procedures performed by fellows.

a. Sinus (31020, 31030, 31032, 31040, 31233, 31235, 31237-31240, 31254-31256, 31267, 31276, 31287, 31288, 31290-31297)


c. Malignant Neoplasms of Bone and Soft Tissue (11620-11624, 11626, 11640-11644, 11646, 21015, 21016, 21034, 21044-21045, 21557, 21558, 30150, 30160, 38700, 38720, 38724, 41110, 41112-41114, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 41825-41827, 42107, 42120, 42140, 42808, 42842, 42844, 42845, 42870, 42890, 42892)

d. Temporomandibular Joint Surgery (21010, 21050, 21060, 21070, 29800, 21240-21243, 29804)

e. Salivary Gland and Duct Procedures (42300-42340, 42408, 42409, 42500-42510, 42600-42665)

f. Infections (40801, 41000, 41006-41009 41015-41018, 42000, 42700, 42720, 42725)

Total

Use this space to enter comments or clarifications for your answers on this page.
26. For the most recently completed academic year (July 1, 2020 to June 30, 2021), please provide the number of reconstructive and cosmetic surgery procedures performed by fellows.

<table>
<thead>
<tr>
<th>Category</th>
<th>Total reconstructive and cosmetic surgery procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Nerve</td>
<td></td>
</tr>
<tr>
<td>b. Flaps and Grafts</td>
<td></td>
</tr>
<tr>
<td>c. Flaps and Grafts: Vestibuloplasty</td>
<td></td>
</tr>
<tr>
<td>d. Flaps and Grafts: Soft Tissue Flaps</td>
<td></td>
</tr>
<tr>
<td>e. Bone, Cartilage and Tissue Grafts</td>
<td></td>
</tr>
<tr>
<td>f. Free Flaps</td>
<td></td>
</tr>
<tr>
<td>g. Vestibuloplasty</td>
<td></td>
</tr>
<tr>
<td>h. Lip Repair</td>
<td></td>
</tr>
<tr>
<td>i. Salivary Gland and Duct</td>
<td></td>
</tr>
<tr>
<td>j. Correction of Facial Nerve Paralysis</td>
<td></td>
</tr>
<tr>
<td>k. Blepharoplasty / Eyelid procedures</td>
<td></td>
</tr>
<tr>
<td>l. Brow / Forehead</td>
<td></td>
</tr>
<tr>
<td>m. Hard &amp; Soft tissue augmentation / Osseous reduction / Recontouring / Genioplasty / Facial implants</td>
<td></td>
</tr>
<tr>
<td>n. Otoplasty</td>
<td></td>
</tr>
<tr>
<td>o. Rhinoplasty</td>
<td></td>
</tr>
<tr>
<td>p. Rhytidectomy &amp; Lipectomy</td>
<td></td>
</tr>
</tbody>
</table>
r. Dermabrasion & Peels (15870, 15781, 15783, 30120)
s. Implants (21244, D6010)

Total

27. Indicate the type of assignment and length of each rotation (in weeks) included in the fellows' off-service program.

<table>
<thead>
<tr>
<th>Type of Assignment</th>
<th>Elective</th>
<th>Required</th>
<th>Not applicable</th>
<th>Length of Rotation (in WEEKS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. NICU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. PICU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Microvascular laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Identify the total number of months fellows are assigned to the oral and maxillofacial surgery services for the entire program.

For the purpose of this question, a month is defined as a period of no less than four weeks. Round to the nearest whole month.

Use this space to enter comments or clarifications for your answers on this page.
REPORT ON ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS PROGRAMS (RESIDENCY AND FELLOWSHIP) ANNUAL SURVEY CURRICULUM SECTIONS

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

The Curriculum Section of the Commission’s Annual Survey is conducted for both orthodontics and dentofacial orthopedics residency programs and clinical fellowship training programs in craniofacial and special care orthodontics in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Sections are provided in Appendix 1 and Appendix 2 for review by the Review Committee on Orthodontics and Dentofacial Orthopedics Education.

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education is requested to review the draft Curriculum Sections of its discipline-specific Annual Surveys (Appendix 1 and Appendix 2).

Recommendation:

Prepared by: Ms. Jennifer E. Snow
Annual Survey Curriculum Section for Orthodontics and Dentofacial Orthopedics Residency Programs

Part II - Orthodontics & Dentofacial Orthopedics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?
Column must add up to 100%. Do not enter percent signs.

   a. Clinical (include related laboratory activity) %
   b. Didactic (include assigned laboratory activity) %
   c. Research %
   d. Teaching %
   e. Other, please specify %

Total %
22. In which of the following interdisciplinary approaches did students/residents receive instruction or gain clinical consultation experience during the past 24-month period for the management of dental patients?

<table>
<thead>
<tr>
<th>Approach</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Case history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Cephalometric analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Intraoral radiographs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Model Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d1. Model Analysis: Plaster cast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d2. Model Analysis: Digital models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Photographics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Cone beam imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. What percentage of all patients are managed by the students/residents in each of following treatment mechanisms?

Column must not exceed 100%. Do not enter percent signs.

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Begg Appliance</td>
<td>0 %</td>
</tr>
<tr>
<td>b. Edgewise</td>
<td>0 %</td>
</tr>
<tr>
<td>c. Functional: Fixed</td>
<td>0 %</td>
</tr>
<tr>
<td>d. Functional: Removable</td>
<td>0 %</td>
</tr>
<tr>
<td>e. Universal</td>
<td>0 %</td>
</tr>
<tr>
<td>f. Aligners</td>
<td>0 %</td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td>0 %</td>
</tr>
<tr>
<td>Total</td>
<td>0 %</td>
</tr>
</tbody>
</table>
24. What clinical procedures exist to ensure program objectives are met? Check all that apply.

- Experience with pre-surgical orthopedics for infants born with cleft lip and palate
- Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition
- Orthodontic management of patients with cleft or craniofacial anomalies
- Surgical/orthodontic treatment planning
- Pre- and post-surgical orthodontic management
- Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement
- Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs
- Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&SC) patients
- Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients
- Supervised participation in craniofacial team activities
- Participate in craniofacial team meetings

25. How many surgical orthodontic cases were managed with the active participation of the students/residents during the 2019-20 academic year?

26. How many patients were managed by the students/residents during the 2019-20 academic year?

Use this space to enter comments or clarifications for your answers on this page.
Part II - Orthodontics & Dentofacial Orthopedics Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

27. What is the total number of patients with craniofacial abnormalities managed with the active participation of the students/residents during the 2019-20 academic year?
Must be equal to or less than the number of patients reported in Question 26.

28. Identify the total number of patients initiating active treatment that were assigned to the students/residents during the 2019-20 academic year.
Total must be equal to or less than the number of patients reported in Question 26.

   a. 1st year students/residents
   b. 2nd year students/residents
   c. 3rd year students/residents
   Total

29. How many patients completed active treatment by the students/residents during the 2019-20 academic year?
Total must be equal to or less than the number of patients reported in Question 26.

   a. 1st year students/residents
   b. 2nd year students/residents
   c. 3rd year students/residents
   Total
30. How many transferred active treatment and active retention patients were assigned to the students/residents during the 2019-20 academic year? Sum of lines a through c in each column must not exceed the number of patients reported in Question 26.

<table>
<thead>
<tr>
<th></th>
<th>Active Treatment</th>
<th>Active Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st year students/residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. 2nd year students/residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 3rd year students/residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the students/residents.
For example, if there are three clinical faculty members who each devote 30 hours per week to clinical supervision, the number of positions would be 3 and the total number of hours per week would be 90.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number of faculty positions</td>
<td></td>
</tr>
<tr>
<td>b. Total number of hours per week</td>
<td></td>
</tr>
</tbody>
</table>

32. How often does the program conduct formal documented evaluations of student/resident clinical performance?
- Weekly
- Monthly
- Quarterly
- Biannually
- Annually
33. How often does the program conduct formal documented evaluations of faculty?

- Weekly
- Monthly
- Quarterly
- Semiannually
- Annually

Use this space to enter comments or clarifications for your answers on this page.
Annual Survey Curriculum Section for Craniofacial and Special Care Orthodontics Fellowship Programs

Part II - Clinical Fellowship in Craniofacial and Special Care Orthodontics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What clinical procedures exist to ensure program objectives are met?
Check all that apply. At least one item must be checked.

☐ Experience with pre-surgical orthopedics for infants born with cleft lip and palate
☐ Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition
☐ Orthodontic management of patients with cleft or craniofacial anomalies
☐ Surgical/orthodontic treatment planning
☐ Pre- and post-surgical orthodontic management
☐ Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement
☐ Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs
☐ Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&SC) patients
☐ Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients
☐ Supervised participation in craniofacial team activities
☐ Participate in craniofacial team meetings

22. Which of the following experiences exist in the program for each fellow?
Check all that apply. At least one item must be checked.

☐ Regularly scheduled grand rounds case presentations
☐ Historical and current scientific literature review
☐ Research methodology and biostatistics
☐ Training in the allied medical sciences and social services required to manage the unique needs of CFA&SC patients and their families
23. What is the average number of patients completing a full sequence of treatment logged by each fellow per year?

Full sequence of treatment includes each of the following: pre-, post-, and long-term treatment, diagnosis and planning, use of specialized orthodontic appliances specifically for the management of CFA&SC patients; and retention.
24. How many orthognathic cases were managed with the active participation of the fellows during the 2019-20 academic year?

25. What is the total number of patients with craniofacial abnormalities managed with the active participation of the fellows during the 2019-20 academic year?

26. How many patients were managed by the fellows during the 2019-20 academic year?
   a. Fellow 1
   b. Fellow 2
   Total
27. Identify the total number of patients initiating active treatment that were assigned to the fellows during the 2019-20 academic year.

28. How many transferred active treatment and retention patients were assigned to the fellows during the 2019-20 academic year?

   Number of patients
   a. Active treatment
   b. Active retention

29. How many patients completed active treatment by the fellows during the 2019-20 academic year?

30. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the fellows.

   Number
   a. Number of faculty positions
   b. Total number of hours per week

For example, if there are three clinical faculty members who each devote 30 hours per week to clinical supervision, the number of positions would be 3 and the total number of hours per week would be 90.
31. How often does the program conduct formal documented evaluations of fellows' clinical performance?

- Weekly
- Monthly
- Quarterly
- Semiannually
- Annually

32. How often does the program conduct formal documented evaluations of faculty?

- Weekly
- Monthly
- Quarterly
- Semiannually
- Annually

33. Does anyone else treat the patients of the orthodontic fellows?

<table>
<thead>
<tr>
<th></th>
<th>Treat craniofacial anomaly patients?</th>
<th>Number of craniofacial anomaly patients</th>
<th>Treat special care needs patients?</th>
<th>Number of special care needs patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Orthodontic students/residents</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>b. Postdoctoral students/residents in other types of programs</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
CONSIDERATION OF PROPOSED REVISIONS TO THE ACCREDITATION STANDARDS FOR CLINICAL FELLOWSHIP TRAINING PROGRAMS IN CRANIOFACIAL AND SPECIAL CARE ORTHODONTICS

Background: The Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics were adopted and implemented by the Commission on Dental Accreditation at its August 7, 2015 meeting. According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a one-year program will be assessed after four (4) years. In accordance with this policy, the Validity and Reliability Study of the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics was initiated in Summer/Fall 2019 with the results considered at the Winter 2020 meeting of the Commission.

In Winter 2020, the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) conducted an initial review of the validity and reliability study report. The Review Committee concluded that further study of the survey data was warranted. The ORTHO RC believed a small workgroup should be formed to further study the report and identify the fellowship Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of a workgroup composed of at least four (4) Orthodontics and Dentofacial Orthopedics Review Committee members and no more than two (2) additional individuals representing the American Association of Orthodontists (AAO) to further study the findings of the 2019 orthodontics fellowship Validity and Reliability Study and identify Accreditation Standards, if any, which warrant revision, with a report to the ORTHO RC and Commission in Summer 2020. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc Committee members included Dr. Brent Larson (ORTHO RC and Ad Hoc Committee chair), Dr. Patrick Foley (ORTHO RC), Dr. Sarandeep Huja (ORTHO RC), Dr. Onur Kadioglu (AAO), Dr. Steven Lindauer (ORTHO RC), and Dr. Kelton Stewart (AAO). The committee conducted its meeting on November 10, 2020.

The committee began with reviewing its charges, which included consideration of the use of the term “should” in the fellowship standards. The committee then conducted a high-level discussion of the results of the validity and reliability study. Although the committee noted the response rate was low and there was a high abandonment rate, the committee considered the comments related to research methodology and biostatistics within the fellowship study results. Since the fellowship is a 12-month program, and it is expected that students/fellows will have already received curriculum and experiences in research methodology and biostatistics in dental school and orthodontics and dentofacial orthopedics residency, the committee agreed with the comments and proposed elimination of Standard 4-3c as shown in the comprehensive document submitted to the Review Committee and the Commission that reflected all proposed revisions to the fellowship standards as a result of the committee’s charges.
The Committee concluded, and the Commission concurred, that the proposed revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (Appendix 1) be circulated to the communities of interest for review and comment for a period of one (1) year, with Hearings conducted at the March 2021 American Dental Education Association (ADEA) Annual Session and the October 2021 American Dental Association (ADA) Annual Meeting, with further consideration at the Commission’s Winter 2022 meeting.

As directed by the Commission, the proposed revised Standards were circulated for comment through December 1, 2021. No (0) comments were received at the ADEA Virtual Hearing, and no (0) comments were received at the ADA Virtual Hearing. The Commission office received one (1) written comment prior to the December 1, 2021 deadline (Appendix 2).

**Summary:** At this meeting, the Orthodontics and Dentofacial Orthopedics Education Review Committee and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (Appendix 1) and all comments received prior to the December 1, 2021 deadline (Appendix 2). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Ms. Jennifer E. Snow
Commission on Dental Accreditation

At its Winter 2021 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2021, for review at the Winter 2022 Commission meeting.

Written comments will only be accepted through the Commission’s Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_3t61Uvg45BCi1Df

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics
Accreditation Standards for
Clinical Fellowship Training Programs in
Craniofacial and Special Care Orthodontics
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-4653
www.ada.org/coda

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<table>
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<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 7, 2015</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revision to Policy on Reporting Program Changes in Accredited Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revised Policy on Enrollment Increases in Advanced Dental Specialty Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revision to Standard 6 2.2</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
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<td>August 4, 2017</td>
<td>Revision to Standard 1, Affiliations</td>
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<tr>
<td>August 4, 2017</td>
<td>Revised Accreditation Status Definitions</td>
<td>Adopted and Implemented</td>
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<tr>
<td>July 1, 2018</td>
<td>Revision to Standard 1, Affiliations</td>
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</tr>
<tr>
<td>August 3, 2018</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2019</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Implemented</td>
</tr>
<tr>
<td>TBD</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics</td>
<td>Adopted</td>
</tr>
<tr>
<td>TBD</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics</td>
<td>Implemented</td>
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<th>PAGE</th>
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</tr>
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<td>6- FELLOWSHIP PROGRAMS</td>
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<td>7- RESEARCH</td>
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Craniofacial and Special Care Orthodontics Fellowship Standards

-4-
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 That Are Fully Operational:

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

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

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

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

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

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

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

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9
Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

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

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

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

A fellowship in craniofacial and special needs orthodontics is a planned post-residency program that contains advanced education and training in a focused area of the discipline of orthodontics. The focused areas include:

- Cleft lip/palate patient care; Syndromic patient care; Orthognathic Surgery; Craniofacial Surgery and Special Care Orthodontics.

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate fellowship programs in each discipline for accreditation purposes. The general and discipline specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the essential educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by fellowships in the particular discipline.

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

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

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

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

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

Levels of Knowledge:

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

Understanding: Adequate knowledge with the ability to apply.

Familiarity: A simplified knowledge for the purpose of orientation and recognition of general principles.

Levels of Skills:

Proficient: The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.

Competent: The level of skill displaying special ability or knowledge derived from training and experience.

Exposed: The level of skill attained by observation of or participation in a particular activity.
Other Terms:

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

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of fellowship student achievement.

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support
Hospitals that sponsor fellowships must be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor fellowships must be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of fellowship programs must assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

The authority and final responsibility for curriculum development and approval, student/fellow selection, faculty selection and administrative matters must rest within the sponsoring institution.

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

1-1 Fellowships which are based in institutions or centers that also sponsor orthodontic residency training programs must demonstrate that the fellowship and residency programs are not in conflict. The fellowship experience must not compete with the residency training program for cases. Separate statistics must be maintained for each program.

1-2 Members of the teaching staff participating in an accredited fellowship program must be able to practice the full scope of the discipline in the focused area and in accordance with their training, experience and demonstrated competence.
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

1-3 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-4 Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

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

Intent: The items are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

1-5 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.

1-6 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

Intent: It is the responsibility of the program director to ensure that all faculty, including those at sites where educational activity occurs, are qualified.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program **must** be administered by a director who has documented expertise in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics. Additionally, the program director **must** either be board certified in orthodontics or have previously served as a director in a craniofacial orthodontic fellowship program prior to January 1, 2008.

Examples of evidence to demonstrate compliance may include: Board certification certificate or current CV identifying previous directorship in a Craniofacial Orthodontic Fellowship and letter from the employing institution verifying service.

2-1 Program Director: The program **must** be directed by one individual. The responsibilities of the program director **must** include:

2-1.1 Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.

2-1.2 Ensuring the provision of adequate physical facilities for the educational process.

2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.

2-1.4 Responsibility for adequate educational resource materials for education of the students/fellows, including access to adequate learning resources.

2-1.5 Responsibility for selection of students/fellows and ensuring that all appointed students/fellows meet the minimum eligibility requirements.

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

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

2-2.1 Provide direct supervision appropriate to a student’s/fellow’s competence, level of training, in all patient care settings.

2-3 Scholarly Activity of Faculty: There **must** be evidence of scholarly activity among the fellowship faculty. Such evidence may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;
b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed
   i. and scientific media;

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

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

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

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

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

Intent: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.

The use of private office facilities as a means of providing clinical experiences in advanced dental education is not approved, unless the discipline has included language that defines the use of such facilities in its discipline-specific Standards.
Intent: Required orthodontic fellowship clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.

3-1 Adequate space must be designated specifically for the clinical fellowship training program in Craniofacial and Special Care Orthodontics.

Intent: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.

3-2 Facilities must permit the students/fellows to work effectively with trained allied dental personnel.

Intent: A program is expected to have auxiliaries available to assist the students/fellows so the program can meet the educational Standards.

Examples of evidence to demonstrate compliance may include:

- Schedule of dental assistants’ assignments

3-3 Radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. Imaging equipment must be available.

3-4 Students/Fellows in a Craniofacial and Special Care Orthodontic program must have access to adequate space, equipment, and physical facilities to do research.

Intent: Adequate space is necessary to do research, but does not need to be dedicated to craniofacial and special care orthodontic research.

3-5 Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/fellows to achieve the educational goals of the program.

Intent: The intent is to assure the students/fellows in Craniofacial and Special Care Orthodontics utilize their time for educational purposes.

3-6 Clinical facilities must be provided within the sponsoring, affiliated institution or surgical center to fulfill the educational needs of the program.

3-7 Sufficient space must be provided for storage of patient records, models and other related diagnostic materials.

3-8 These records and materials must be readily available to effectively document active treatment progress and immediate as well as long term post-treatment results.
Proposed Revisions to Orthodontics Fellowship Standards
Orthodontics and Dentofacial Orthopedics RC
CODA Winter 2022

Intent: Students/Fellows are expected to have easy access to active, post treatment, and retention records. These records should be complete.

3-9 Radiography equipment must be available and accessible to the craniofacial clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.

Intent: High quality radiographic images are essential for orthodontic and dentofacial orthopedic therapy. Three dimensional cone-beam CT images of the dentition, face and TMJs are acceptable if clinically indicated.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

The fellowship program must be designed to provide special knowledge and skills beyond residency training. Documentation of all program activities must be assured by the program director and available for review.

4-1 The fellowship program is a structured post-residency program which is designed to provide special knowledge and skills for management of Craniofacial Anomalies and Special Care (CFA&SC) patients. These patients have craniofacial anomalies that affect the face and stomatognathic system and require special care due to physical mental and/or psychological conditions. The goals of the fellowship program must be clearly identified and documented.

4-2 The duration of the fellowship program must be a minimum of twelve months.

4-3 The fellowship program must include a formally structured curriculum. The curriculum must include the following experiences for each student/fellow:

a. regularly scheduled grand rounds case presentations
b. historical and current scientific literature review
c. research methodology and biostatistics
d. training in the allied medical sciences and social services required to manage the unique needs of CFA&SC patients and their families

4-4 The fellowship program must provide a complete sequence of patient experiences which includes:

a. pre-treatment evaluation and orthodontic record taking;
b. diagnosis and treatment planning;
c. advanced training in the use of the specialized orthodontic appliances required for the management of CFA&SC patients;
d. retention and long-term post-treatment evaluation.

4-5 The student/fellow must maintain a treatment log of all patients under their care with associated treatment plans/procedures performed and include at least the date of the procedure, patient name, patient identification number, and the outcome of the procedure, and long-term follow-up plans when applicable.
STANDARD 5 – STUDENTS/FELLOWS

ELIGIBILITY AND SELECTION

Orthodontists who have completed their formal orthodontic residency training are eligible for fellowship program consideration.

5-1 Nondiscriminatory policies must be followed in selecting students/fellows.

5-2 There must be no discrimination in the selection process based on professional degree(s).

Specific written criteria, policies and procedures must be followed when admitting students/fellows.

EVALUATION

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

a. Periodically, but at least semiannually, evaluates the knowledge, skills, ethical conduct and professional growth of its fellowship students, using appropriate written criteria and procedures;

b. Provide to fellowship students an assessment of their performance, at least semiannually;

c. Maintains a personal record of evaluation for each fellowship student which is accessible to the fellowship student and available for review during site visits.

Intent: A copy of the final written evaluation stating that the student/fellow has demonstrated competency to practice independently should be provided to each individual upon completion of the fellowship program.

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the fellowship students must be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all fellowship students must be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.
STANDARD 6 - FELLOWSHIP PROGRAMS

Those enrolled in an accredited clinical fellowship program in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics complete advanced training in a focused area:

6-1 Fellowship Program: A fellowship is a structured post-residency educational experience devoted to enhancement and acquisition of skills in a focused area and must be taught to a level of proficiency.

6-2 Craniofacial and Special Care Orthodontics:

Craniofacial is that area of orthodontics that treats patients with congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures. Special Care is that area of orthodontics that treats patients with special needs including disabilities and medically compromised patients who require comprehensive treatment.

6-2.1 Goals/Objectives: To provide comprehensive clinical and didactic training as the orthodontist, who works with a craniofacial team treating patients with a broad scope of craniofacial deformities and special needs situations.

6-2.2 Clinical Experience: Clinical experience must include the following procedures and must exist in sufficient number and variety to assure that objectives of the training are met:

- experience with pre-surgical orthopedics for infants born with cleft lip and palate;
- orthodontic therapy for patients with craniofacial deformities from the primary through adult dentition;
- orthodontic management of patients with cleft or craniofacial anomalies;
- surgical/orthodontic treatment planning;
- pre and post surgical orthodontic management;
- surgical splint design and construction;
- observation of surgical procedures, including splint placement;
- orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs;
i. participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists providing restorative services for CFA & SC patients;

j. exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients.

k. supervised participation in craniofacial team activities.

l. participate in craniofacial team meetings.

Examples of Evidence to demonstrate compliance may include:

• Roster of who attends craniofacial team meetings
• Schedule as to how often the craniofacial team meets
• Sense of what is discussed at meetings of craniofacial team, e.g., meeting minutes.
STANDARD 7 - RESEARCH

Students/Fellows must engage in an evidence-based research project approved by the director of the program, which should include one or more of the following:

7.1 Analyses based on clinical case records.
7.2 Participation in clinical and/or basic research particularly in projects funded following peer review and Institutional Review Board (IRB) approval.
7.3 Publication of case reports or hypotheses-driven research in peer reviewed journals related to the field of Craniofacial Anomalies and Special Care (CFA&SC) orthodontics.
7.4 Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.

Examples of evidence to demonstrate compliance may include:

a. Basic Sciences or Clinical Research Investigation
b. Meta-Analyses or Systematic Reviews of scientific literature
c. Analyses based on clinical case records.
   Participation in clinical and/or basic research particularly in projects funded following peer review and Institutional Review Board (IRB) approval.
d. Publication of case reports or hypotheses-driven research in peer reviewed journals related to the field of Craniofacial Anomalies and Special Care (CFA&SC) orthodontics.
e. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.
The Commission on Dental Accreditation has received your comment(s). Below, please find a copy of your submission.

Please do not respond to this email; reply has been disabled. Thank you.
Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, at its June 2021 meeting, Council members considered and supported the proposed revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics and reinforce that research remain a prime focus of training.

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

Do you have additional comment?
I have NO additional comment and ready to submit.
REPORT ON PEDIATRIC DENTISTRY PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for pediatric dentistry programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in **Appendix 1** for review by the Review Committee on Pediatric Dentistry.

**Summary:** The Review Committee on Pediatric Dentistry is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (**Appendix 1**).

**Recommendation:**

Prepared by: Ms. Kirsten Nadler
Part II - Pediatric Dentistry Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?
Column must add up to 100%. Do not enter percent signs.

a. Clinical (include related laboratory activity)  

b. Didactic (include assigned laboratory activity)  

c. Research  

d. Teaching 

e. Other, please specify

Total

22. Instruction can be provided in a variety of settings. Please estimate the total number of clock hours (didactic and clinical) of instruction students/residents receive in each of the following subject areas during the entire program.

a. Biomedical Sciences (Biostatistics and Clinical Epidemiology, Pharmacology, Microbiology, Embryology, Genetics, Anatomy and Oral Pathology)

b. Behavior Guidance (Non-pharmacological techniques, Sedation, and Inhalation analgesia)

c. Growth and Development (Craniofacial growth and development/Normal and abnormal physical, psychological and social development)
d. Oral Facial Injury and Emergency Care

e. Oral Diagnosis, Oral Pathology and Oral Medicine and Radiology

f. Prevention and Health Promotion
23. In which of the following conscious sedation techniques did students/residents receive instruction and clinical experience during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Instruction provided?</th>
<th>Clinical experience provided?</th>
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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a. Oral</td>
<td>o</td>
</tr>
<tr>
<td>b. Inhalation</td>
<td>o</td>
</tr>
<tr>
<td>c. Intramuscular</td>
<td>o</td>
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<tr>
<td>d. Intravenous</td>
<td>o</td>
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<tr>
<td>e. Other, please specify</td>
<td>o</td>
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24. What is the average number of general anesthetic patients managed by
each student/resident during the 2019-20 academic year?

Make sure to enter the number of patients divided by the number of students/residents, NOT the total number of patients for the entire program.

Patients per student/resident

/
25. How many patient visits were managed by all students/residents during the 2019-20 academic year?

26. Of all the patient visits identified in Question 25, what percentage were patients with diagnosed emotional, physical, or mental problems managed by the advanced pediatric dentistry students/residents?
27. Below are hospital service rotations. Please indicate whether the rotation is required or an elective, the total length of the rotation (in weeks), and the number of hours per week spent by students/residents on the rotation.

<table>
<thead>
<tr>
<th>Type of assignment</th>
<th>Length of rotation</th>
<th>Hours per week</th>
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<td>Required</td>
<td>Elective</td>
<td>Not applicable</td>
</tr>
<tr>
<td>a. Anesthesiology</td>
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<tr>
<td>b. Emergency Room</td>
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<tr>
<td>c. Pediatric Medicine</td>
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27 (continued). Please identify hospital rotations not listed in lines a-c above and indicate whether the rotation is required, elective, the total length of the rotation (in weeks), and the number of hours per week spent by students/residents on the rotation.

If any lines do not apply, leave the entire row(s) blank.

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<tr>
<th>Other rotation (please specify)</th>
<th>Type of assignment</th>
<th>Length of rotation (in weeks)</th>
<th>Hours per week</th>
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28. How many formal documented student/resident evaluations are conducted per year?
REPORT OF THE AD HOC COMMITTEE ON PEDIATRIC DENTISTRY ANESTHESIA STANDARDS

Background: At its August 2021 meeting, the Commission on Dental Accreditation (CODA) considered current issues in pediatric dentistry related to sedation anesthesia and its changing landscape, including the possibility of future restrictions for pediatric dentistry students/residents serving as primary operator in delivering sedation. The PED RC believed it is important to consider a strategic shift from the current delivery model that focuses on the required number of cases to complete, to a strategy with a foundation in emergency management training in patient management using sedation. Therefore, the PED RC believed a multidisciplinary work group made up of current and former PED RC members, as well as representation from the Dental Anesthesiology Review Committee, should be formed to further study these issues, including the potential need for revision of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 1), as applicable, with a report to the Commission in Winter 2022.

At its August 2021 meeting, the Commission on Dental Accreditation directed the establishment of a multidisciplinary work group composed of current and former Pediatric Dentistry Review Committee members as well as representation from the Dental Anesthesiology Review Committee and the Oral and Maxillofacial Surgery Review Committee to study the use of sedation in patient management, including the potential need for revision of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, as applicable, with a report to the Commission in Winter 2022.

The following individuals were appointed to the Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards: Dr. Joel Berg (chair and PED Commissioner), Dr. James Boynton (PED RC Member), Dr. Cynthia Hipp (former PED RC Member), Dr. Tad Mabry (PED RC Member), Dr. Anupama Rao Tate (PED RC Member), Dr. George Kushner (OMS Commissioner), and Dr. Joseph Giovannitti (DENT ANESTH Commissioner). The Ad Hoc Committee conducted virtual meetings on November 2, 2021, (all members present except Dr. Boynton and Dr. Giovannitti) and November 12, 2021 (all members present except Dr. Mabry). Dr. Sherin Tookes, director, CODA, and Ms. Kirsten Nadler, and Ms. Jennifer Snow, managers, Advanced Dental Education, CODA, were in attendance at all meetings.

Below is the Ad Hoc Committee’s report and recommendations to the Pediatric Dentistry Review Committee and Commission following its meetings of November 2, 2021, and November 12, 2021.

Report and Recommendations of the Ad Hoc Committee:
The Ad Hoc Committee reviewed its charge and a general plan for its work to review the use of sedation in patient management, including the potential need for revision of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry.
The Ad Hoc Committee’s review of the current Accreditation Standards included the requirement of fifty (50) experiences in conscious sedation, with twenty five (25) as the primary operator and similar standards for nitrous oxide and general anesthesia cases. The Ad Hoc Committee noted that the PED Review Committee recently recommended and the Commission directed revision to the Accreditation Standards for Pediatric Dentistry; these revised standards were adopted in August 2020 and implemented on July 1, 2021.

As a result of COVID and with review of the flexibility granted to programs at that time, the PED Review Committee learned of a variety of modalities to provide experiences in anesthesia. Many programs reported the use of simulation in addition to the number of cases required by the CODA Standards. The Ad Hoc Committee discussed that the review of potential revision to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry should look at considerations from the perspective of simulation experiences, as well as the role (operator) that a student/resident may have in the educational experience.

The Ad Hoc Committee further wished to discuss classifications of primary operator versus monitor in cases of sedation, including IV sedation experiences. The Ad Hoc Committee noted the potential need to define an age limit for sedations for children under the age of 13. Further, the Committee discussed the potential need to consider the types of anesthesia experiences needed for patients with special needs. The need for emergency preparedness including simulation of emergency situations related to areas including sedation was also considered, as well as the potential to develop a section on safety similar to the Oral and Maxillofacial Surgery Accreditation Standards model. While outside the scope of its current charge, the Ad Hoc Committee also discussed Hospital Dentistry standards and the growing trend of experiences in office-based anesthesia/outpatient ambulatory care facilities, which could be further reviewed by the PED RC at a later time. In preparation for the second meeting, Ad Hoc Committee members proposed revisions to Standards 4-6 and 4-7 for further consideration by the Committee.

The Ad Hoc Committee’s second meeting began with a synopsis of the prior meeting and charge, noting members of the Committee submitted comments and proposed changes for discussion. The Ad Hoc Committee’s discussion then focused on the number of hours and/or the number of experiences that should be included in both didactic and clinical education. Further, the Ad Hoc Committee discussed whether additional documents should be included beyond the American Academy of Pediatric Dentistry’s REFERENCE MANUAL regarding expected levels of didactic and clinical education. The Ad Hoc Committee also noted the need to determine how to incorporate the American Dental Association (ADA) sedation guidelines into the pediatric dentistry standards, and that input from other sources on these issues may be needed for further consideration. Further, the Committee noted the importance of licensure for clinical practice and, as such, noted that training programs should include adequate didactic and clinical training to prepare graduates for obtaining licensure without the need for any additional training.

The Ad Hoc Committee concluded its second meeting by identifying additional issues related to pediatric dentistry anesthesia training that require further consideration by the Ad Hoc Committee, Review Committee, and Commission, including but not limited to:
Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards

PED RC
Winter 2022

- Simulation requirements
  - Defining the content and scope (e.g. written and/or practical) requirement and number of practice experiences
- Review of ADA and AAPD Guidelines
  - What guidelines are relevant to the Pediatric Dentistry Accreditation Standards, and how should the related information be incorporated
- Definition of the levels of anesthesia
- Definition of use of the word pediatric
- Discussion of functional group monitoring (PED Standard 4-7b2a)
- The number of hours required for both didactic and clinical training regarding sedation and use of nitrous oxide

The Ad Hoc Committee concluded with a discussion that an additional perspective and clarification of expectations for pediatric dentistry anesthesiology guidelines, was needed. The Ad Hoc Committee recommended that the Commission appoint an additional Ad Hoc Committee member from the AAPD, specifically requesting that the AAPD Chair of the Council on Clinical Affairs, Committee on Sedation and Anesthesia be appointed to the CODA Ad Hoc Committee.

Summary:
Following discussion, the Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards determined that a definition for “Sole Primary Operator” should be added to Definition of Terms within the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry. Additionally, the Ad Hoc Committee determined that an intent statement should be added to Pediatric Dentistry Standard 4-7 to clarify that “Each patient encounter shall have only one (1) sole primary operator.” The Ad Hoc Committee recommended that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 2) be adopted by the Commission with immediate implementation.

The Ad Hoc Committee also believed that the workgroup required additional meetings to discuss outstanding issues related to its charge, with the inclusion of an additional member to provide further perspectives on the AAPD anesthesia guidelines. As such, the Ad Hoc Committee recommended that the Commission invite the American Academy of Pediatric Dentistry’s Chair of the Council on Clinical Affairs, Committee on Sedation and Anesthesia to join the Ad Hoc Committee as an additional member to provide a perspective on the potential revision to the Accreditation Standards for Pediatric Dentistry Education Programs. The Ad Hoc Committee will continue its work with a report to the Commission at its Summer 2022 meetings.

Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards Recommendations:
It is recommended that the Commission on Dental Accreditation adopt the proposed definition of “Sole Primary Operator” within the Definition of Terms, and the proposed intent statement within Standard 4-7 of the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry, with immediate implementation.
It is further recommended that the Commission on Dental Accreditation invite the American Academy of Pediatric Dentistry’s Chair of the Council on Clinical Affairs, Committee on Sedation and Anesthesia to join the Ad Hoc Committee as an additional member to provide a perspective on the potential revision to the Accreditation Standards for Pediatric Dentistry Education Programs related to anesthesia education for pediatric dentistry.

**Recommendation:**

Prepared by: Ms. Kirsten Nadler
Commission on Dental Accreditation

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

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org/coda
Accreditation Standards for
Advanced Dental Education Programs in Pediatric Dentistry

Document Revision History

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<tr>
<td>August 7, 2020</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry</td>
<td>Adopted</td>
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<tr>
<td>July 1, 2021</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry</td>
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## Standards

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

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

Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Should**: Indicates a method to achieve the standards.

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

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

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

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

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

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

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

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

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

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

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

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

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

Resident Clinical Log (RCL): A secure and valid account of procedures and experiences of a student/resident maintained by the program for use in evaluation, accreditation, quality assurance and other purposes.
Treatment: Refers to direct care provided by the student/resident for that condition or clinical problem.

Management: Refers to provision of appropriate care and/or referral for a condition consistent with contemporary practice and in the best interest of the patient.


Interprofessional Education**: When students/residents and/or professionals from two or more professions learn about, from and with each other to enable effective collaboration to improve health outcomes. *(Adapted from the WHO 2010)*

Social Determinants of Health***: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. *(From the WHO)*


STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

The authority and final responsibility for curriculum development and approval, student/resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

The institution/program must have a formal system of quality assurance for programs that provide patient care.

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

**USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS**

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

1-1 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. The following items must be covered in such inter-institutional agreements:

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

**Intent:** The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

1-2 A Commission-accredited advanced education program in pediatric dentistry must use, among other outcomes measures, the successful completion by its graduates of the American Board of Pediatric Dentistry certification process.

**Intent:** This is one of the many measures of outcomes assessment that a program may use in their outcomes assessment process.

1-3 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.

**Intent:** All pediatric dental faculty are educationally qualified pediatric dentists. All non-pediatric dentistry members of the teaching staff are educationally qualified or have special expertise in their area(s) of instruction.

If the program utilizes educational activity sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

2-1 The program director must be evaluated annually.

2-2 Administrative Responsibilities: The program director must have sufficient authority and time to fulfill administrative program assessment and teaching responsibilities in order to achieve the educational goals of the program including:

**Intent:** Program directors with remote programs have resources to visit these programs.

2-2.1 Student/Resident selection, unless the program is sponsored by federal services utilizing a centralized student/resident selection process.
2-2.2 Curriculum development and implementation.

2-2.3 Ongoing evaluation of program goals, objectives and content and outcomes assessment.

**Intent:** The program uses a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement that relate directly to the stated program goals and objectives.

2-2.4 Annual evaluations of faculty performance by the program director or department chair; including a discussion of the evaluation with each faculty member.

2-2.5 Evaluation of student/resident performance.

2-2.6 Participation with institutional leadership in planning for and operation of facilities used in the educational program.

2-2.7 Evaluation of student’s/resident’s training and supervision in affiliated institutions.

2-2.8 Maintenance of records related to the educational program, including written instructional objectives, course outlines and student/resident clinical logs (RCLs) documenting the completion of specified procedures and/or patient complexity, including:

   a) nitrous oxide analgesia patient encounters as primary operator
   b) patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used
   c) operating room cases
   d) clinical procedures (e.g. emergency, trauma, restorative, preventative, orthodontic, multi-disciplinary, etc.)
   e) patient diversity/complexity (e.g. well-patient, medically complex, special needs, hospital based, etc.)

**Intent:** These records are to be available for on-site review: overall program objectives, objectives of student/resident rotations, specific student/resident schedules by semester or year, completed student/resident evaluation forms for current students/residents and recent alumni, self-assessment process, curricula vitae of faculty responsible for instruction. The RCL provides programs with data required for program improvement and gives students/residents and official record of clinical
procedures required by regulatory boards and hospitals. The RCL may be comprised of a HIPAA-compliant patient and procedure log and/or a printout of procedure codes, for example, and may be compiled by the program, student/resident, and/or staff.

2-2.9 Responsibility for overall continuity and quality of patient care.

2-2.10 Oversight responsibility for student/resident research.

2-2.11 Responsibility for determining the roles and responsibilities of associate program director(s) and their regular evaluation.

2-3 Activities of Teaching Staff:

2-3.1 Pediatric dentistry members of the teaching staff, including those at sites where educational activity occurs, must be certified by the American Board of Pediatric Dentistry or have completed the educational requirements to pursue board certification.

For clinical disciplines other than pediatric dentistry, the supervising faculty member responsible for the specific discipline must be credentialed in that discipline within the institution.

**Intent:** The curriculum is taught by educationally qualified pediatric dentists and, when necessary to enhance training, by credentialed faculty members for the curriculum areas for which they are responsible.

2-3.2 Internationally trained pediatric dentists must demonstrate evidence of educational qualifications, licensure and credentialing as required by the institution.

**Intent:** Individuals who are graduates of Commission on Dental Accreditation accredited programs or those with which the Commission on Dental Accreditation has reciprocity are exempt from this requirement.

2-3.3 The program clinical faculty and attending staff must have specific and regularly scheduled clinic assignments to ensure the continuity of the program.

2-3.4 Clinical faculty must be immediately available to provide direct supervision to students/residents for all clinical sessions.
Intent: Clinical faculty are physically in the treatment area for clinical sessions with scheduled patients and, immediately available within one minute, for all sedation patients. Indirect supervision should only be used after careful consideration of the competence of the student/resident and also based on the delineation of privileges and procedure types. Clinical faculty are held accountable for responsibilities and attendance. Certain funding sources require specific faculty to student/resident ratios which should be observed.

2-3.5 The faculty includes members who are engaged in scholarly activity.

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

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

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural, gender, and generational competency
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities

2-5 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

Intent: The students/residents receive comparable training and evaluation by all faculty.
Examples of evidence to demonstrate compliance may include:

- Ongoing faculty training
- Documentation of faculty participation in calibration exercises
- Calibration training manuals
- Periodic monitoring for compliance
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

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

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

3-1 Students/Residents and faculty engaged in the provision of sedation in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used must have training in and maintenance of age-specific advanced life support (e.g., PALS, ACLS, PEARs), in accordance with current recommendations of the REFERENCE MANUAL, and institutional and state regulations.

**Intent:** Guidelines require that providers of sedation have these credentials.

3-2 Private practitioners who provide training must have faculty appointments.

**Intent:** Private offices can be used for training and should meet the same facility standards as institutional facilities.

3-3 The program must have access to clinical facilities that include:

3-3.1 Space designated specifically for the advanced dental education program in pediatric dentistry.

3-3.2 Flexibility to allow for changes in equipment location and for additions or deletions to improve operating efficiency, and promote efficient use of dental instrumentation and allied personnel.

3-3.3 Diagnostic imaging and laboratory facilities in close proximity to the patient treatment area.

3-3.4 Accessibility for patients with special health care needs.

3-3.5 Recovery area facilities.

**Intent:** A recovery area is defined as a designated space equipped properly for patients recovering from sedation. This space must provide for observation/monitoring by appropriately trained personnel. This could be the operatory where the child was sedated.

3-3.6 Reception and patient education areas.

**Intent:** Patient education may also occur in treatment areas.
3-3.7 A suite equipped for carrying out comprehensive oral health care procedures under general anesthesia and/or sedation.

**Intent:** The treatment facility could be an appropriately-equipped ambulatory suite in a non-hospital setting.

3-3.8 Inpatient facilities to permit management of general and oral health problems for individuals with special health care needs.

**Intent:** Students/Residents have the opportunity to manage oral health problems of inpatients with serious medical problems. Individuals with special health care needs include those with medical, physical, psychological or social circumstances that require modification of dental treatment. These individuals include (but are not limited to) people with developmental disabilities, complex medical problems and significant physical limitations.

3-3.9 A sufficient number of operatories to accommodate the number of students/residents enrolled.

3-4 Personnel resources **must** include:

3-4.1 Adequate administrative and clerical personnel.

3-4.2 Adequate allied dental personnel assigned to the program to ensure clinical and laboratory technical support are suitably trained and credentialed.

**Intent:** Allied dental personnel are expected to be available for operating room cases, conscious/deep sedation patients, surgical procedures and behavior management situations. There are instances when a student/resident assisting another student/resident may be beneficial as long as the experience does not negatively impact the students'/residents’ education. Clinic scheduling and off-service rotations will be considered in assessing adequacy of allied dental personnel.

3-5 Research Facilities: Facilities **must** be available for students/residents to conduct basic and/or applied (clinical) research.

3-6 Information Resources: Appropriate information resources **must** be available including access to biomedical textbooks, dental journals, online resources, and other sources pertinent to the area of pediatric dentistry practice and research.

**Intent:** Students/Residents have access to electronic-based information resources in the program.
3-7 Patient Availability: An adequate and diverse pool of patients requiring a sufficient scope, volume and variety of oral health care needs and a delivery system to provide ample opportunity for training must be available, including healthy individuals as well as individuals with special health care needs. These health care needs must include, but are not limited to, medical, physical, psychological, or social situations that make consideration of a wide range of assessment and care options necessary.

**Intent:** Documentation of the scope, volume and variety of patients and procedures completed by the students/residents, including those with complex impairment who require substantial functional support and modifications to dental treatment, will be provided via the RCLs as described in Standard 2-2.8. These records are to be available for on-site review.
STANDARD 4 – CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

4-1 An advanced dental education program in pediatric dentistry must prepare a graduate who is competent in providing both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including individuals with special health care needs. The program educates future pediatric dentists to be competent in communicating and collaborating with other members of healthcare and social disciplines, to facilitate the provision of health care.

**Intent:** Students/Residents are trained to provide services in institutional, private, and/or public health settings. The program should encourage the development of a critical and inquiring attitude that is necessary for the advancement of practice, research, and teaching in pediatric dentistry.

All curricula must be formulated in accordance with the REFERENCE MANUAL, if applicable.

4-2 Students/Residents must participate in interprofessional education and collaborative practice programs and receive training to assume a leadership role as a care team member in oral healthcare initiatives.

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

PROGRAM DURATION

4-3 The duration of an advanced dental education program in pediatric dentistry must be a minimum of 24 months of full-time formal training.

CURRICULUM

4-4 The program must provide the opportunity to extend the student’s/resident’s diagnostic ability, basic and advanced clinical knowledge and skills, and critical judgment beyond that provided in predoctoral education. The program must also provide experience in closely related areas to ensure that students/residents become competent in comprehensive care.
Intent: A supporting portion of the curriculum extends the student’s/resident’s educational experience and enhances his/her ability to think critically and independently and to communicate information clearly, effectively and accurately.

BIOMEDICAL SCIENCES

4-5 Biomedical sciences must be included to support the clinical, didactic and research portions of the curriculum. The biomedical sciences may be integrated into existing curriculum designed especially for the pediatric dentistry program.

Intent: Instruction in biomedical sciences need not occur only in formal courses. Such instruction may be acquired through clinical activities, off-service rotations and other educational activities.

Instruction must be provided at the understanding level in the following biomedical sciences with an emphasis on the infant, child and adolescent, including individuals with special health care needs:

a. BIOSTATISTICS, HEALTH INFORMATICS and CLINICAL EPIDEMIOLOGY: Including probability theory, descriptive statistics, hypothesis testing, inferential statistics, meta-analysis, systematic review, principles of clinical epidemiology and research design;

b. PHARMACOLOGY: Including pharmacokinetics, pharmacogenetics, potential drug interactions and adverse side effects with emphasis on oral manifestations, pain and anxiety control, drug dependency and substance use disorders;

c. MICROBIOLOGY: Including immunology, oral microbiome, infectious disease with emphasis on head and neck manifestations, including dental caries and periodontal disease;

d. EMBRYOLOGY: Including principles of embryology with a focus on the developing head and neck, and craniofacial anomalies;

e. GENETICS: Including human chromosomal anomalies/syndromes, Mendelian, polygenic and epigenetic patterns of inheritance, expressivity, basis for genetic disease, pedigree construction, physical examination and laboratory evaluation methods, genetic factors in craniofacial disease and formation and management of genetic diseases;

f. ANATOMY: Including a review of general as well as head and neck anatomy; and

g. PATHOPHYSIOLOGY: Including a review of major organ diseases with emphasis on head and neck manifestations and the modification of the delivery of oral health care. There will be an understanding of the
epidemiology, etiopathogenesis, clinical presentation, diagnostic imaging and laboratory studies, differential diagnosis, treatment and prognosis for these diseases.
CLINICAL SCIENCES

BEHAVIOR GUIDANCE

4-6 Didactic Instruction: Didactic instruction in behavior guidance must be at the in-depth level and include:

a. Physical, psychological and social development. This includes the basic principles and theories of child development and the age-appropriate behavior responses in the dental setting;
b. Child behavior guidance in the dental setting and the objectives of various guidance methods;
c. Principles of communication, listening techniques, and communication with parents and caregivers;
d. Principles of informed consent relative to behavior guidance and treatment options;
e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the REFERENCE MANUAL; and
f. Recognition, treatment and management of adverse events related to sedation and general anesthesia, including airway problems.

Intent: The term “treatment” refers to direct care provided by the residents/student for that condition or clinical problem. The term “management” refers to provision of appropriate care and/or referral for a condition consistent with contemporary practice and in the best interest of the patient.

4-7 Clinical Experiences: Clinical experiences in behavior guidance must enable students/residents to achieve competency in patient management using behavior guidance:

a. Experiences must include infants, children and adolescents including individuals with special health care needs, using:
   1. Non-pharmacological techniques;
   2. Sedation; and
   3. Inhalation analgesia.

b. Students/Residents must perform adequate patient encounters to achieve competency:

   1. Students/Residents must complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and
2. Students/Residents **must** complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.

   a. Of the 50 patient encounters, each student/resident **must** act as sole primary operator in a minimum of 25 sedation cases.

   b. Of the remaining sedation cases (those not performed as the sole primary operator), each student/resident **must** gain clinical experience, which can be in a variety of activities or settings, including individual or functional group monitoring and human simulation.

   c. All sedation cases **must** be completed in accordance with the recommendations of the REFERENCE MANUAL and/or applicable institutional policies and state regulations.

**Intent:** Programs will provide or make available adequate opportunities to meet the above requirements which are consistent with those experiences required by jurisdictions with policies regulating pediatric sedation in dental practice. The numbers of encounters cited in the Standard represents the minimal number of experiences required for a student/resident. In the sole primary operator role, the student/resident is expected to provide the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies.

In the remaining sedation cases, where the student/resident is not the primary operator, the supplemental cases provide the student/resident with:

(1) direct clinical participation in patient care in an observational, data-gathering, monitoring, and/or recording capacity,

(2) simulation experiences with direct clinical application to elements of the REFERENCE MANUAL, or

(3) participation in ongoing activities related to specific patient care episodes such as quality improvement and safety initiatives, apparent cause analysis, Morbidity & Mortality conferences, and/or clinical rounds that review essential elements of an actual patient sedation visit.

These experiences require documentation and inclusion in the RCL. It is not an appropriate learning experience for groups of students/residents to passively observe a single sedation being performed.
The intent of this standard is not for multiple operators to provide limited treatment on the same sedated patient in order to fulfill the sedation requirement.

GROWTH & DEVELOPMENT

4-8 Didactic Instruction: Didactic instruction in craniofacial growth and development must be at the in-depth level with content to enable the student/resident to understand and manage the diagnosis and appropriate treatment modalities for malocclusion problems affecting orofacial form, function, and esthetics in infants, children, adolescents, and individuals with special health care needs. This includes, but is not limited to, an understanding of:

a. Theories of normative dentofacial growth mechanisms;
b. Principles of diagnosis and treatment planning to identify normal and abnormal dentofacial growth and development;
c. Differential classification of skeletal and dental malocclusion in children and adolescents;
d. The indications, contraindications, and fundamental treatment modalities in guidance of eruption and space supervision procedures during the developing dentition that can be utilized to obtain an optimally functional, esthetic, and stable occlusion;
e. Basic biomechanical principles and the biology of tooth movement. Growth modification and dental compensation for skeletal problems including limitations; and
f. Appropriate consultation with and/or timely referral to other specialists when indicated to achieve optimal outcomes in the developing occlusion.

4-9 Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in:

a. Diagnosis and management of dental, skeletal, and functional abnormalities in the primary, mixed, and young permanent dentition stages of the developing occlusion; and
b. Treatment of those conditions that can be corrected or significantly improved by evidence-based early interventions which might require guidance of eruption, space supervision, and interceptive orthodontic treatments. These transitional malocclusion conditions include, the recognition, diagnosis, appropriate referral and/or focused management of:

1. Space maintenance and arch perimeter control associated with the early loss of primary and young permanent teeth;
2. Transverse arch dimensional problems involving simple posterior crossbites;
3. Anterior crossbite discrepancies associated with localized dentoalveolar crossbite displacement and functional anterior shifts (e.g. pseudo-Class III);
4. Anterior spacing with or without dental protrusion;
5. Deleterious oral habits;
6. Preservation of leeway space for the resolution of moderate levels of crowding;
7. Ectopic eruption, ankylosis and tooth impaction problems; and
8. The effects of supernumerary (e.g. mesiodens) and/or missing teeth.

**ORAL FACIAL INJURY AND EMERGENCY CARE**

**4-10** Didactic Instruction: Didactic instruction in oral facial injury and emergency care in infants, children, adolescents, and individuals with special health care needs must be at the in-depth level and include:

a. Evaluation, diagnosis and management/treatment of dentoalveolar trauma to the primary, mixed and permanent dentitions, such as repositioning, replantation, treatment of fractured teeth, and stabilization of intruded, extruded, luxated, and avulsed teeth;
b. Evaluation, diagnosis, and management/treatment of the pulpal, periodontal and associated soft and hard tissues following traumatic injury;
c. Evaluation of injuries including fractures of the maxilla and mandible and referral for treatment by the appropriate specialist; and
d. Assessment, evaluation, management and reporting of child abuse and neglect and non-accidental trauma.

**4-11** Clinical Experiences: Clinical experiences in oral facial injury and emergency care must enable students/residents to achieve competency in:

a. Evaluation, diagnosis and management of traumatic injuries of the oral and perioral structures including the soft tissues, and the primary and permanent dentition;
b. Emergency services including assessment and management/treatment of dental pain and infections; and
c. Interprofessional and collaborative care management for patients with complex orofacial/dentoalveolar injuries.

**ORAL DIAGNOSIS, ORAL PATHOLOGY, ORAL RADIOLOGY AND ORAL MEDICINE**

**4-12** Didactic Instruction: Didactic instruction in oral diagnosis, oral pathology, oral radiology and oral medicine with emphasis on the most frequently encountered and important anomalies,
diseases and lesions that affect the infant, child, adolescent and individuals with special health care needs must be at the in-depth level and include:

a. Epidemiology, etiology, clinical and radiographic findings, differential diagnosis, management/treatment, and prognosis of entities affecting the oral and maxillofacial region, including gingival and periodontal diseases;
b. Head and neck manifestations of systemic diseases, behavioral disorders and genetic conditions;
c. Referral requirements to appropriate professionals;
d. Radiation theory, hygiene and safety;
e. Radiographic imaging selection and technique for oral diagnosis including modifications for individuals with special health care needs; and
f. Radiographic interpretation of normal anatomy, anomalies and oral and maxillofacial lesions/diseases.

Didactic instruction must be at the understanding level in:

g. Ordering and performing uncomplicated oral biopsies, adjunctive tests including salivary gland function, microbial cultures and common, baseline laboratory studies; and
h. Ordering advanced head and neck imaging, including CBCT and MRI and recognizing deviations from normal.

4-13 Clinical Experiences: Clinical experiences in oral diagnosis, oral pathology, oral radiology and oral medicine must enable students/residents to achieve competency in:

a. Detecting and providing differential diagnoses of common and important oral and maxillofacial lesions, including gingival and periodontal diseases;
b. Obtaining and interpreting oral and maxillofacial images;
c. Using radiation hygiene and recommended radiographic images; and
d. Managing/Treating common oral and maxillofacial lesions and diseases, including gingival and periodontal diseases.

**COMPREHENSIVE ORAL HEALTH CARE**

**PREVENTION AND HEALTH PROMOTION**

4-14 Didactic Instruction: Didactic instruction in prevention must be at the in-depth level and include:

a. Characteristics and role of the dental home;
b. Perinatal oral health and infant oral health;
c. Assessment of the risk of dental caries manifestations, periodontal disease, dental trauma and malocclusion;
d. Anticipatory guidance;
e. Patient/parent/caregiver education on home care;
f. Communication strategies to help patients/parents/caregivers guide behavior change, such as teach back and motivational interviewing;
g. Prevention of dental disease strategies including;
   1. Fluorides and non-fluoride caries preventive and remineralizing agents;
   2. Diet, nutrition and sugars, and their role in oral health and disease;
   3. Pit and fissure sealants;
h. Trauma prevention;
i. The scientific basis for the etiology, detection, diagnosis, prevention, management and restorative treatment of dental caries manifestations; and
j. The provision of a risk-based, patient/family-centered comprehensive treatment plan that includes a prevention and health promotion plan.

Didactic Instruction: Didactic instruction in prevention must be at the understanding level and include:
k. Social determinants of health; and
l. Relationship between oral health and systemic conditions.

4-15 Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in the provision of:
a. Risk-based, patient/family-centered prevention and health promotion plans for patients and families in the context of a dental home;
b. Infant oral health;
c. Anticipatory guidance;
d. Dental caries risk assessment and related risk of caries lesion progression;
e. Risk-based dental caries management protocols including risk reduction methods and early management of dental caries lesions;
f. Patient/Parent/Caregiver education on oral hygiene practices, diet and nutrition;
g. Effective communication strategies to help guide behavior change;
h. Prevention of dental disease strategies including the use risk-based dental caries management protocol; and
i. Use of fluoride and non-fluoride dental caries lesion preventive and remineralizing agents.

**DIAGNOSIS OF CARIES, NON-RESTORATIVE MANAGEMENT AND RESTORATIVE TREATMENT**
Didactic Instruction: Didactic instruction must be at the in-depth level and include:

a. Caries lesion detection and diagnosis techniques; and
b. Caries lesion management strategies.

**Intent:** Dental caries management strategies may include active surveillance to assess disease and lesion progression; minimally invasive restorative treatment and determination of when to restore; deep caries lesion excavation and partial decay excavation; pit and fissure sealant indications, technique and materials; resin infiltration; restorative and prosthetic therapy indications, techniques and dental materials, including conventional restorations, interim therapeutic restorations, alternative restorative techniques and esthetic restorations; and remineralization and dental caries lesion arresting strategies.

Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in:

a. Caries lesion detection and diagnosis.
b. Caries management strategies that include:
   1. Active surveillance to assess disease progression;
   2. Minimally invasive restorative treatment and determination of when to restore;
   3. Deep decay excavation and partial decay excavation;
   4. Pit and fissure sealant indications, technique and materials;
   5. Restorative and prosthetic therapy indications, techniques and dental materials, including conventional restorations, interim therapeutic restorations, alternative restorative techniques and esthetic restorations; and
   6. Remineralization and dental caries lesion arresting strategies.

**PULP THERAPY**

Didactic Instruction: Didactic instruction must be at the in-depth level and include:

a. Pulp histology and pathology of primary and young permanent teeth, including indications and rationale for various types of indirect and direct pulp therapy; and
b. Management of pulpal and periradicular tissues in the primary and developing permanent dentition.

**Intent:** Pulp therapy management strategies may include vital pulp therapy for primary teeth, including indirect pulp treatment, direct pulp cap, pulpotomy; non-vital pulp treatment for primary teeth including pulpectomy; vital pulp therapy for young permanent teeth including apexogenesis, indirect pulp treatment, direct pulp cap, partial pulpotomy for
carious exposures, partial pulpotomy for traumatic exposures; and non-vital pulp therapy for young permanent teeth including apexification, pulpal regeneration and decoronation.

4-19 Clinical Experiences: Clinical experiences **must** enable students/residents to achieve competency in:

a. Diagnosis of pulpal disease in primary and permanent teeth;
b. Vital and non-vital pulp therapy in primary teeth;
c. Vital pulp therapy in immature permanent teeth;
d. Management of non-vital pulp therapy in immature permanent teeth; and
e. Treatment/Management of pulpal disease in mature permanent teeth, including emergency care, stabilization and referral to specialists.

**MANAGEMENT OF A CONTEMPORARY DENTAL PRACTICE**

4-20 Didactic Instruction: Didactic instruction **must** be at the understanding level and include:

a. The design, implementation and management of a contemporary practice of pediatric dentistry, emphasizing business skills for proper and efficient practice;
b. Jurisprudence and risk management specific to the practice of Pediatric Dentistry;
c. Use of technology in didactic, clinical and research endeavors, as well as in practice management and telehealth systems;
d. Principles of biomedical ethical reasoning, ethical decision making and professionalism as they pertain to the academic environment, research, patient care and practice management; and
e. Working cooperatively with consultants and clinicians in other dental specialties and health fields, including interprofessional education activities.

Didactic instruction **must** be at the in-depth level for the following:

f. The development and monitoring of systems for prevention and management of adverse events and medical emergencies in the dental setting;
g. Exposure to the principles of quality management systems and the role of continuous process improvement in achieving overall quality in the dental practice setting;
h. Exposure to the principles of ethics and professionalism in dental practice is an integral component of all aspects of this process improvement experience; and
i. Employing principles of quality improvement, infection control, and safety, including an understanding of the mechanisms to ensure a safe practice environment.
**Intent:** (d) Graduates should draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern, (e) The student/resident learns to prevent, recognize and manage common medical emergencies for infants and children through adolescence and when to refer to other health care professionals and (g) Graduates should experience the elements of process improvement and the manner in which to involve the entire team.

Examples of evidence may include (d and g):

- Participation in courses or seminars involving biomedical ethics and/or informed consent issues;
- Institutional review boards;
- Literature reviews;
- Discussion of case scenarios;
- Emergency drills;
- Quality improvement projects;
- Interprofessional education and practice experiences;
- Standardized simulations;
- Standardized case studies; and
- Standardized clinical scenarios.

4-21 Clinical Experiences: Clinical experiences **must** enable students/residents to be involved in a structured system of continuous quality improvement for patient care.

**Intent:** Programs are expected to involve students/residents in quality improvement activities to understand the process and contribute to patient care improvement.

**INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS**

4-22 Didactic Instruction: Didactic instruction **must** be at the in-depth level and include:

a. Formulation of treatment plans for individuals with special health care needs.

b. Medical conditions and the alternatives in the delivery of dental care that those conditions might require.

c. Management of the oral health of individuals with special health care needs, i.e.:
   1. Medically compromised;
   2. Physically compromised or disabled; and diagnosed to have developmental disabilities, psychiatric disorders or psychological disorders.
   3. Transition to adult practices
Intent: (a) The student/resident learns how and when to modify dental care options as required by a patient’s medical condition; and (c) Individuals with special health care needs include those with medical, physical, psychological or social circumstances that require modification in normal dental routines to provide dental treatment.

4-23 Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in:

a. Examination, treatment and management of infants, children, adolescents and individuals with special health care needs; and
b. Participation in interprofessional experiences and collaborative care, including craniofacial teams.

Intent: Pediatric dentists often remain providers of oral health care for individuals with special health care needs into adulthood and should be able to render basic dental services to adults with special health care needs. These individuals include (but are not limited to) individuals with developmental disabilities, craniofacial anomalies, complex medical problems and significant physical limitations. Management should be understood to include consideration of social, educational, vocational and other aspects of special health care needs.

HOSPITAL DENTISTRY

4-24 Didactic Instruction: Didactic instruction must be at the understanding level and include:

a. Hospital experiences intended to expose students/residents to hospital function which may include attendance at conferences, seminars, clinic participation, and, if applicable, clinical inpatient rounds;
b. Hospital policies and procedures, including organization of the medical/dental staff and medical staff/dental staff member responsibilities; and
c. The scope of practice of other healthcare professionals in relationship to the overall health and wellbeing of infants, children, adolescents and individuals with special health care needs.

4-25 Clinical Experiences: Clinical experiences must enable students/residents to acquire knowledge and skills to function as health care providers within the hospital setting.

a. Dental treatment in the Operating Room Setting:
1. Each student/resident must participate in the treatment of pediatric patients under general anesthesia in the operating room.
2. Each student/resident **must** participate in a minimum of twenty (20) operating room cases; and these are documented in the RCL (Resident Clinical Log). In ten (10) of the operating room cases above, each student/resident provides the pre-operative workup and assessment, conducting medical risk assessment, admitting procedures, informed consent, and intra-operative management including completion of the dental procedures, post-operative care, discharge and follow up and completion of the medical records.

**Intent:** *(a.1) Each student/resident participates in and directly provides dental treatment to pediatric patients under general anesthesia in the operating room. Experiences may occur in an out-patient ambulatory care facility.*

b. Inpatient Care:
1. Each student/resident **must** collaborate in the evaluation and medical management of pediatric patients admitted to the hospital; and
2. Each student/resident **must** collaborate in admitting procedures, completion of consultations, obtaining and evaluating patient/family history, orofacial examination and diagnosis, ordering radiological and laboratory tests, writing patient management orders, pediatric patient monitoring, discharging and chart completion.

c. Anesthesiology Rotation:
1. Students/residents **must** complete a rotation under the supervision of an anesthesiologist in a facility approved to provide general anesthesia;
2. This rotation **must** be at least four (4) weeks in length, which does not have to be consecutive, and is the principal activity of the student/resident during this scheduled time;
3. The anesthesiology rotation **must** provide the student/resident with knowledge and experience in the management of infants, children and adolescents undergoing general anesthesia; and
4. The rotation **must** provide and document experiences in: (1) pre-operative evaluation, (2) risk assessment, (3) assessing the effects of pharmacologic agents, (4) venipuncture techniques, (5) airway assessment and management, (6) general anesthetic induction and intubation, (7) administration of anesthetic agents, (8) patient monitoring, (9) prevention and management of anesthetic emergencies and adverse events, (10) post anesthesia recovery management, and (11) postoperative appraisal and follow up.

d. Additional Hospital Experiences:
1. Each student/resident **must** participate in continually accessible call through the hospital emergency department and provide treatment in collaboration
2. Each student/resident must participate on interdisciplinary/multidisciplinary teams, including participation on a Craniofacial Team.
3. Each student/resident must participate in interprofessional education to other health care professionals within the hospital setting.

**PEDIATRIC MEDICINE**

4-26 Didactic Instruction: Didactic instruction must be at the understanding level and include:

a. Fundamentals of pediatric medicine, including those related to healthy pediatric patients and those with special health care needs such as:
   1. Well child care and anticipatory guidance
   2. Developmental milestones; and
   3. Acute and chronic disease/disorders.

b. Normal speech and language development and the recognition of speech and language delays/disorders.

c. The anatomy and physiology of articulation and normal articulation development; causes of defective articulation with emphasis on oral anomalies, craniofacial anomalies, dental or occlusal abnormalities, velopharyngeal insufficiency (VPI), history of cleft lip/palate and normal velopharyngeal function and the effect of VPI on resonance.

4-27 Clinical Experiences: Clinical experiences must expose students/residents to pediatric medicine:

a. Students/Residents must participate in a pediatric medicine rotation of at least two (2) weeks in length, which does not have to be consecutive and is the principal activity during this scheduled period.

b. The rotation must include exposure to obtaining and evaluating medical histories, parental interviews, system-oriented physical examinations, clinical assessments of patients, selection of laboratory tests and evaluation of data, evaluation of physical, motor and sensory development, genetic implications of childhood diseases, the use of drug therapy in the management of diseases, and parental management through discussions and explanation.

**Intent:** This rotation may occur in a variety of settings i.e., Emergency Department, subspecialty clinics, multi-disciplinary team clinics, and general pediatrics. When appropriate, and to a limited extent, pediatric medicine clinical experiences may be supplemented by clinical simulation.
Examples of evidence to demonstrate compliance may include:

- Observe management of acute asthma attack;
- Identify child abuse/neglect and referral to social services;
- Observe management of seizure;
- Observe management of acute abdominal pain;
- Observe management of shock;
- Listen to heart and lung sounds;
- Observe rapid sequence intubation for pediatric emergency airway management;
- Recognize possible causes and treatment for unconsciousness;
- Understand triage procedures for medical emergencies;
- Observe a cranial-nerve exam; and
- Discuss the selection of laboratory tests.
ADVOCACY AND EDUCATION

4-28 Didactic Instruction: Didactic instruction must be at the understanding level and include:

a. The fundamental domains of child advocacy including knowledge about the disparities in the delivery of dental care, issues pertaining to access to dental care and possible solutions;
b. The social determinants of health and the impact on general and oral health;
c. Services available through healthcare and oral healthcare programs for at-risk populations, such as U.S. governmental programs (e.g., Medicaid and SCHIP); and
d. Principles of learning and teaching to diverse audiences.

**Intent:** Pediatric dentists serve as the primary advocates for the oral health of children. The intent of the competency standards is to ensure that the resident is adequately trained to assume this role. Such training includes enhancing knowledge about oral health disparities and available services within the state and federal programs directed at meeting those needs. It also includes knowledge about their role as advisors to policy makers and organized dentistry.

4-29 Experiences: Experiences must provide exposure of the student/resident to:

a. Communicating, teaching, and collaborating with groups and individuals on children’s oral health issues; and/or
b. Advocating and advising public health policy legislation and regulations to protect and promote the oral health of children; and/or
c. Participating at the local, state and/or national level in organized dentistry and child advocacy groups/organizations to represent the oral health needs of children, particularly the underserved.

4-30 Students/Residents must engage in teaching activities which may include peers, predoctoral students, community based programs and activities, and other health professionals, including interprofessional education programs.
STANDARD 5 - ADVANCED EDUCATION STUDENTS/RESIDENTS

ELIGIBILITY AND SELECTION

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

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

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

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

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

**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.
EVALUATION

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

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

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

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

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

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

5-1 Programs must define the scope of supervision and responsibility for students/residents in the various components of their program for various stages of their education.

Intent: As students/residents advance in the program, they may and should assume differing levels of responsibility defined by their educational progress and skill acquisition. Programs, by their individual institutional rules and policies may grant independence to students/residents for specific procedures and situations. Programs should be able to demonstrate changes in roles of advanced students/residents.
STANDARD 6 - RESEARCH

Advanced dental education students/residents must engage in scholarly activity.

6-1 Students/Residents must:
   a. Participate in and complete a research project;
   b. Use data collection and analysis;
   c. Use elements of scientific method; and
   d. Report results in a scientific forum.

Intent: Students/Residents gain an understanding of the scientific method such that they will be able to critically analyze the scientific literature and, independently, conduct a fundamental research project. An understanding of the scientific method requires knowledge and experiences in literature review, experimental design, statistical analysis, and accurate reporting of findings. Due to the complexity of some projects and need for prolonged follow-up periods, a team approach may be utilized with each student/resident defining his or her own research hypothesis, methods, data analysis, reporting of results and discussion in accordance with Standard 6-1 a through d.

Examples of evidence to demonstrate compliance may include:

- Systematic review
- Quality improvement research
- Survey research
- Basic and translational research
- Educational methodology and assessment research
- Clinical research
Commission on Dental Accreditation

Submitted by the Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards

Proposed Revisions to Standards
Additions are Underlined
Strikethroughs indicate Deletions

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

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org/coda
# Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry

## Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 7, 2020</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry</td>
<td>Adopted</td>
</tr>
<tr>
<td>July 1, 2021</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry</td>
<td>Implemented</td>
</tr>
<tr>
<td>February 11, 2022</td>
<td>Addition of Sole Primary Operator to Definition of Terms and Revision to Standard 4-7 Intent Statement</td>
<td>Adopted and Implemented</td>
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</table>

Ad Hoc Committee on Pediatric Dentistry Anesthesia Standards  
PED RC  
Winter 2022
Definitions of Terms Used in Pediatric Dentistry Accreditation Standards

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

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

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

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

**Should**: Indicates a method to achieve the standards.

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

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

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

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

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

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

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

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

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

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

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

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

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

Resident Clinical Log (RCL): A secure and valid account of procedures and experiences of a student/resident maintained by the program for use in evaluation, accreditation, quality assurance and other purposes.
Treatment: Refers to direct care provided by the student/resident for that condition or clinical problem.

Management: Refers to provision of appropriate care and/or referral for a condition consistent with contemporary practice and in the best interest of the patient.


Sole Primary Operator: The student/resident providing the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies. Each patient encounter shall have only one (1) sole primary operator.

Interprofessional Education**: When students/residents and/or professionals from two or more professions learn about, from and with each other to enable effective collaboration to improve health outcomes. (Adapted from the WHO 2010)

Social Determinants of Health***: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. (From the WHO)


STANDARD 4 – CURRICULUM AND PROGRAM DURATION

CLINICAL SCIENCES

BEHAVIOR GUIDANCE

4-7 Clinical Experiences: Clinical experiences in behavior guidance must enable students/residents to achieve competency in patient management using behavior guidance:

a. Experiences must include infants, children and adolescents including individuals with special health care needs, using:
   1. Non-pharmacological techniques;
   2. Sedation; and
   3. Inhalation analgesia.

b. Students/Residents must perform adequate patient encounters to achieve competency:
   1. Students/Residents must complete a minimum of 20 nitrous oxide analgesia patient encounters as primary operator; and
   2. Students/Residents must complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.

   a. Of the 50 patient encounters, each student/resident must act as sole primary operator in a minimum of 25 sedation cases.

   b. Of the remaining sedation cases (those not performed as the sole primary operator), each student/resident must gain clinical experience, which can be in a variety of activities or settings, including individual or functional group monitoring and human simulation.

   c. All sedation cases must be completed in accordance with the recommendations of the REFERENCE MANUAL and/or applicable institutional policies and state regulations.

**Intent:** Programs will provide or make available adequate opportunities to meet the above requirements which are consistent with those experiences required by jurisdictions with policies regulating pediatric sedation in dental practice. The numbers of encounters cited in
the Standard represents the minimal number of experiences required for a student/resident. In the sole primary operator role, the student/resident is expected to provide the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies. Each patient encounter shall have only one (1) sole primary operator.

In the remaining sedation cases, where the student/resident is not the primary operator, the supplemental cases provide the student/resident with:

(1) direct clinical participation in patient care in an observational, data-gathering, monitoring, and/or recording capacity,
(2) simulation experiences with direct clinical application to elements of the REFERENCE MANUAL, or
(3) participation in ongoing activities related to specific patient care episodes such as quality improvement and safety initiatives, apparent cause analysis, Morbidity & Mortality conferences, and/or clinical rounds that review essential elements of an actual patient sedation visit.

These experiences require documentation and inclusion in the RCL. It is not an appropriate learning experience for groups of students/residents to passively observe a single sedation being performed. The intent of this standard is not for multiple operators to provide limited treatment on the same sedated patient in order to fulfill the sedation requirement.
REPORT ON PERIODONTICS PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for periodontics programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in **Appendix 1** for review by the Review Committee on Periodontics Education.

**Summary:** The Review Committee on Periodontics Education is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (**Appendix 1**).

**Recommendation:**

Prepared by: Ms. Jennifer E. Snow
Annual Survey Curriculum Section for Periodontics Programs

Part II - Periodontics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. Over the course of the entire program, how much time do students/residents devote to each of the following areas?
Column must add up to 100%. Do not enter percent signs.

a. Clinical (include related laboratory activity)

b. Didactic (include assigned laboratory activity)

c. Research

d. Teaching

/
22. Provide the average number of documented periodontitis patients completed by each student/resident per case category according to year in the program during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Case Category</th>
<th>1st year students/residents</th>
<th>2nd year students/residents</th>
<th>3rd year students/residents</th>
<th>4th year students/residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Moderate periodontitis</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Severe periodontitis</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

23. Provide the average number of implants each student/resident placed according to the year of the program during the 2019-2020 academic year.

<table>
<thead>
<tr>
<th>Year of Program</th>
<th>Average number of implants per student/resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st year</td>
<td>□</td>
</tr>
<tr>
<td>b. 2nd year</td>
<td>□</td>
</tr>
<tr>
<td>c. 3rd year</td>
<td>□</td>
</tr>
<tr>
<td>d. 4th year</td>
<td>□</td>
</tr>
</tbody>
</table>

24. How many periodontal diagnostic and treatment planning conferences were conducted by the program during the 2019-20 academic year?

NOTE: The conferences included should be limited to the periodontics program and not interdisciplinary in nature.

□

25. How many interdisciplinary diagnostic and treatment planning conferences were attended by the students/residents for each of the
following during the 2019-20 academic year?

Conferences attended

a. Periodontics / Endodontics

b. Periodontics / Orthodontics

c. Periodontics / Prosthodontics

Use this space to enter comments or clarifications for your answers on this page.

Part II - Periodontics Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

26. Provide the average number of adult moderate parenteral sedation patients completed by the students/residents according to the year of the program for the 2019-20 academic year.

Average patients per student/resident

a. 1st year

b. 2nd year

c. 3rd year

d. 4th year

27. How often does the program conduct formal documented evaluations of student/resident clinical performance?
28. How often does the program conduct formal documented evaluations of faculty?

- Weekly
- Monthly
- Quarterly
- Semiannually
- Annually

29. How often does the program conduct faculty calibration at sites where educational activity occurs?

- Weekly
- Monthly
- Semiannually
- Annually
- Other, please specify

Use this space to enter comments or clarifications for your answers on this page.
CONSIDERATION OF PROPOSED REVISIONS TO THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PERIODONTICS

**Background:** The Accreditation Standards for Advanced Dental Education Programs in Periodontics were adopted by the Commission on Dental Accreditation at its January 31, 2013 meeting for implementation January 1, 2014. According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a three-year program will be assessed after six (6) years. In accordance with this policy, the Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Periodontics was initiated in Summer/Fall 2019 with the results considered at the Winter 2020 meeting of the Commission.

In Winter 2020, the Periodontics Review Committee (PERIO RC) conducted an initial review of the validity and reliability study report. The Review Committee concluded that further study of the survey data was warranted. The PERIO RC believed the six (6) members of the PERIO RC should further study the report and identify Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the members of the PERIO RC to further study the findings of the Periodontics Validity and Reliability Study and identify Accreditation Standards, if any, which warrant revision, with a report to the PERIO RC and Commission in Summer 2020. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee to consider standards revisions for Periodontics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc Committee conducted its meetings on September 24, 2020 and November 13, 2020. The committee members at the time of the September 24, 2020 meeting included Dr. James Katancik (chair), Dr. Linda Hatzenbuehler, Dr. Georgia Johnson, Dr. Paul Luepke, Dr. Charles Powell, and Dr. Jaqueline Sobota. At the time of the November 13, 2020 meeting, the committee members included Dr. James Katancik (chair), Dr. Linda Hatzenbuehler, Dr. Georgia Johnson, Dr. Paul Luepke, Dr. Angela Palaiologou-Gallis, and Dr. Jaqueline Sobota.

At its September 24, 2020 meeting, the committee identified member assignments and a work plan. At its November 13, 2020 meeting, the committee began with reviewing its charges, which included consideration of the revised definition of “should” within the Accreditation Standards. The committee conducted a high-level discussion of the results of the validity and reliability study. Although the committee noted the response rate was low, it focused discussion on standards that were potentially too demanding versus not demanding. Concurrently, the committee considered the use of the term “should” in the periodontics standards in light of the revised definition.

First, the committee proposed adding the definition of a “board certified periodontist” to the Definition of Terms as an accompaniment to Standard 2. The advanced dental education common (boilerplate) standard requires the program director to be board certified in the respective advanced dental education discipline. The committee noted that defining a board certified periodontist for the Periodontics Standards would be similar to other advanced dental education disciplines’ standards containing their respective definitions.
Based on the validity and reliability results, as well as the definition of “should,” the committee proposed to delete the last sentence of Standard 2-4 stating “Part-time faculty should contribute to the didactic as well as the clinical component of the program.” The committee believed that it is up to a program to decide what part-time faculty do and don’t do.

Given that Standards 3-2, 3-3, and 3-8 contained “should,” with no “must” statements, the committee believed that these non-required statements could be reorganized to an “intent” statement under the relevant standard to better align with the format of the Accreditation Standards and eliminate potential confusion. These examples, and other instances of reorganization of numbered Standards containing “should” statements to “intent” statements, were incorporated into the comprehensive document submitted to the Review Committee and Commission.

The committee thoroughly discussed validity and reliability survey feedback on standards with higher responses in a particular category; for example, some respondents reported that faculty calibration at educational activity sites is too demanding. The committee felt this activity is important and determined that the standard should be retained as is. Conversely, some respondents believed that encouraging immunizations under Standard 3 was not demanding enough; the committee determined that this common (boilerplate) standard is an institutional policy matter and should be retained as written.

Through the course of their review, the committee considered Standard 4-10.2d with regard to provisionalization of dental implants. The committee agreed that it does not intend for programs to train students/residents to competency in full restoration. Rather, the committee believed the intent is that periodontics students/residents learn to collaborate with the restorative dentist. However, if the program takes implants to final restoration, the committee found that this is acceptable. Therefore, the committee recommended that the standard be retained as written. The committee also affirmed its desire for programs to follow the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students as required by Standard 4-11 and recommended that this standard also be retained as written.

With regard to Standard 4-7, the committee agreed with survey respondents that tracking data such as gender, age, and health status is cumbersome. While the committee noted that it is important to have a range of clinical experiences, the second sentence of the standard is not necessary. Therefore, the committee proposed to revise the standard to state that “The program must maintain an ongoing record of the number and variety of clinical experiences accomplished by each student/resident.” Lastly, the committee determined that the intent statement under Standard 4-8b should be stricken as it is unnecessary.

As the Commission adopted revised Standards at its Winter 2020 meeting, for implementation on January 1, 2021, the proposed revisions were reflected on this version of the Accreditation Standards for Advanced Dental Education Programs in Periodontics.

The Committee concluded, and the Commission concurred, that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics (Appendix 1) be circulated to the communities of interest for review and comment for a period of one (1) year, with
Hearings conducted at the March 2021 American Dental Education Association (ADEA) Annual Session and the October 2021 American Dental Association (ADA) Annual Meeting, with further consideration at the Commission’s Winter 2022 meeting.

As directed by the Commission, the proposed revised Standards were circulated for comment through December 1, 2021. One (1) comment was received at the ADEA Virtual Hearing (Appendix 2), and no (0) comments were received at the ADA Virtual Hearing. The Commission office received two (2) written comments prior to the December 1, 2021 deadline (Appendix 3).

**Summary:** At this meeting, the Periodontics Education Review Committee and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics (Appendix 1) and all comments received prior to the December 1, 2021 deadline (Appendix 2 and Appendix 3). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Ms. Jennifer E. Snow
Commission on Dental Accreditation

At its Winter 2021 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2021, for review at the Winter 2022 Commission meeting.

Written comments will only be accepted through the Commission’s Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_b45NxzExHvE6FQ9

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Periodontics
Accreditation Standards for
Advanced Dental Education Programs
in Periodontics

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-4653
www.ada.org/coda
### Document Revision History

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<td>August 10, 2012</td>
<td>Revised Mission Statement</td>
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<td>January 31, 2013</td>
<td>Revision to Policy on Accreditation of Off-Campus Sites</td>
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<td>Revision to Standard 5, Eligibility and Selection</td>
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Periodontics Standards
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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
Programs That Are Fully Operational:
Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

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

Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

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

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

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

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.

Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.
Other Terms

Board Certified Periodontist: A periodontist who has satisfied all requirements of the certification process of the American Board of Periodontology (ABP), has been declared Board Certified by the Directors of the ABP, and maintains Board certification. This individual is a Diplomate of the ABP.

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

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

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

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

Resident: The individual enrolled in an accredited advanced dental education program in oral and maxillofacial surgery.

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

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

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

Summative Assessment*: making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility; and providing professional self-regulation and accountability.
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

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

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

Ethics and Professionalism

1-1 Graduates must receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

The authority and final responsibility for curriculum development and approval, student/resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

The institution/program must have a formal system of quality assurance for programs that provide patient care.

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

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

1-2 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-3 The following items must be covered in such inter-institutional agreements:

a. Designation of a single program director;
b. Teaching staff and means for calibration where competency assessments occur;
c. Availability and adequacy of staff;
d. Student/Resident oversight and responsibility;
e. The educational objectives of the program;
f. The period of assignment of students/residents; and
g. Each institution’s financial commitment.

Intent: The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

2-1 The program director should be an experienced educator in periodontics and should be a full-time faculty member with a primary commitment to periodontics.

2-2 The program director must have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following:
Periodontics Standards

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Proposed Revisions to Periodontics Standards
CODA Winter 2022

a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences;
b. Promote cooperation between periodontics, general dentistry, related dental specialties and other health sciences;
c. Select students/residents qualified to undertake training in periodontics unless the program is sponsored by a federal service utilizing a centralized student/resident selection process;
d. Develop and implement the curriculum plan;
e. Evaluate and document student/resident and faculty performance;
f. Document educational and patient care records as well as records of student/resident attendance and participation in didactic and clinical programs; and
g. Responsibility for the quality and continuity of patient care.

*Intent: The program director should be an experienced educator in periodontics and should be a full-time faculty member with a primary commitment to periodontics.*

2-32 The program director must prepare graduates to seek certification by the American Board of Periodontology.

a. The program director must track Board Certification of program graduates.

2-43 A combination of full-time and part-time faculty is most desirable. The number and time commitment of faculty must be sufficient to provide didactic and administrative continuity. Part-time faculty should contribute to the didactic as well as the clinical component of the program.

2-54 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

2-65 Faculty must be assigned for all clinical sessions and immediately available for consultation with students/residents and patients. There must be direct supervision by periodontists of students/residents who are performing periodontal and dental implant related surgical procedures.

2-76 Faculty must take responsibility for patient care and actively participate in the development of treatment plans and evaluation of all phases of treatment provided by students/residents.
2-87 Faculty must be formally evaluated at least annually by the program director to determine their effectiveness in the educational program.

2-98 In addition to their regular responsibilities in the program, full-time faculty must have adequate time to develop and foster advances in their own education and capabilities in order to ensure their constant improvement as clinical periodontists, teachers and/or researchers.

2-10 — **Intent:** The program director and faculty should demonstrate their continued pursuit of new knowledge in periodontics and related fields.

2-119 The program director and faculty must actively participate in the assessment of the outcomes of the educational program.
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

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

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

3-1 Adequate clinical and radiographic facilities must be readily available in order to meet the objectives of the program. **State-of-the-art imaging resources should be accessible to the student/resident.** There must be a sufficient number of operatories to efficiently accommodate the number of students/residents enrolled. **One operatory should be available to each student/resident during clinic assignments.**

*Intent: State-of-the-art imaging resources should be accessible to the student/resident. One operatory should be available to each student/resident during clinic assignments. Hospital facilities should be available to support research.*

3-2 **Hospital facilities should be available to enhance the clinical program.**

3-3 **Facilities should be available to support research.**

3-42 Clinical photography is essential for case documentation. Students/Residents must have clinical photographic equipment available.

3-53 The institution must provide audiovisual and reproduction capabilities for student/resident seminars.

3-64 Students/Residents must have ready access to dental and biomedical libraries containing equipment for retrieval and duplication of information.

3-75 Adequate support personnel must be assigned to the program to ensure chairside and technical assistance.

3-8 **Intent: Dental hygiene support should be available for the clinical program. Adequate facilities should be provided for this activity.**
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of Evidence to demonstrate compliance may include:

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

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

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

If an institution or program enrolls part-time students/residents, the institution must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis must assure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.
4-1. The goal of the curriculum is to allow the student/resident to attain skills representative of a clinician competent in the theoretical and practical aspects of periodontics. The program duration must be three consecutive academic years with a minimum of 30 months of instruction. At least two consecutive years of clinical education must take place in a single educational setting.

**BIOMEDICAL SCIENCES**

4-2. Although students/residents entering postdoctoral programs will have taken biomedical science courses in their predoctoral dental curriculum, this material must be updated and reviewed in the program at an advanced level. Education in the biomedical sciences must provide the scientific basis needed to understand and carry out the diagnostic and therapeutic skills within the scope of periodontics.

4-3. Formal instruction in the biomedical sciences must enable students/residents to achieve the following competencies:

   a. Identification of patients at risk for periodontal diseases and use of suitable preventive and/or interceptive treatments;
   b. Diagnosis and treatment of patients with periodontal diseases and related conditions according to scientific principles and knowledge of current concepts of etiology, pathogenesis, and patient management; and
   c. Critical evaluation of the scientific literature.

4-4. Formal instruction must be provided to achieve in-depth knowledge in each of the following areas:

   a. Gross, surgical and ultrastructural anatomy;
   b. Microbiology with emphasis on periodontal diseases;
   c. Inflammatory mechanisms and wound healing with emphasis on periodontal diseases;
   d. Infectious processes in oral and periodontal diseases;
   e. Immunology with emphasis on oral and periodontal diseases;
   f. Oral pathology;
   g. Etiology, pathogenesis, histopathology, and natural history of periodontal diseases;
   h. Epidemiology, including risk assessment, of periodontal diseases;
   i. Genetics, epigenetics and the concepts of molecular biology as they relate to oral and periodontal diseases;
   j. Biostatistics, research design and methods; and
k. Behavioral sciences especially as they affect patient behavior modification and communication skills with patients and health professionals.

Intent: Various methods may be used for providing biomedical science instruction, such as traditional course presentations, seminars, self-instructional module systems and rotations through hospital, clinical and research departments. It is recognized that the approach to be utilized will depend on the availability of teaching resources and the educational policies of the individual school and/or department.

CLINICAL SCIENCES

4-5 The educational program must provide training to the level of competency for the student/resident to:

a. Collect, organize, analyze and interpret data;

b. Interpret conventional and three-dimensional images as they relate to periodontal and dental implant therapy;

c. Formulate diagnoses and prognoses;

d. Develop a comprehensive treatment plan;

e. Understand and discuss a rationale for the indicated therapy;

f. Evaluate critically the results of therapy;

gh. Communicate effectively to patients the nature of their periodontal health status, risk factors and treatment needs;

h. Communicate effectively with dental and other health care professionals, interpret their advice and integrate this information into the treatment of the patient;

i. Integrate the current concepts of other dental disciplines into periodontics;

j. Organize, develop, implement and evaluate a periodontal maintenance program;

k. Utilize allied dental personnel effectively; and

l. Integrate infection control into clinical practice.

4-6 Each student/resident must: (a) treat a variety of patients with different periodontal diseases and conditions as currently defined by The American Academy of Periodontology; and (b) complete an adequate number of documented moderate to severe periodontitis cases to achieve competency.

4-7 The program must maintain an ongoing record of the number and variety of clinical experiences accomplished by each student/resident must be maintained.
This must include periodontal diagnosis, disease severity, periodontal treatment, as well as patient's age, gender and health status.

4-8 The educational program must provide clinical training for the student/resident to the level of competency. This must include, but is not limited to, the following treatment methods for health, comfort, function and esthetics:

a. Nonsurgical management of periodontal diseases, including:
   1. Biofilm control;
   2. Mechanical scaling and root planing therapy;
   3. Local and systemic adjunctive therapy; and
   4. Occlusal therapy.

b. Surgical management of periodontal diseases and conditions, including:
   1. Resective surgery, including gingivoplasty, gingivectomy, periodontal flap procedures, osteoplasty, osteotomy, and tooth/root resection;
   2. Regenerative and reparative surgery including osseous grafting, guided tissue regeneration, the use of biologics, and utilization of tissue substitutes, where appropriate; and
   3. Periodontal plastic and esthetic surgery techniques including gingival augmentation, root coverage procedures and crown lengthening surgery.

Intent: The emphasis of surgical training should be periodontal surgical procedures.

c. Tooth extraction in the course of periodontal and implant therapy.

4-9 The educational program must provide didactic instruction and clinical training in oral medicine and periodontal medicine.

4-9.1 In depth didactic instruction must include the following:
   a. Aspects of medicine and pathology related to the etiology, pathogenesis, diagnosis and management of periodontal diseases and other conditions in the oral cavity;
   b. Mechanisms, interactions and effects of drugs used in the prevention, diagnosis and treatment of periodontal and other oral diseases;
   c. Mechanisms, interactions and effects of therapeutically used agents in the management of systemic diseases that may influence the progression of periodontal diseases or the management of patients with periodontal diseases;
   d. Principles of periodontal medicine to include the interrelationships of periodontal status and overall health; and
   e. Clinical and laboratory assessment of patients with specific instruction in:
1. Physical evaluation;
2. Laboratory evaluation;

4-9.2 Clinical training to the level of competency must include the following:

a. Periodontal treatment of medically compromised patients;
b. Management of patients with periodontal diseases and interrelated systemic diseases or conditions; and
c. Management of non-plaque related periodontal diseases and disorders of the periodontium.

4-10 The educational program must provide didactic instruction and clinical training in dental implants, as defined in each of the following areas:

4-10.1 In depth didactic instruction in dental implants must include the following:

a. The biological basis for dental implant therapy and principles of implant biomaterials and bioengineering;
b. The prosthetic aspects of dental implant therapy;
c. The examination, diagnosis and treatment planning for the use of dental implant therapy;
d. Implant site development;
e. The surgical placement of dental implants;
f. The evaluation and management of peri-implant tissues and the management of implant complications;
g. Management of peri-implant diseases; and
h. The maintenance of dental implants.

4-10.2 Clinical training in dental implant therapy to the level of competency must include:

a. Implant site development to include hard and soft tissue preservation and reconstruction, including ridge augmentation and sinus floor elevation;
b. Surgical placement of implants; and
c. Management of peri-implant tissues in health and disease.
d. Provisionalization of dental implants.

Intent: To provide clinical training that incorporates a collaborative team approach to dental implant therapy, enhances soft tissue esthetics and
facilitates immediate or early loading protocols. This treatment should be provided in consultation with the individuals who will assume responsibility for completion of the restorative therapy.

4-11 The educational program must provide training for the student/resident in the methods of pain control and sedation to achieve:

a. In-depth knowledge in all areas of minimal, moderate and deep sedation as prescribed by the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; and

b. Clinical training to the level of competency in adult minimal enteral and moderate parenteral sedation as prescribed by the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.

Intent: To follow the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* regarding all aspects of training in minimal enteral and moderate parenteral sedation including didactic instruction, health status assessment, monitoring, airway management, emergency care, and number of required cases. The ADA Guidelines were developed and approved by the ADA Council on Dental Education and Licensure and adopted by the ADA House of Delegates.

4-12 The educational program must provide instruction in the following interdisciplinary areas:

a. The management of orofacial pain to a level of understanding;

b. Orthodontic procedures in conjunction with periodontal therapy to a level of understanding;

c. Surgical exposure of teeth for orthodontic purposes, to a level of understanding;

d. Management of endodontic-periodontal lesions to a level of understanding; treatment should be provided in consultation with the individuals who will assume the responsibility for the completion of the case or supervision of endodontics therapy; and

e. The management of patients with disabilities to a level of understanding.

4-13 The educational program must provide instruction to the level of understanding in the management of a periodontal practice.
4-13.1 The use of private office facilities not affiliated with a university as a means of providing clinical experiences in advanced dental education is not approved. However, visiting private offices to view office design and practice management techniques is encouraged.

4-14 Students/residents must have training and experience in teaching of periodontology, which should include interaction with dental students, residents and/or dental hygiene students. The teaching curriculum must not exceed 10% of the total program time.

*Intent: Training and experience in teaching of periodontology should include interaction with dental students, residents, and/or dental hygiene students.*
STANDARD 5 - ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS
ELIGIBILITY AND SELECTION

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

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

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

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

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

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

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

a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods;

b. Provides to students/residents an assessment of their performance, at least semiannually;

c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and

d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.

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

5-1 Written criteria for evaluating the quality of a student’s/resident’s performance must be used. These criteria must be shared with appropriate staff and students/residents.

5-1.1 A record of each student’s/resident’s clinical and didactic activities must be maintained and reviewed as part of each student’s/resident’s evaluation.

5-1.2 Evaluation results must be provided to students/residents in writing.

5-1.3 Documentation of evaluation meetings with students/residents, along with records of students’/residents’ activities, and formal evaluations of students/residents must be kept in a permanent file.
DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

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

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

Advanced dental education students/residents must engage in scholarly activity.

6-1 Graduates of periodontal training programs must possess a general understanding of the theory and methods of performing research.

6-1.1 Postdoctoral students/residents must be given the opportunity to participate in research.
Commission on Dental Accreditation
Hearing on Accreditation Standards

2021 CODA Hearing on Standards
(ADEA Annual Meeting Hearing)
Thursday, March 11, 2021, 5:00pm - 6:00pm Central Standard Time
Virtual Hearing

Commissioners in Attendance: Dr. Jeffery Hicks (chair), Dr. Bruce Rotter (vice-chair), Dr. Joel Berg, Mr. Marco Gargano, Dr. William Nelson, Dr. Susan Kass, and Dr. Sanjay Mallya.

Staff: Dr. Sherin Tooks, director, CODA, and Ms. Dawn Herman, Ms. Kirsten Nadler, Mr. Gregg Marquardt, Ms. Michelle Smith, Ms. Jennifer Snow, Ms. Peggy Soeldner, managers, CODA.

Accreditation Standards for Advanced Dental Education Programs in Periodontics (Appendix 3)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Christopher Okunseri</td>
<td>Marquette University</td>
<td>Where do the standards revisions come from?</td>
</tr>
</tbody>
</table>
From: The Commission on Dental Accreditation [mailto:noreply@qemailserver.com]
Sent: Tuesday, June 15, 2021 11:49 AM
To: Snow, Jennifer <snowj@ada.org>
Subject: Comments on Proposed Revision of Standards for Periodontics Education Programs

The Commission on Dental Accreditation has received your comment(s). Below, please find a copy of your submission.

Please do not respond to this email; reply has been disabled. Thank you.

Recipient Data:
Time Finished: 2021-06-15 10:47:57 MDT

Response Summary:

Please complete the requested information.
First Name  Annette
Last Name  Puzan
Email  puzana@ada.org
Title  Manager, Dental Education & Licensure

Please select one of the following options that best describes you or your organization:
Other (Please specify) -- Council on Dental Education and Licensure (CDEL)

Is this an official comment from your organization?
Yes. Please enter the name of your organization below. -- Council on Dental Education and Licensure (CDEL)

Enter the Standard number(s), page(s) and line(s) to which you would like to comment.
Accreditation Standards for Advanced Dental Education Programs in Periodontics

Do you agree with the proposed revision?
Agree

Enter your comment. Type or copy and paste in the text box below.
The following comment is being submitted on behalf of Dr. Jaqueline Plemons, chair, and the members of the ADA Council on Dental Education and Licensure:

A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, at its June 2021 meeting, Council members considered and
supported the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics.

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

Do you have additional comment?
I have NO additional comment and ready to submit.
From: The Commission on Dental Accreditation [mailto:noreply@qemailserver.com]
Sent: Monday, November 29, 2021 6:59 PM
To: Snow, Jennifer <snowj@ada.org>
Subject: Comments on Proposed Revision of Standards for Periodontics Education Programs

The Commission on Dental Accreditation has received your comment(s). Below, please find a copy of your submission.

Please do not respond to this email; reply has been disabled. Thank you.

Recipient Data:
Time Finished: 2021-11-29 17:58:52 MST

Response Summary:

Please complete the requested information.
  First Name  Charles
  Last Name  Powell
  Email  charles.powell@abperio.org
  Title  President

Please select one of the following options that best describes you or your organization:
  Certifying Board/Organization

Is this an official comment from your organization?
  Yes. Please enter the name of your organization below. -- American Board of Periodontology

Enter the Standard number(s), page(s) and line(s) to which you would like to comment.
  standard 2.1

Do you agree with the proposed revision?
  Agree

Enter your comment. Type or copy and paste in the text box below.
  We concur that the program director should be an experienced, full-time faculty member with a primary commitment to periodontics.

Do you have additional comment?
  YES, I have additional comment.

Enter the Standard number(s), page(s) and line(s) to which you would like to comment.
standard 4-7

Do you agree with the proposed revision?
Agree

Enter your comment. Type or copy and paste in the text box below.
We strongly support the more concise reporting requirements in documenting of the record of clinical experiences accomplished by each student/resident.

Do you have additional comment?
YES, I have additional comment.

Enter the Standard number(s), page(s) and line(s) to which you would like to comment.
standard 4-14

Do you agree with the proposed revision?
Agree

Enter your comment. Type or copy and paste in the text box below.
We encourage the continued interaction of periodontics students/residents with dental students, residents, and/or dental hygiene students in the teaching of periodontology.

Do you have additional comment?
I have NO additional comment and ready to submit.
CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PERIODONTICS RELATED TO PATIENTS WITH SPECIAL NEEDS

Background: At its Summer 2021 meeting, the Review Committee on Periodontics Education (PERIO RC) reviewed a request from the American Dental Association’s Council on Dental Education and Licensure (CDEL) to consider revising the Accreditation Standards to require graduates to be competent in treating patients with special needs (Appendix 1).

The Periodontics RC began discussion by noting the January 1, 2021 implementation of Periodontics Standard 4-12e, which requires that the educational program must provide instruction in the management of patients with disabilities to a level of understanding. The Committee recalled the discussion of this topic amongst periodontics program directors, and the subsequent circulation of the revision to the communities of interest for a period of comment, prior to the Commission’s adoption and implementation of Standard 4-12e. The PERIO RC further recalled concerns such as potential clinical facility accommodations and sufficient patient pool as the Committee originally considered whether requiring clinical training to a level of competency in the treatment of patients with disabilities was appropriate for postgraduate periodontics programs. The Review Committee strongly considered whether adding instruction in the treatment of patients with disabilities to the level of understanding to Standard 4-12e would be reasonable, given the breadth of patient types that students/residents in periodontics programs are already treating.

The Committee also reviewed Periodontics Standard 4-9.2a, which requires that clinical training to the level of competency must include periodontal treatment of medically compromised patients. The Committee deliberated on whether “special needs” could be added to Standard 4-9.2b, which currently requires that clinical training to the level of competency must include management of patients with periodontal diseases and interrelated systemic diseases or conditions.

In addition, the Review Committee noted the definition of patients with special needs and Dental Education Standard 2-25 within the Accreditation Standards for Dental Education Programs. This standard, along with its intent statement, addresses competency in assessing and managing the treatment of patients with special needs; the PERIO RC considered whether similar language in the Accreditation Standards for periodontics programs may be beneficial.

The PERIO RC also considered Periodontics Standard 4-13.1 with regard to the fact that the use of private office facilities not affiliated with a university as a means of providing clinical experiences is not approved, noting that it may need to consider whether the current language is too restrictive when unique patient treatment opportunities for periodontics students/residents may be available in private office facilities.

Following discussion the Review Committee concluded, and the Commission concurred, that consideration of revisions to the Accreditation Standards for Advanced Dental Education
Programs in Periodontics related to patients with special needs warranted further study at the Winter 2022 meeting of the PERIO RC with a report submitted for consideration at the Winter 2022 meeting of the Commission.

**Summary:** At this meeting, the Periodontics Review Committee and Commission are requested to consider the proposed revision to the Accreditation Standards (*Appendix 1*) submitted by the Council on Dental Education and Licensure. 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: Ms. Jennifer E. Snow
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 Tooks, director, Commission on Dental Accreditation
     Ms. Karen M. Hart, director, Council on Dental Education and Licensure
REPORT ON PROSTHODONTICS PROGRAMS
ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for prosthodontics programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020. The next Curriculum Section will be conducted in August/September 2022. The draft Curriculum Section is provided in Appendix 1 for review by the Review Committee on Prosthodontics.

**Summary:** The Review Committee on Prosthodontics is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (Appendix 1).

**Recommendation:**

Prepared by: Ms. Kirsten Nadler
Part II - Prosthodontics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?
Column must add up to 100%. Do not enter percent signs.

   a. Clinical (include related laboratory activity) %
22. How many documented evaluations of student/resident performances are conducted annually by the teaching staff?

23. How many prosthodontic procedures were completed by all students/residents in each of the following areas during the 2019-20 academic year?

a. Fixed prosthodontics (no implants):

1. Single fixed restoration (all types)
2. Total number of fixed partial denture retainers (retainers only)
3. Complete arch restorations (List only the number of arches)
b. Removable prosthodontics (no implants):

1. Complete denture, both arches
b4. Please indicate the number of prostheses listed in lines b1 (Complete dentures, both arches) and b2 (Single complete dentures) that involved tooth-supported overdentures.

c. Implant supported restorations:

1. Removable complete denture, both arches
2. Removable single complete denture
3. Removable partial denture
4. Single fixed restoration (all types)
5. Total number of fixed partial denture retainers (retainers only)
6. Complete arch fixed restorations (List only the number of arches)

d. Implant placement:

1. Implants placed to support removable prostheses
2. Implants placed for single tooth restorations
3. Implants placed for fixed complete prostheses

4. Implants placed for fixed partial prostheses

5. Site augmentation/preservation (all types) as part of implant placement
6. Immediate implant placement

7. Total number of CBCT studies

   e. Total number of maxillofacial prostheses (all types) completed by all students/residents.

Use this space to enter comments or clarifications for your answers on this page.

Part II - Prosthodontics Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

24. How many patients were managed by all students/residents during the 2019-20 academic year?
25. Instruction in advanced prosthodontics programs can be provided in a variety of settings. For each of the following subject areas, identify the manner in which students/residents receive instruction. If instruction is not provided in any of the settings listed, click "None". Do not leave any row blank.
<table>
<thead>
<tr>
<th>Formal courses</th>
<th>Lectures/Seminars</th>
<th>Rotations</th>
<th>e-Learning</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong> Diagnosis of diseases affecting prosthodontic treatment including caries risk assessment and intervention</td>
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<tr>
<td><strong>b.</strong> Fixed prosthodontics</td>
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<tr>
<td><strong>c.</strong> Removable prosthodontics</td>
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<tr>
<td><strong>d.</strong> Implants and implant therapy</td>
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<td><strong>e.</strong> Occlusion</td>
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<tr>
<td><strong>f.</strong> Esthetics</td>
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<tr>
<td><strong>g.</strong> Biomaterials</td>
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<tr>
<td><strong>h.</strong> Digital technology</td>
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<tr>
<td><strong>i.</strong> Wound healing</td>
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<tr>
<td><strong>j.</strong> Surgical principles</td>
<td></td>
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<tr>
<td><strong>k.</strong> Infection control</td>
<td></td>
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<tr>
<td><strong>l.</strong> Craniofacial anatomy and physiology</td>
<td></td>
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<tr>
<td><strong>m.</strong> Diagnostic imaging</td>
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</tbody>
</table>

25 (continued). Instruction in advanced prosthodontics programs can be provided in a variety of settings. For each of the following subject areas,
identify the manner in which students/residents receive instruction.

If instruction is not provided in any of the settings listed, click "None". Do not leave any row blank.

<table>
<thead>
<tr>
<th>Formal courses</th>
<th>Lectures/Seminars</th>
<th>Rotations</th>
<th>e-Learning</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

n. Prosthodontic diagnosis and treatment planning

<p>| | | | | |
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|                |                   |           |            |      |
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<tr>
<th>Formal courses</th>
<th>Lectures/Seminars</th>
<th>Rotations</th>
<th>e-Learning</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>o. Oral pathology</td>
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<tr>
<td>p. Applied pharmacology</td>
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<tr>
<td>q. Oral microbiology</td>
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<tr>
<td>r. Temporomandibular disorders and orofacial pain</td>
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<tr>
<td>s. Evidence-based decision-making</td>
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<tr>
<td>t. Ethics and professionalism</td>
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<tr>
<td>u. Pre-prosthetic surgery</td>
<td></td>
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<tr>
<td>v. Geriatrics</td>
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<tr>
<td>w. Maxillofacial prosthetics</td>
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<tr>
<td>x. Medical emergencies</td>
<td></td>
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<tr>
<td>y. Research methodology</td>
<td></td>
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<tr>
<td>z. Pain control and sedation</td>
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</table>

**aa. Diagnostic and treatment planning aspects of:**

If instruction is not provided in any of the settings listed, click "None". Do not leave any row blank.

<table>
<thead>
<tr>
<th>Formal courses</th>
<th>Lectures/Seminars</th>
<th>Rotations</th>
<th>e-Learning</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Endodontics</td>
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<tr>
<td>2. Orthodontics</td>
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<tr>
<td>3. Oral and maxillofacial radiology</td>
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<tr>
<td>4. Oral and maxillofacial surgery</td>
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<tr>
<td>5. Periodontics</td>
<td></td>
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</tbody>
</table>
25 (continued). Instruction in advanced prosthodontics programs can be provided in a variety of settings. For each of the following subject areas, identify the manner in which students/residents receive instruction. If instruction is not provided in any of the settings listed, click "None". Do not leave any row blank.

<table>
<thead>
<tr>
<th>Subject Area</th>
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<th>Rotations</th>
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<th>None</th>
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</thead>
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<tr>
<td>bb. Craniofacial growth and development</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>cc. Biostatistics</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>dd. Intraoral photography</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>ee. Practice management</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>ff. Scientific writing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>gg. Sleep disorders</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>hh. Teaching methodology/Public speaking</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>ii. Behavioral science</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.
Part II - Maxillofacial Prosthetics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

Note for standalone Maxillofacial Prosthetics programs: Questions 21-25 do not apply and are hidden on the survey by design. As a result, be aware that the question numbers jump from 20 on the previous page to 26 on this page for these types of programs.

26. How many maxillofacial prosthetics patients were managed by all students/residents in each of the following general categories?  

Number of patients

- a. Treated for craniomandibular disorders
- b. Treated for acquired developmental or congenital defects
- c. Treated for defects as a result of trauma or disease
- d. Undergone radiation therapy to the head and neck region
- e. Maxillary defects of the hard palate, soft palate and/or alveolus
- f. Mandibular continuity and discontinuity defects
- g. Undergoing radio- and/or chemotherapy for oncologic treatment

27. How many maxillofacial prosthetics patients were treated in each of the following specific categories during the 2019-20 academic year?

Number of patients

- a. Immediate surgical prostheses for patients undergoing maxillectomy
- b. Interim prosthesis to support the post-surgical rehabilitation of
maxillectomy patients

c. Definitive prosthesis to restore maxillary defect

d. Interim prosthesis to support the post-surgical rehabilitation of velopharyngeal resection
28. Are maxillofacial prosthetic students/residents provided the opportunity to gain experience in the management of dental patients in the hospital operating room?

   Yes
   No

29. Instruction in advanced maxillofacial prosthetics programs can be provided in a variety of settings. For each of the following subject areas, identify the manner in which students/residents receive instruction.
Appendix 1
Subpage 15

P ROS
CODA Winter 2022

Formal courses

Lectures/Seminars

Rotations

Yes
No
Yes
No
Yes
No

a. Speech pathology and therapy
b. Oncology
<table>
<thead>
<tr>
<th></th>
<th>Formal courses</th>
<th>Lectures/Seminars</th>
<th>Rotations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>c. Radiation oncology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Principles of head and neck surgery</td>
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<td></td>
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<tr>
<td>e. Hospital protocol</td>
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<tr>
<td>f. Management techniques of medically compromised patients</td>
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</table>

Use this space to enter comments or clarifications for your answers on this page.
INFORMATIONAL REPORT ON THE CONDUCT OF A VALIDITY AND RELIABILITY STUDY FOR THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PROSTHODONTICS

Background: The Accreditation Standards for Advanced Dental Education Programs in Prosthodontics were adopted by the Commission on Dental Accreditation at its August 7, 2015 meeting, with implementation on July 1, 2016.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1), the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula:

The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.

Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation.

According to the Commission’s timetable for validity and reliability studies, the study for prosthodontics will be initiated in the spring of 2022. Survey results will be considered at the Summer 2022 meetings of the PROS RC and the Commission on Dental Accreditation. The communities will be surveyed to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

Methodology and Survey Design: In cooperation with the ADA’s HPI, a timetable will be developed, surveys will be distributed to the audiences, and responses will be due to the HPI within two weeks of receipt of the survey. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2022. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2022 meeting.

A survey instrument will be developed to obtain evaluations of each of the requirements in the current standards. Respondents will be asked to indicate the relevance of each criterion to the prosthodontics curricula:
Informational Report on Validity and Reliability Study
for Prosthodontics Programs
Prosthodontics RC
CODA Winter 2022

- Relevant/ Too demanding: Criterion relevant but too demanding
- Retain as is: Retain criterion as is
- Relevant/ Not demanding: Criterion relevant but not sufficiently demanding
- Not relevant: Criterion not relevant
- No opinion. No opinion on this criterion

In addition, they will be asked to add and provide a rationale for any issues that they believe should be added to the standards. A sample format of the survey is presented in Appendix 2.

The following alternatives might result from the assessment of the adequacy of the standards:
- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

If it is determined that revisions to the accreditation standards is warranted, further analysis of the data obtained in the validity and reliability study would be conducted to provide more in-depth information for the revision process. In addition, other resources could provide further information, including:
- The annual Frequency of Citings Report of Accreditation Standards for Advanced Dental Education Programs in Prosthodontics.
- Data identifying trends in accredited advanced dental education programs in prosthodontics.
- Issues related to advanced dental education programs in prosthodontics.
- Requests for standards revisions received but postponed until the regular validity and reliability study.
- Relevant reports from the higher education and practice communities, e.g., Institute of Medicine Report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce.”

When a comprehensive revision of an accreditation standards document is required, the new document is developed with input from the communities of interest in accordance with Commission policies. The document is drafted using resources such as those noted above. When the document is finalized, it is shared with the communities of interest and hearings are held, as appropriate. Written and oral comments from the hearings and written comments received during the comment period are reviewed when considering the document for adoption. An implementation date is specified when the document is adopted.

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

Prepared by: Ms. Kirsten Nadler
POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of standards are made to reflect significant changes in disease and practice patterns, scientific or technological advances, or in response to changing professional needs for which the Commission has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year after the validity and reliability of the standards has been assessed, the Commission will conduct a study to determine whether the accreditation standards continue to be appropriate to the discipline. This study will include input from the broad communities of interest. The communities will be surveyed and invited to participate in some national forum, such as an
invitational conference, to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

The following alternatives, resulting in a set of new standards, might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with Commission policies. An implementation date is specified and copyright privileges are sought when the document is adopted. Assessment of the validity and reliability of these new standards will be scheduled in accord with the policy specified above. Exceptions to the prescribed schedule may be approved to ensure a consistent timetable for similar disciplines (e.g. advanced dental education programs and/or allied dental education programs).

Revised: 8/18; 7/07, 07/00; Reaffirmed: 8/12, 8/10, 7/06; Adopted: 12/88
SAMPLE ADVANCED DENTAL EDUCATION PROGRAMS IN PROSTHODONTICS
VALIDITY AND RELIABILITY SURVEY

Listed below are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Prosthodontics for accreditation purposes. For each standard, please circle the appropriate number that corresponds to your rating in terms of its relevance of the criterion to the curriculum. Please note that certain standards have multiple items to be rated.

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>For each of the five-point rating scales use:</th>
</tr>
</thead>
</table>
| Advanced Dental Education Program in Prosthodontics: the discipline pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes. | 1 = criterion relevant but too demanding  
2 = retain criterion as is  
3 = criterion relevant but not sufficiently demanding  
4 = criterion not relevant  
5 = no opinion |

STANDARD 1 – INSTITUTIONAL COMMITMENT / PROGRAM EFFECTIVENESS

1. List Standards in this column

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
</table>

List comments related to Standard 1 – Institutional and Program Effectiveness.

STANDARD 2 – PROGRAM DIRECTOR AND TEACHING STAFF

1. List Standards in this column

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
</table>

List comments related to Standard 2 – Educational Program.

STANDARD 3 – FACILITIES AND RESOURCES

1. List Standards in this column

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
</table>

List comments related to Standard 3 – Faculty and Staff.
STANDARD 4 – CURRICULUM AND PROGRAM DURATION

1. List Standards in this column


STANDARD 5 – ADVANCED DENTAL EDUCATION STUDENTS / RESIDENTS

1. List Standards in this column

List comments related to Standard 5 – Patient Care Services.

STANDARD 6 – RESEARCH

1. List Standards in this column

List comments related to Standard 5 – Patient Care Services.
PROGRESS REPORT ON THE 2021 VALIDITY AND RELIABILITY STUDY OF THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN DENTAL ANESTHESIOLOGY

Background: The Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (Appendix 1) was adopted by the Commission on Dental Accreditation at its January 25, 2007 meeting for immediate implementation.

According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a one-year program will be assessed after four (4) years. Significant revisions were made to the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology in 2012 and 2015. Therefore, the validity and reliability study for Advanced Dental Education Programs in Dental Anesthesiology was initiated in the Spring of 2021.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) conducted an initial review of the results of the validity and reliability survey, as well as written comments gathered (Appendix 2). As a result of initial analysis and discussion of the validity and reliability survey data and written comments, the AGDOO RC concluded that further study of the survey data and review of the Accreditation Standards is warranted, in particular data and comments related to the minimum number of clinical procedures that must be obtained by residents and curriculum content in pain associated with the head and neck regions. In addition, the AGDOO RC believed that the newly formed Review Committee on Dental Anesthesiology, which will conduct its first meeting in Winter 2022, should further study the data and identify dental anesthesiology Accreditation Standards which may warrant revision. At its August 5, 2021 meeting, the Commission agreed and directed further review and analysis of the study to the Review Committee on Dental Anesthesiology to identify Accreditation Standards, if any, which warrant revision with a report for consideration by the Commission in Winter 2022.

Summary: At this meeting, the Dental Anesthesiology Review Committee (DentAnes RC) is requested to review the survey data and the written comments gathered through the Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology to identify Accreditation Standards, if any, which warrant revision. 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: Ms. Peggy Soeldner
Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology
Accreditation Standards For
Advanced Dental Education Programs
in Dental Anesthesiology

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678

(312) 440-4653
www.ada.org/coda
## Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology

### Document Revision History

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<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
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<td>January 25, 2007</td>
<td>Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology</td>
<td>Approved, Implemented</td>
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<tr>
<td>July 26, 2007</td>
<td>Standards to Ensure Program Integrity Examples of Evidence Modified (Standard 1-2)</td>
<td>Adopted and Implemented</td>
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<td>July 26, 2007</td>
<td>Name Change: The Joint Commission on Accreditation of Healthcare Organizations to The Joint Commission</td>
<td>Adopted and Implemented</td>
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<tr>
<td>February 1, 2008</td>
<td>Revised Definition of Terms and Usage of Examples of Evidence</td>
<td>Adopted and Implemented</td>
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<tr>
<td>July 31, 2008</td>
<td>Addition of intent statement to Standard 1-5</td>
<td>Adopted and Implemented</td>
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<tr>
<td>January 29, 2009</td>
<td>Revised Standards 2-2 and 3-2</td>
<td>Adopted and Implemented</td>
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<tr>
<td>July 31, 2009</td>
<td>Revised Definition of Terms (Anxiety and Pain Control), Revised Standards 2-6 and 5-3</td>
<td>Adopted and Implemented</td>
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<tr>
<td>August 6, 2010</td>
<td>Revised Accreditation Status Definitions section</td>
<td>Adopted</td>
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<td>January 1, 2011</td>
<td>Revised Accreditation Status Definitions section</td>
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<tr>
<td>February 4, 2011</td>
<td>Revised Standard 3-2</td>
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<td>Ethics and Professionalism Standard (1-10)</td>
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<td>Ethics and Professionalism Standard (1-10)</td>
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<tr>
<td>August 5, 2011</td>
<td>Addition of intent statement to Standard 5-4</td>
<td>Adopted, Implemented</td>
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<tr>
<td>Date</td>
<td>Revision Details</td>
<td>Approval Status</td>
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<tr>
<td>February 1, 2013</td>
<td>Revised definitions, Standards 2-4, 2-6, 2-7, 2-7, 2-8, 2-9, 2-10, 2-17, 3-2, 5-3, and 6-1, and removal of “proficient and proficiency”</td>
<td>Adopted</td>
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<td>February 1, 2013</td>
<td>Addition of Standard 3-7</td>
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<td>July 1, 2013</td>
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<td>February 6, 2015</td>
<td>Revised Standard 1-1</td>
<td>Adopted, Implemented</td>
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<tr>
<td>February 6, 2015</td>
<td>Revised Standard 4-4</td>
<td>Adopted, Implemented</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 That Are Fully Operational

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

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

Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

Programs That Are Not Fully Operational

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Dental Anesthesiology for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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 advanced dental education programs in dental anesthesiology, the Commission recognizes that methods of achieving standards may vary according to the 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 has an obligation to the public, the profession and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in Dental Anesthesiology provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in Dental Anesthesiology are educational programs designed to train the dental resident, in the most comprehensive manner, to use pharmacologic and non-pharmacologic methods to manage anxiety and pain of adults, children, and patients with special care needs undergoing dental, maxillofacial and adjunctive procedures, as well as to be qualified in the diagnosis and non-surgical treatment of acute orofacial pain and to participate in the management of patients with chronic orofacial pain.

The goals of these programs should include preparation of the graduate to:
1. Deliver anxiety and pain control services for emergency and comprehensive multidisciplinary oral health care.
2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively within the hospital, dental office, ambulatory surgery center, and other health care environments.
5. Function effectively within interdisciplinary health care teams.
6. Apply scientific principles to learning and anesthesia-related oral health care. This includes using critical thinking, evidence- or outcomes-based clinical decision-making, and technology-based information retrieval systems.
7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.
Definitions of Terms

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

**Anxiety and Pain Control**: Includes the following: analgesia; local anesthesia; minimal, moderate, and deep sedation; and general anesthesia as defined in the American Dental Association’s “Guidelines for the Use of Sedation and General Anesthesia by Dentists.”

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

**Competent**: The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

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

**In-Depth**: A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.

**Intent**: Intent statements are presented to provide clarification to the advanced dental education programs in dental anesthesiology in the application of and in connection with compliance with the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology. 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.

**Interdisciplinary**: Including dentistry and other health care professions.

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

**Multidisciplinary**: Including all disciplines within the profession of dentistry.

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

**Outpatient Anesthesia for Dentistry**: The administration of anesthesia services to patients who are discharged from anesthetic care within the same treatment day (same-day surgery) from a facility where only procedures within the scope of dental practice are carried out.
Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

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

Sponsor: The institution which has the overall administrative control and responsibility for the conduct of the program.

Resident: The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
- Accreditation certificate or current official listing of accredited institutions
- Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of Evidence to demonstrate compliance may include:
- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.

Examples of evidence to demonstrate compliance may include:
- Program budgetary records
Budget information for previous, current and ensuing fiscal year

1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. **Intent:** Sites where educational activity occurs include any dental practice setting (e.g., private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

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

1-6 The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

a) Vote and hold office;
b) Serve on institutional staff committees; and  
c) Admit, manage, and discharge patients.

**Examples of evidence to demonstrate compliance may include:**
All institutional bylaws related to a, b, and c
Copy of institutional committee structure and/or roster of membership by dental faculty

1-7 Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.

**Examples of evidence to demonstrate compliance may include:**
Institutional staff roster
Related institutional bylaws

**Intent:** Residents are to be appointed to at least one of the above noted institutions.

1-8 The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:
a) anesthesia for dentistry,
b) resident education, and
c) patient care.

and include training residents to provide dental anesthesia care in office-based and hospital settings.

**Intent:** The “program” refers to the Dental Anesthesiology Residency that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standard 2-1 and 2-2. Specific learning objectives for residents are intended to be described as competency requirements and included in the response to Standards 2-1 and 2-2. An example of overall goals can be found in the Goals section on page 8 of this document.

**Examples of evidence to demonstrate compliance may include:**
Mission statement and supporting written program goals and objectives

**1-9** The program **must** have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

**Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-8 are being met and make program improvements based on an analysis of those data.

The outcomes process developed should include each of the following steps:
1. development of clear, measurable goals and objectives consistent with the program's purpose/mission;
2. implementation of procedures for evaluating the extent to which the goals and objectives are met;
3. collection of data in an ongoing and systematic manner;
4. analysis of the data collected and sharing of the results with appropriate audiences;
5. identification and implementation of corrective actions to strengthen the program; and
6. review of the assessment plan, revision as appropriate, and continuation of the cyclical process.

**Examples of evidence to demonstrate compliance may include:**
Mission statement and supporting written goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results

Ethics and Professionalism

1-10 The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

**Intent:** Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program must list the written competency requirements that describe the intended outcomes of residents’ education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

Intent: The program is expected to develop specific competency-statements that describe what the resident will be able to do upon completion of the program. These statements should describe the resident’s abilities rather than educational experiences the residents may participate in. These competency statements are to be circulated to program faculty and staff and made available to applicants of the program.

Examples of evidence to demonstrate compliance may include:
Written competency requirements

2-2 Upon completion of training, the resident must be:

a) Able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;
b) Able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;
c) Competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;
d) Competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;
e) Competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;
f) Competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
g) Competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

h) Competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region;

i) Familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and

j) Able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

**Intent:** The program’s specific competency requirements and the didactic and clinical training and experiences in each area described above are expected to be at a level of skill and complexity beyond that accomplished in pre-doctoral training and consistent with preparing the dentist to utilize anxiety and pain control methods safely in the most comprehensive manner as set forth in the specific standards contained in this document.

**Examples of evidence to demonstrate compliance may include:**
- Written competency requirements
- Didactic coursework, including lecture schedules and assigned reading
- Case review conferences
- Records of resident clinical activity including procedures performed in each area described above
- Resident logs
- Patient records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards
- Resident evaluations

The program must have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program’s written competency requirements.

**Intent:** The program is expected to organize the didactic and clinical educational experience into a formal written curriculum plan.

For each specific competency statement described, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

**Examples of evidence to demonstrate compliance may include:**
Formal written curriculum plan with educational experiences tied to specific competency requirements
Didactic schedules
Clinical schedules
Didactic Components

2-4 Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

a) Applied biomedical sciences foundational to dental anesthesiology,

   **Intent:** Instruction should include physiology, pharmacology, anatomy, biochemistry, pathology, physics, pathophysiology, and clinical medicine as it applies to anesthesiology. The instruction should be sufficiently broad to provide for a thorough understanding of the body processes related to anxiety and pain control. Instruction should also provide an understanding of the mechanisms of drug action and interaction, as well as information about the properties of drugs used.

b) Physical diagnosis and evaluation,

   **Intent:** This instruction should include taking, recording and interpreting a complete medical history and physical examination, and understanding the indications for and interpretations of diagnostic procedures and laboratory studies.

c) Behavioral medicine,

   **Intent:** This instruction should include psychological components of human behavior as related to the management of anxiety and pain.

d) Methods of anxiety and pain control,

   **Intent:** This instruction should include a detailed review of all methods of anxiety and pain control and pertinent topics (e.g., anesthesia delivery devices, monitoring equipment, airway management adjuncts, and perioperative management of patients).

e) Complications and emergencies,

   **Intent:** This instruction should include recognition, diagnosis, and management of anesthesia-related perioperative complications and emergencies.

f) Pain management, and
Intent: This instruction should include information on pain mechanisms and on the evaluation and management of acute and chronic orofacial pain.

g) Critical evaluation of literature.

Intent: This instruction should include an understanding of scientific literature pertaining to dental anesthesiology and the development of critical evaluation skills, including an understanding of relevant research and statistical methodology.

Clinical Components

2-5 The program must ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program’s stated goals and competency requirements in dental anesthesiology.

Examples of evidence to demonstrate compliance may include:
Records of resident clinical activity, including specific details of the variety, type, and quantity of cases treated and procedures performed.

2-6 The following list represents the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
   (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway technique requirements can be blind nasal intubations.
   (2) One hundred and twenty five (125) children age seven (7) and under, and
   (3) Seventy five (75) patients with special needs,

b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation; and

c) Exposure to the management of patients with chronic orofacial pain.
**Intent:** The resident should be competent in the various methods of sedation and anesthesia for a variety of diagnostic and therapeutic procedures in the office or ambulatory care setting and the operating room. The resident should gain clinical experience in current monitoring procedures, fluid therapy, acute pain management and operating room safety. Instruction and experience in advanced airway management techniques are important parts of the training program and may include but are not limited to the following devices and techniques: blind nasal intubation, bougie, fiberoptic intubation, intubating laryngeal mask airway (LMA), light wand, and video laryngoscopes.

**General Anesthesia Experience/Anesthesia Service**

2-7 At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

**Examples of evidence to demonstrate compliance may include:**
Anesthesia rotation schedules
Records of resident clinical activity

2-8 Residents must be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

**Intent:** This service should be under the direction of an anesthesiologist with a full time commitment, and each resident should participate in all of the usual duties and responsibilities of anesthesiology residents, including preanesthetic patient evaluation, administration of anesthesia in the operating room on a daily scheduled basis, postanesthetic patient management, and emergency call.

**Outpatient Anesthesia for Dentistry**

2-9 At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:
1. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.
2. Experience as the provider of supervised anesthesia care.

**Intent:** Adequate experience in the unique aspects of dental anesthesia care with and without the use of an anesthesia machine and operating room facilities should be provided. Supervising dentist anesthesiologists shall have completed a CODA-accredited dental anesthesiology residency program or a two-year anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable provided that continuous significant practice of general anesthesia in the previous two years is documented.

**Examples of evidence to demonstrate compliance may include:**
Anesthesia rotation schedules
Records of resident clinical activity
Schedules of dental anesthesia faculty

**Medicine Rotations**

Residents **must** participate in at least four (4) months of clinical rotations from the following list. If more than one rotation is selected, each **must** be at least one month in length.

- a) Cardiology,
- b) Emergency medicine,
- c) General/internal medicine,
- d) Intensive care,
- e) Pain medicine,
- f) Pediatrics,
- g) Pre-anesthetic assessment clinic (max. one [1] month), and
- h) Pulmonary medicine.

**Intent:** The dental anesthesia resident should have a strong foundation in clinical medicine that can be achieved through rotations in the above-mentioned areas. When the resident entering the program has minimal clinical medicine experience, the program director should attempt to increase the time in these rotations beyond the minimum number of months required. The goal is to give the resident experience in medical evaluation and long-term management of patients. Therefore, only one month of the four
months of this requirement may be met in the pre-anesthetic assessment clinic, although longer periods of time may be arranged as desired.

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations

2-11 Each assigned rotation or experience must have:

a) Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and
c) Evaluations performed by designated faculty.

Intent: This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.

Examples of evidence to demonstrate compliance may include:
Written objectives of rotations
Description and schedule of rotations
Resident evaluation reports

2-12 Residents must be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

Intent: Programs are expected to define the educational goals or competency statements in this area. Residents should be able to interact appropriately with other health care providers.

Examples of evidence to demonstrate compliance may include:
Consultation records or patient records
Written competency requirements
Resident evaluations

2-13 The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a) Taking, recording, and interpreting a complete medical history;
b) Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;

c) Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and

d) Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

**Intent:** It is intended that medical risk assessment be conducted during formal instruction as well as during in-patient, same-day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and medical risk assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data are being recorded.

**Examples of evidence to demonstrate compliance may include:**
- Course outlines
- Patient records
- Resident evaluations
- Record review policy
- Documentation of record review

**Other Components**

**2-14** The program **must** provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

**Intent:** Information about the credentialing processes involved in hospitals, free-standing surgical centers, and private offices should be provided.

**Examples of evidence to demonstrate compliance may include:**
- Didactic schedules

**2-15** Residents **must** be given assignments that require critical review of relevant scientific literature.

**Intent:** Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care.

**Examples of evidence to demonstrate compliance may include:**
- Evidence of experiences requiring literature review

**2-16** The program **must** conduct and involve residents in a structured system of continuous quality improvement for patient care.
Intent: Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.

Examples of evidence to demonstrate compliance may include:
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

Program Length

2-17 The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-18 Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

Intent: Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-19 The program’s resident evaluation system must assure that, through the director and faculty, each program:

   a) Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;
b) Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and

c) Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

**Intent:** While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific competency and anesthesia case requirements described in response to Standards 2-1, 2-2, and 2-6.

**Examples of evidence to demonstrate compliance may include:**
- Written evaluation criteria and process
- Resident evaluations
- Resident case logs
- Personal record of evaluation for each resident
- Evidence that corrective actions have been taken
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

Intent: The program director’s responsibilities include:

1. program administration;
2. development and implementation of the curriculum plan;
3. ongoing evaluation of program content, faculty teaching and resident performance;
4. evaluation of resident training and supervision in affiliated institutions and off-services rotations;
5. maintenance of records related to the educational program; and
6. Resident selection.

It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:

1. what duties are assigned;
2. to whom they are assigned; and
3. what systems of communication are in place between the program director and individuals who have been assigned responsibilities.

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:
Program director’s job description
Job description of individuals who have been assigned some of the program director’s job responsibilities
Formal plan for assignment of program director’s job responsibilities as described above
Program records

3-2 The program director must be board certified in dental anesthesiology. Program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology. The program director must have...
completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.

**Intent:** The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology.

**Examples of Evidence to demonstrate compliance may include:**
Certificate of completion of anesthesiology residency
Copy of board certification certificate
Letter from board attesting to current/active board certification

3-3 All sites where educational activity occurs **must** be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.

**Intent:** Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible. The faculty, collectively, should have competence in all areas of dental anesthesiology covered in the program.

The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of dental anesthesiology if that faculty member is not trained in dental anesthesiology. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of discipline-specific faculty as trained consultants for the development of a mission and curriculum, and for teaching.

**Examples of evidence to demonstrate compliance may include:**
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Written criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of dental anesthesiology
Program documentation that non-discipline specific faculty members are responsible for teaching an area of dental anesthesiology
Program documentation that faculty members are responsible for a particular teaching area

3-4 The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

Examples of evidence to demonstrate compliance may include:
Faculty roster
Clinical and didactic schedules

3-5 A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

Intent: The written annual performance evaluations should be shared with the faculty members.

Examples of evidence to demonstrate compliance may include:
Faculty files
Performance appraisals

3-6 A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

Examples of evidence to demonstrate compliance may include:
Faculty clinic schedules

3-7 The program must show evidence of an ongoing faculty development process.

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

Examples of evidence to demonstrate compliance may include:
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty

Dental Anesthesiology Standards
-31-
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-8 At each site where educational activity occurs, adequate support staff, including allied
dental personnel and clerical staff, must be consistently available to allow for efficient
administration of the program.

Intent: The program should determine the number and participation of allied support
and clerical staff to meet the educational and experiential goals and objectives.

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-9 The program must provide ongoing faculty calibration at all sites where educational
activity occurs.

Intent: Faculty calibration should be defined by the program.

Examples of evidence to demonstrate compliance may include:
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution must provide adequate learning resources to support the goals and objectives of the program.

*Intent:* Appropriate information resources should be readily available and include access to electronic databases, biomedical textbooks, dental journals, the internet and other learning resources. Lecture and seminar rooms and study areas for residents should be available.

Examples of evidence to demonstrate compliance may include:
Description of resources

Selection of Residents

4-2 Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:

a. Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b. Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c. Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-3 Specific written criteria, policies, and procedures must be followed when admitting residents.

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

Examples of evidence to demonstrate compliance may include:
Written criteria, policies, and procedures

4-4 Admission of residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program. Residents with
advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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

**Examples of evidence to demonstrate compliance may include:**
- Written policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

4-5 The program’s description of the educational experience to be provided must be available to program applicants and include:

a) A description of the educational experience to be provided
b) A list of competencies of residency training
c) A description of the nature of assignments to other departments or institutions

**Intent:** Programs are expected to make their lists of competency requirements developed in response to Standards 2-1 and 2-2 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs for which to apply. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

**Examples of evidence to demonstrate compliance may include:**
- Program brochure, application documents or website content
- Description of system for making information available to applicants who do not visit the program


Due Process

4-6 There **must** be specific written due-process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

*Intent:* Adjudication procedures should include institutional policy that provides due process for all individuals who may potentially be involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due-process policy, and current accreditation status of the program.

**Examples of evidence to demonstrate compliance may include:**
Written policy statements and/or resident contract

Health Services

4-7 Resident, faculty, and appropriate support staff **must** be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

**Examples of evidence to demonstrate compliance may include:**
Immunization policy and procedure documents
STANDARD 5 - FACILITIES AND RESOURCES

5-1 Institutional facilities and resources must be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

**Intent:** The facilities and resources (e.g., support(secretarial staff, allied personnel, and/or technical staff) should permit the attainment of program competency requirements. To ensure health and safety for patients, residents, faculty, and staff, the physical facilities and equipment should effectively accommodate the educational and patient care programs. Equipment and supplies for delivery of all forms of anesthesia care for dental patients should be readily accessible and functional. There should be a space properly equipped for monitoring patients’ recovery from general anesthesia and sedation.

5-2 In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies must be available in accord with all applicable accrediting bodies and state rules and regulations.

**Examples of evidence to demonstrate compliance may include:**
Certifications of current compliance/accreditation by appropriate governmental/accrediting agencies

5-3 All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care must be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating advanced cardiovascular life support training or summary log of certification/recognition maintained by the program

5-4 All other faculty (not included in Standard 5-3) and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support for health care providers.

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program

5-5 Secretarial and clerical assistance **must** be sufficient to permit efficient operation of the program.

**Intent:** The intent is to ensure operations of the program are managed in an efficient and expeditious manner without placing undue hardship on the faculty and residents in the program.

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

5-6 The program **must** document its compliance with the institution’s policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies **must** be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases **must** be made available to applicants for admission and to patients.

**Intent:** The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.

**Examples of evidence to demonstrate compliance may include:**
Infection and biohazard control policies
Radiation policy

5-7 The program’s policies **must** ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

**Examples of evidence to demonstrate compliance may include:**
Confidentiality policy
HIPAA policy
STANDARD 6 – RESEARCH

6-1 Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

Intent: One (1) month of scholarly activity could be gained in one (1) block or in smaller segments. Scholarly activity may include a hypothesis-driven research project, formal case review or review of literature. Options for advanced academic degrees are highly desirable.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology 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 Advanced Dental Education Programs in Dental Anesthesiology accreditation standards. The 2021 Accreditation Standards Validity and Reliability Survey - Dental Anesthesiology 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:

- Members of the American Society of Dentist Anesthesiologists
- Recent graduates of CODA-accredited dental anesthesiology programs
- Deans of dental schools in the United States
- Chief administrative officers of the dental service of institutions sponsoring accredited Dental Anesthesiology programs
- Chief administrative officers of the dental service of institutions sponsoring accredited Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, and Orofacial Pain programs
- Directors of accredited Dental Anesthesiology programs
- Directors of accredited Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, and Orofacial Pain programs
- CODA site visitors for Dental Anesthesiology programs
- CODA site visitors for Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, and Orofacial Pain programs
- Presidents of state dental societies
- Chief executive officers of the Federal Dental Services
- Executive directors of state boards of dentistry and 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
Progress Report on Validity and Reliability Study for Dental Anesthesiology
DentAnes RC
CODA Winter 2022

- American Association of Dental Boards
- Academy of General Dentistry
- American Dental Education Association
- American Student Dental Association
- American Dental Association
A total of 1,138 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 291 responses, for an overall adjusted response rate of 25.8% (excluding 11 individuals whose email addresses were undeliverable). A breakdown of responses by category is found on the next page.

### Number of Recipients, Number that Opened Survey, Number of Responses, Unadjusted Response Rate and Abandon Rate by Recipient Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Sent Survey</th>
<th>Opened Survey</th>
<th>Number of Responses</th>
<th>Unadj Resp Rate</th>
<th>Abandon Rate¹</th>
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<tbody>
<tr>
<td>Program Director-Dental Anesthesiology</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>87.5%</td>
<td>0.0%</td>
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<tr>
<td>Program Director-Other</td>
<td>281</td>
<td>151</td>
<td>105</td>
<td>37.4%</td>
<td>30.5%</td>
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<tr>
<td>Chief Administrative Officer-Dental Anesthesiology</td>
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<td>3</td>
<td>3</td>
<td>50.0%</td>
<td>0.0%</td>
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<tr>
<td>Chief Administrative Officer-Other</td>
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<td>75</td>
<td>39</td>
<td>23.1%</td>
<td>48.0%</td>
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<tr>
<td>Site Visitor- Dental Anesthesiology</td>
<td>12</td>
<td>10</td>
<td>7</td>
<td>58.3%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Site Visitor-Other</td>
<td>63</td>
<td>33</td>
<td>28</td>
<td>44.4%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Dental School Dean</td>
<td>67</td>
<td>22</td>
<td>20</td>
<td>29.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Dental Anesthesiologist (ASDA member or recent grad)</td>
<td>387</td>
<td>128</td>
<td>63</td>
<td>16.3%</td>
<td>50.8%</td>
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<tr>
<td>National Dental Organization/Board Executive Director</td>
<td>30</td>
<td>8</td>
<td>6</td>
<td>20.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>State Dental Society President</td>
<td>53</td>
<td>12</td>
<td>9</td>
<td>17.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>State Dental Board Executive Director</td>
<td>53</td>
<td>5</td>
<td>3</td>
<td>5.7%</td>
<td>40.0%</td>
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<tr>
<td>Chief of Federal Dental Services</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Clinical Testing Agency Executive Director</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>20.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>1,138</td>
<td>455</td>
<td>291</td>
<td>25.6%</td>
<td>36.0%</td>
</tr>
</tbody>
</table>

¹ The Abandon Rate is calculated by subtracting the Number of Responses form the number that Opened Survey, then dividing that result by the number that Opened Survey. It signifies the percentage of survey recipients who accessed the online survey but did not complete it.

The survey had an abandonment rate of 36.0%, meaning that more than one out of every 3 recipients who opened the online survey did not complete it (while nearly two-thirds of recipients who opened the online survey did 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 residents
- **Sufficiently demanding** = Criterion is relevant to type of program and sufficiently demanding for programs and/or residents
- **Not demanding** = Criterion is relevant but not demanding enough for programs and/or residents
- **Not relevant** = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
- **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 dental anesthesiology site visitor and program director samples, that person would be assigned to the program director 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 – Dental Anesthesiologists

The survey was sent to a 387 dental anesthesiologists in the United States, using membership lists from the American Society of Dentist Anesthesiologists and lists of graduates from accredited dental anesthesiology programs. A total of 128 recipients opened the survey; 63 completed it, yielding a response rate of 16.3% (and a survey abandon rate of 50.8%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 55.6% and 98.4% of the 63 dental anesthesiologists who responded indicated the standards were “Sufficiently demanding.”

The standards that were identified as “Too demanding” by the highest percentage (20.6%) of dental anesthesiologists who completed the survey were:

- Upon completion of training, the resident must be competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region. (Standard 2-2)
- Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum. (Standard 6-1)

The standards that were identified as “Not demanding” by the highest percentage (20.6%) of dental anesthesiologists who completed the survey were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training; a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following):

- 1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. (27.0%)
- 2. One hundred and twenty five (125) children age seven (7) and under, and; (31.8%)

Two standards were identified as “Not relevant” by 11.1% of the dental anesthesiologists who responded to the survey:

- c. Exposure to the management of patients with chronic orofacial pain. (Standard 2-6)
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18)

The three standards with the most dental anesthesiologists having no opinion were:

- United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria. (In Standard 1-1) 20.6%
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 20.6%
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 15.9%
Executive Summary – Directors of Dental Anesthesiology Education Programs

The survey was sent to eight directors of dental anesthesiology education programs. A total of seven recipients opened and completed the survey, yielding a response rate of 87.5%. Once opened, no program directors abandoned the survey.

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 28.6% and 100.0% of the seven dental anesthesiology program directors who responded indicated the standards were “Sufficiently demanding.”

The standards that were identified as “Too demanding” by two dental anesthesiology program directors (28.6%) were:
- i. Upon completion of training, the resident must be familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and; (Standard 2-2)
- a2. One hundred and twenty five (125) children age seven (7) and under, and; (Standard 2-6)

The standards that were identified as “Not demanding” by the highest percentage (42.9%) of dental anesthesiology program directors were who completed the survey were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training; a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:).
- a1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.
- a3. Seventy-five (75) patients with special needs.

Three standards, all in Standard 2, were identified as “Not relevant” by two or more dental anesthesiology program directors who completed the survey:
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 42.9%
- i. Upon completion of training, the resident must be familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and; (Standard 2-2) 28.6%
- c. Exposure to the management of patients with chronic orofacial pain. (Standard 2-6) 28.6%

No more than one dental anesthesiology program director had no opinion on any standard.
Executive Summary – Directors of Other Education Programs

The survey was sent to 281 directors of advanced education in general dentistry, general practice residency, oral medicine, and orofacial pain programs. A total of 151 recipients opened the survey, and 105 completed the survey, yielding a response rate of 37.4% (and an abandoned rate of 30.5%).

Among all 95 individual “must” statements from the dental anesthesiology program accreditation standards listed in the survey, between 62.9% and 92.4% of the 105 other program directors who responded indicated the standards were “Sufficiently demanding.”

No standards were identified as “Too demanding” by more than 9% of the 105 other program directors who completed the survey.

The three standards that were identified as “Not demanding” by highest percentage of other program directors who completed the survey were:

- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 21.9%
- Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:
  - Graduates from a predental education program accredited by the Commission on Dental Accreditation;
  - Graduates from a predental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and
  - Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program. (Standard 4-2) 18.1%
- The program's resident evaluation system must assure that, through the director and faculty, each program: Periodically, but at least twice annually, evaluates and documents the resident's progress towards achieving the program's written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures; (Standard 2-19) 18.1%

No standards were identified as “Not relevant” by more than 3% of the 105 other program directors who completed the survey.

The four standards for which 20% or more of the respondents in this group had no opinion were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training;):

- a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: 21.0%
- a1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. 20.0%
- a2. One hundred and twenty five (125) children age seven (7) and under, and; 21.9%
- a3. Seventy-five (75) patients with special needs. 20.0%
Executive Summary – Chief Administrative Officers and Dental School Deans

The survey was sent to six chief administrative officers (CAOs) of institutions sponsoring accredited dental anesthesia education programs, 169 CAOs of institutions sponsoring accredited advanced education in general dentistry, general practice residency, oral medicine, and orofacial pain programs, and 67 deans of dental schools accredited by CODA. A total of 100 recipients opened the survey; 62 completed the survey, yielding a response rate of 25.6% (and a survey abandon rate of 38.0%).

Among all 95 individual “must” statements from the dental anesthesia education program accreditation standards listed in the survey, between 66.1% and 96.8% of CAOs and dental school deans who responded indicated the standards were “Sufficiently demanding.”

No standards were identified as “Too demanding” by more than 9% of the 62 CAOs and dental school deans who completed the survey.

The two standards that were identified as “Not demanding” by the highest percentage of the 62 CAOs and dental school deans who completed the survey were:

- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 24.2%
- Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum. (Standard 6-1) 19.4%

No standards were identified as “Not relevant” by more than 5% of the 62 CAOs and dental school deans who completed the survey.

More than 10% of respondents in this group had no opinion on six parts of Standard 2:

- The first four were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training):
  - a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: 16.1%
  - a.1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. 14.5%
  - a.2. One hundred and twenty five (125) children age seven (7) and under, and; 12.9%
  - a.3. Seventy-five (75) patients with special needs. 14.5%
- 1. At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients: At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists. (Standard 2-9) 12.9%
- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 11.3%
Executive Summary –Dental Anesthesiology Education Program Site Visitors

The survey was sent to 12 dental anesthesiology education program site visitors. A total of 10 recipients opened the survey, and 7 completed it, yielding a response rate of 58.3% (and a survey abandon rate of 30.0%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 57.1% and 100.0% of the seven dental anesthesiology site visitors who responded indicated the standards were “Sufficiently demanding.”

The standard with the largest percentage of dental anesthesiology site visitors selecting “Too demanding” (28.6%) was: The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to: c. Admit, manage and discharge patients. (Standard 1-6)

The standards that were identified as “Not demanding” by the highest percentage (42.9%) of dental anesthesiology site visitors who completed the survey were:

- The program must develop a mission statement and supporting written overall program goals and objectives that emphasize: c. Patient care and include training residents to provide dental anesthesia care in office-based and hospital settings. (Standard 1-8)
- Three parts of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training; a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following):
  - 1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.
  - 2. One hundred and twenty five (125) children age seven (7) and under, and;
  - 3. Seventy-five (75) patients with special needs.
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1)

The two standards that were identified as “Not relevant” by the highest percentage (28.6%) of the dental anesthesiology site visitors who completed the survey were:

- Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18)
- Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program. (Standard 4-4)

The only standard where any dental anesthesiology site visitors had no opinion was: United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria. (Standard 1-1) 28.6%
Executive Summary – Other Program Site Visitors

The survey was sent to 63 site visitors of advanced education in general dentistry, general practice residency, oral medicine, and orofacial pain programs. A total of 33 recipients opened the survey, and 28 completed it, yielding a response rate of 44.0% (and a survey abandon rate of 15.2%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 60.7% and 89.3% of the 28 other site visitors who responded indicated the standards were “Sufficiently demanding.”

The two standards with the largest percentage of other site visitors selecting “Too demanding” (10.7% each) were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training;).

- a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
- a3. Seventy-five (75) patients with special needs.

The standards that were identified as “Not demanding” by the highest percentage of other site visitors who completed the survey were:

- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 28.6%
- Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum. (Standard 6-1) 28.6%
- The program’s resident evaluation system must assure that, through the director and faculty, each program: Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures; (Standard 2-19) 21.4%

No more than 8% of other site visitors who responded to the survey identified any standard as “Not relevant.”

The standard with the highest percentage of other site visitors who had no opinion was: Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents. (Standard 2-18) 17.9%
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, nine opened the survey, and seven completed the survey, yielding a response rate of 17.9% (and a survey abandon rate of 22.2%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 57.1% and 100.0% of the seven leaders of national dental organizations who responded indicated the standards were “Sufficiently demanding.”

No standard was identified as “Too demanding” by more than one of the seven leaders of national dental organizations (14.3%) who completed the survey.

The standard that were identified as “Not demanding” by the highest percentage of leaders of national dental organizations who completed the survey was: The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1) 28.6%

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

28.6% of respondents in this group had no opinion on six standards:

- The first three were part of Standard 2-6 (The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:)
  - a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
    - a1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.
    - a2. One hundred and twenty five (125) children age seven (7) and under;
- At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients: Experience as the provider of supervised anesthesia care. (Standard 2-9)
- The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided. (Standard 2-14)
- The program director must have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. (A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.) (Standard 3-2)
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, 17 opened the survey, and 12 completed the survey, yielding a response rate of 11.3% (and a survey abandon rate of 29.4%).

Among all 95 individual “must” statements from the dental anesthesiology education program accreditation standards listed in the survey, between 58.3% and 100.0% of the 12 leaders of state dental organizations who responded indicated the standards were “Sufficiently demanding.”

The standard that was identified as “Too demanding” by the largest percentage (16.7%) of state dental organization leaders who responded to the survey was: The program director must be board certified in dental anesthesiology; program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology. (Standard 3-2)

The two standards that were identified as “Not demanding” by the highest percentage (25.0%) of state dental organization leaders who responded to the survey were:

- At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology. (Standard 2-7)
- The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. (Standard 3-1)

No standard was identified as “Not relevant” by more than one of the 12 leaders of state dental organizations (8.3%) who completed the survey.

25.0% of respondents in this group had no opinion on six standards:

- b. Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation; (Standard 2-6)
- At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients: At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists. (Standard 2-9)
- Residents must participate in at least four (4) months of clinical rotations from the following list:
  - Cardiology
  - Emergency medicine
  - General/internal medicine
  - Intensive care
  - Pain medicine
  - Pediatrics
  - Pre-anesthetic assessment clinic (max. one [1] month), and
  - Pulmonary medicine (Standard 2-10)
- If more than one rotation is selected [from the list in Question 24], each must be at least one month in length. (Standard 2-10)
- The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training. (Standard 2-17)
- The program must show evidence of an ongoing faculty development process. (Standard 3-7)
Advanced Dental Education Programs in Dental Anesthesiology
Accreditation Standards
STANDARD 1: INSTITUTIONAL AND PROGRAM EFFECTIVENESS

(ST1-1.1) 1. The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital.

<table>
<thead>
<tr>
<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD. DentAnes</th>
<th>PD. Other</th>
<th>Dean/CAO</th>
<th>SV. DentAnes</th>
<th>SV. Other</th>
<th>Nat'l Org</th>
<th>State Org</th>
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<td>62</td>
<td>7 28</td>
<td>7 12</td>
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(ST1-1.2) 2. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-1.3) 3. United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria.

(ST1-2) 4. 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.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-3) 5. The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

<table>
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<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
<th>PD-Other</th>
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(ST1-4) 6. The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.
(ST1-5) 7. Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

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(ST1-6) 8. The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

a. Vote and hold office:

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST1-6) 8. The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

b. Serve on institutional staff committees; and

c. Admit, manage and discharge patients.
(ST1-7) 9. Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-8) 10. The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:

a. Anesthesia for dentistry;

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b. Resident education; and

<table>
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<th>Field</th>
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c. Patient care and include training residents to provide dental anesthesia care in office-based and hospital settings.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST1-9) 11. The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

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Ethics and Professionalism

(ST1.11) 12. The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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STANDARD 2 - EDUCATIONAL PROGRAM

Curriculum Content

(ST2-1) 13. The program must list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST2-2) 14. Upon completion of training, the resident must be:

a. able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;

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b. able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;

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(continued, ST2-2) 14. Upon completion of training, the resident must be:

c. competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;

d. competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;

e. competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

f. competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;

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g. competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

h. competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region;

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i. familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-2) 14. Upon completion of training, the resident must be:

j. able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

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(ST2-3) 15. The program must have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program’s written competency requirements.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Didactic Components

(ST2-4) 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

a. Applied biomedical sciences foundational to dental anesthesiology;

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

b. Physical diagnosis and evaluation;

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c. Behavioral medicine;

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-4) 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

d. Methods of anxiety and pain control;

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e. Complications and emergencies;

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f. Pain management; and
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-4) 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

g. Critical evaluation of literature.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 2 - EDUCATIONAL PROGRAM (continued)

Clinical Components

(ST2-5) 17. The program must ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program’s stated goals and competency requirements in dental anesthesiology.

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<tr>
<th>Field</th>
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(ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:

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<td>62</td>
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<td>28</td>
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<td>12</td>
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</tbody>
</table>
(continued, ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations.

2. One hundred and twenty five (125) children age seven (7) and under, and
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

3. Seventy-five (75) patients with special needs.

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<td>60.7%</td>
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b. Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation;

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</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-6a) 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

c. Exposure to the management of patients with chronic orofacial pain.

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</table>
(ST2-7) 19. At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

<table>
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</table>

(ST2-8) 20. Residents must be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Outpatient Anesthesia for Dentistry

(ST2-9) 21. At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

a. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.

<table>
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b. Experience as the provider of supervised anesthesia care.

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</table>
Medicine Rotations

(ST2-10.1) 22. Residents must participate in at least four (4) months of clinical rotations from the following list:

- Cardiology
- Emergency medicine
- General/internal medicine
- Intensive care
- Pain medicine
- Pediatrics
- Pre-anesthetic assessment clinic (max. one [1] month)
- Pulmonary medicine

(ST2-10.2) 23. If more than one rotation is selected [from the above list], each must be at least one month in length.
(ST2-11) 24. Each assigned rotation or experience must have:

a. Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;

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b. Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and

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c. Evaluations performed by designated faculty.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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(ST2-12) 25. Residents must be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

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(ST2-13) 26. The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a. Taking, recording, and interpreting a complete medical history;
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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b. Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-13) 26. The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

c. Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and

d. Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

**Other Components**

(ST2-14) 27. The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

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(ST2-15) 28. Residents must be given assignments that require critical review of relevant scientific literature.

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(ST2-16) 29. The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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Program Length

(30) The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

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<th>PD-Other</th>
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(31) Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

Evaluation

(ST2-19) 32. The program's resident evaluation system must assure that, through the director and faculty, each program:

a. Periodically, but at least twice annually, evaluates and documents the resident's progress towards achieving the program's written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;

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<th>SV-Other</th>
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</table>

b. Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and

<table>
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<th>PD-Other</th>
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<td>57</td>
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</tbody>
</table>


2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(continued, ST2-19) 32. The program's resident evaluation system must assure that, through the director and faculty, each program:

c. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

<table>
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 3 - FACULTY AND STAFF

(ST3-1) 33. The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

<table>
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<th>Field</th>
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(ST3-2.1) 34. The program director must be board certified in dental anesthesia; program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesia.

<table>
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<tr>
<th>Field</th>
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<th>PD-Other</th>
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</table>
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-2.2) 35. The program director must have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. (A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.)

(ST3-3) 36. All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.
(ST3-4) 37. The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

<table>
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<th>PD- Other</th>
<th>Dean/CAO</th>
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<th>Nat'l Org</th>
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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-5) 38. A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

<table>
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<th>Field</th>
<th>Dental Anesthesiologist</th>
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<td>7 12</td>
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</table>

(ST3-6) 39. A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

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(ST3-7) 40. The program must show evidence of an ongoing faculty development process.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST3-8) 41. At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for efficient administration of the program.

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<thead>
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<th>Field</th>
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(ST3-9) 42. The program must provide ongoing faculty calibration at all sites where educational activity occurs.

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STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

(ST4-1) 43. The sponsoring institution must provide adequate learning resources to support the goals and objectives of the program.

Selection of Residents

(ST4-2) 44. Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:

- Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;
- Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and
- Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST4-3) 45. Specific written criteria, policies and procedures must be followed when admitting residents.

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<th>Field</th>
<th>Dental Anesthesiologist</th>
<th>PD-DentAnes</th>
<th>PD-Other</th>
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(ST4-4.1) 46. Admission of students/residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program.

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(ST4-4.2) 47. Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST4-5) 48. The program's description of the educational experience to be provided must be available to program applicants and include:

a. A description of the educational experience to be provided;

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b. A list of competencies of residency training; and

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c. A description of the nature of assignments to other departments or institutions.
### 2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

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Due Process

(ST4-6) 49. There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

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Health Services

(ST4-7) 50. Resident, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

STANDARD 5 - FACILITIES AND RESOURCES

(ST5-1.1) 51. Institutional facilities and resources must be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards.

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(ST5-1.2) 52. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

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2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST5-2) 53. In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies must be available in accord with all applicable accrediting bodies and state rules and regulations.

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(ST5-3) 54. All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care must be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

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</table>

(ST5-4) 55. All other faculty (not included in Question 56) and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support for health care providers.

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</table>

(ST5-5) 56. Secretarial and clerical assistance must be sufficient to permit efficient operation of the program.
(ST5-6.1) 57. The program must document its compliance with the institution’s policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases.

( ST5-6.2) 58. Policies must be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance.
2021 Accreditation Standards Validity and Reliability Survey – Dental Anesthesiology

(ST5-6.3) 59. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients.

<table>
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<th>Field</th>
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<th>PD-Other</th>
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(ST5-7) 60. The program’s policies 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

(ST6) 61. Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.
Responses to Open-ended Questions
Standard 1 – Institutional and Program Effectiveness

Questions 1-6 (Standards 1-1 to 1-4)

(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).

Dental Anesthesiologist

I do not think that the sponsoring hospital needs to set the curriculum, they do not necessarily understand the starting points or end points for dentist anesthesiologists.

Military institutions should be held to exactly the same standards as non-Military institutions.

Dean/CAO

4. Not sure of the purpose of this but I interpreted it to mean that outside forces could not exert substantial influence over what is best for the program. This needs to be more clear. At the end of the day, if financial support comes from outside the sponsoring institution, then the program is going to do what is dictated by that group. Even if it is not in the best interest of the program.

Standard One question 1: There are accrediting agencies that can have an office meet the standards of CMS. For example, there could well be a site/office that would have AAAHC accreditation. That would be a viable source for sponsoring a dental residency program.

Nat'l Org

#5 - The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution --- I believe that there should be minimal standards set forth that the sponsoring institution must follow and thus not have exclusive or final authority as noted in this standard.

Program Director-DentAnes

No comments

Program Director-Other

2. Not every program deals with Medicaid. Medicaid should be irrelevant.

3. If the Program is just to teach active duty personnel the basics of field medicine (in anesthesia), I think it would be acceptable. If the purpose to accredit them as anesthesiologists, I think there should be some affiliation with a hospital or US educational organization.
4. Is not specific as to what constitutes compromise and who will make that determination.  

I believe that military programs should be connected to military hospitals can achieve the standards of this residency. 

Military institutions can be evaluated by the same accrediting bodies in my opinion. Responsibility for resident recruitment and curriculum development should lie with the program director.

**Questions 1-6 (Standards 1-1 to 1-4) - continued**

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**State Org**

#3 - I do not believe that simply demonstrating the successful achievement of Service-specific organizational inspection criteria is enough to assure the quality of the education received.

5. I think that curriculum development is something CODA should express more control over. I worked with a DA that did not feel confident hiring associates that graduated from one specific program. Their graduates were consistently not up to what he deemed to be standard competency.

**Site Visitor-DentAnes**

No comments

**Site Visitor-Other**

Std 1.1 - I believe that it is possible for a dental anesthesia program to exist at an educational institution that is not affiliated with a hospital.
Questions 7-12 (Standards 1-5 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).

Dental Anesthesiologist

8a. I don’t think the ability to vote or hold an office within an institution is a necessity for sponsoring a dental residency program.

8a. This should apply to some faculty but many faculty members would be considered part-time based on time spent under the sponsoring institution, making a voting requirement too demanding to expect.

8c. Most hospitals will not allow for the anesthesia dept to admit patients, rather they would be admitted to a hospitality service, therefore not relevant.

Admit and discharge are handled by different departments - typically internal medicine, surgery and PACU.

Admitting patients is beyond the scope of our field. The recommendation to do so is appropriate, but to admit patients is a responsibility that belongs to the primary team.

It is not necessary to be able to admit patients to the hospital. Although important for OMS, even physician anesthesiologists do not admit patients. And any other dental specialist can not admit. Regarding Standard 7, this is fine if a "mobile practice" is considered ONE site as it is for AAAHC accreditation. The actual office where the mobile practice goes should NOT be considered "a site"

Not all physicians have hospital admitting privileges, let alone dentists. Hospitals usually have their primary care doctors as medical officers to admit patients. Dental anesthesiologists should not be required to have admitting privileges.

Outcome assessments which includes a resident's performance and ethical standards should be a requirement throughout the residency, which is why I feel this is not demanding.

The program needs to have annual assessment exams and practicals to ensure quality teaching and curriculum. Residents must be kept on track.

The requirement for the facility to allow dentists to admit patients would in theory be nice, but many prohibit dentists other than OMFS from admitting without a hospitalist.

voting and/or holding office while aspirational are not necessarily relevant to the strength of a dental anesthesiology residency

Dean/CAO

8. Dentist Anesthesiologists rarely admit or discharge patients. Not relevant 10c. Many hospital programs essentially use DA residents as cheap CRNA's and they do not want them providing care in true dental outpatient settings such as a pediatric office etc. This needs to be clearly delineated and a specified number of cases applied for outpatient, non-hospital based care.

8a. Does not seem to be important.

Anesthesiology is for a person, irrelevant whether limited to dentistry or not.
Most dentists do not have the medical knowledge to accept that much responsibility to admit and discharge at this level. Co-managing would be the best option for patient and provider safety. Having a relationship with medical providers would be a good pattern of practice.

Nat'l Org
No comments

Questions 7-12 (Standards 1-5 to 1-9) - continued

(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).

Program Director-DentAnes
No comments

Program Director-Other

8c - In my opinion, a dental anesthesia resident is part of an interdisciplinary team. With that being stated, the patient's core team leader will be a physician or dentist who will be responsible for admitting, managing and discharging a patient.

Does not seem reasonable to appoint residents as "staff"; I may be misunderstanding the usage but no residents in any of our programs are appointed as "staff", only instructors are appointed as staff.

General dentists provide anesthesia for dental work so I'm trying to see how you would write a goal to be specific for this program and not be broad as in for an AEGD or GPR even.

I do not see why a mission statement should be required.

Not every site utilized by a program is used for the same purpose, therefore, if a resident goes to an outside site, they may not need the same credentials as other residents at that site, only for the purpose of their utilization of that site.

Question 8:Difficult to change by-laws at affiliate hospitals. Recommend at Sponsoring or co-sponsoring only.

Right to admit patients when we have hospitalist and interventionalist might be too demanding.

The duration of the program would not make it practical for the student to take part in committee activity or hold office at the institution. Admitting and discharging patients would not be a normal activity for an anesthesiologist.

State Org
No comments

Site Visitor-DentAnes
#10. Office based anesthesia care should be mandated not just emphasized.  #12. Ethics are impossible to regulate.

10.a.: Ideally an overall emphasis on anesthesiology for dentistry is not relevant and is covered by c. Anesthesiology is anesthesiology no matter what body part is the target of surgical or other intervention. We could stress exposure primarily to anatomical targets other than teeth overall.

8.c. Dental anesthesia residents typically do not have admitting or discharge privileges.

Questions 7-12 (Standards 1-5 to 1-9) - continued

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Site Visitor-Other

Beyond the scope of dentists in some hospital systems to admit patients.

While entirely appropriate to allow dentists to be privileged to admit patients, an easier path would be to coordinate with the anesthesiology department or the ED for admitting to give potential faculty the option if they'd like to pursue hospital privileges for admitting.
Standard 1 Comments

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

Dental Anesthesiologist

The training programs should have comprehensive anesthesia training in all types of medical cases with some emphasis on treating outpatient dental patients in an office-based setting. The dentist anesthesia should be competent in a operating room managing most types of anesthesia for medical patients undergoing surgery. The DA should also have experience managing medical/surgical intensive care patients, as well as rotations in internal medicine and cardiology.

Dean/CAO

Not sure if voting and holding office is that important

No additional comments

Nat’l Org

No comments

Program Director-DentAnes

No comments

Program Director-Other

All statements of the requirements seem very appropriate.

Dentist do not have the medical training to manage medically compromised patients or patients that need admit due to complications from a general anesthesia procedure

I agree with the 12 statements and they should be implemented into program

I am not aware if there is a research requirement in the DA program?

Look solid

Ongoing verified Continuing Education of Program Directors and Attendings of both the program and the sponsoring facility should be in place to insure that the quality of the program remains focused and relevant in future years. This could be done in a non-threatening online learning environment produced by instructional designers where course content and knowledge requirements could be managed by the CODA governing body.

State Org

No comments
Site Visitor-DentAnes

No comments

Standard 1 Comments - continued

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

Site Visitor-Other

An excellent survey - very appropriate!

 Mostly Boiler Plate

Shouldn't there be a standard that addresses the type of credential the residents earn? (i.e. Certificate, or degree)

Std 1.8.c - I think requiring hospitals to give admitting privileges will reduce the number of hospitals willing to affiliate with the programs.

The program must have a mission that is supported by the goals and objectives.
Standard 2 – Educational Program

Questions 13-14 (Standards 2-1 to 2-2)

(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).

Dental Anesthesiologist

14h. We are not facial pain specialists and the wording of this implies that we should be able to diagnose and non-surgically treat acute head and neck pain. I do not believe this should be a requirement. I think the wording regarding acute pain should be similar to the wording used in 14i regarding chronic pain.

Ability to demonstrate knowledge of current literature should not be limited to dental anesthesiology, but rather expanded to anesthesiology in general, as the disciplines are largely intertwined.

Anesthesia is not for the treatment of chronic pain.

Chronic head and neck pain diagnosis and treatment: Chronic management belongs to other healthcare providers.

Chronic head and neck pain has its own specialty, Orofacial pain.

Chronic pain of the head and neck is more apropos to an Oral Facial Pain Dental residency or chronic pain medical fellowship for long term care of chronic head and neck pain. Acute pain of the head and neck region is a valuable skill that may be learned during residency but shouldn't be required for anesthetic management of most patients.

Competency in the diagnosis and non-surgical treatment of acute pain in the head and neck region could be considered outside the scope of dental anesthesiology.

H. and I. - oral facial pain rotations involving the acute/chronic diagnosis and treatment are not relevant to an anesthesiology program. Time is better spent in direct anesthesiology training. If residents interested in furthering their oral facial pain knowledge, there are programs already established to support that interest.

I am concerned with 14a and b. In-depth is very subjective. I think it should say "in depth knowledge comparable to a physician anesthesiology resident as applicable to anesthesia for dentistry, of the....."

I am not aware of any DA who manages acute or chronic pain of the head and neck as a part of their practice. Perhaps my experience is too limited. Nevertheless, I think this requirement falls outside the bounds of typical clinical practice.

i. Understanding the diagnosis and treatment should only be required as to how it would pertain to anesthetic management, but residents should not be expected to be able to make diagnoses or know treatment algorithms for these chronic conditions.

Most residents will not treat ASA 4 or do complex surgeries after graduation, thus a complete understanding of every disease process in relation to anesthesia is not necessary.
Questions 13-14 (Standards 2-1 to 2-2) - continued

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Dean/CAO

14. h. and 14.i. The training provided in other programs covers these two topics - Oral Medicine and Orofacial Pain. Do not believe it wise require this crossover training for Dental Anesthesiology. 

familiarity with the diagnosis and treatment of chronic pain would not adequately prepare trainees to address the needs of the patient population being managed

I would not expect all anesthesia providers to cross over in the dental specialty of facial pain. This would cases to refer out. It would not prevent a provider from gaining those skills, but not necessary for all providers.

There is an entire recently recognized specialty dedicated to pain acute and chronic. h should read similar to i

Nat'l Org

No comments

Program Director-DentAnes

Chronic orofacial pain falls into the scope of another specialty. Having exposure to chronic pain is not a competency and should be optional for a program to offer exposure but should not be a standard with equal weight as the other standards.

I don't believe Standard 2-14 H and I are relevant any longer now that Orofacial Pain is a recognized specialty. The overwhelming majority of dentist anesthesiologists are providing clinical anesthesia to patients, not diagnosing and treating acute or chronic pain of the head and neck.

Since there is now a specialty in Head and Neck Pain, this stand should read: "competent in managing (sedating or anesthetizing) patients for dental procedures who present with chronic pain of the head and neck."

Standard 14 i. (Familiar with dx and tx of chronic pain related to head and neck region) I believe that area of clinical expertise is covered best by the emerging specialty of Orofacial Pain. [redacted] I have found it the need to include exposure or familiarity with Chronic Head and Neck Pain an awkward fit to the curriculum of a dental anesthesiology residency. It also takes away time from subjects and experience more directly relevant to DA resident training.

Program Director-Other

Surgical tx of acute pain falls within the domain of oral surgery and chronic pain within the domain of oral medicine OR orofacial pain speciality

These criteria would require training beyond that offered in the program.
They are not training to be pain experts. Acute pain is one thing, but expecting them to be experts in chronic pain is quite another.

**Questions 13-14 (Standards 2-1 to 2-2) – continued**

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**State Org**

Evaluation and treatment of acute and chronic pain is relevant to all dentists and should not be considered part of advanced specialty training.

I don’t believe in #h that the provider needs in depth knowledge but general knowledge of these conditions

**Site Visitor-DentAnes**

13.f.: "...in dentistry." is not relevant. 13.j.: Dentist anesthesiologists do not practice "dental anesthesiology," a term that implies anesthetizing teeth for tooth procedures. Dentist anesthesiologists practice "Anesthesiology," period, and may or may not limit themselves to tooth procedures.

**Site Visitor-Other**

h. too demanding because it is unrealistic to require competence in all possible aspects of acute pain - this is also the realm of neurology, otolaryngology, orofacial pain, etc.

to numeral i describes the OFP programs overall goals - a specialty on its own. Perhaps "familiar" is not the best qualifier
Questions 15-16 (Standards 2-3 to 2-4)

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Dental Anesthesiologist

Again, term in-depth is too vague. See previous comment.

Behavioral medicine is outside our scope.

Dean/CAO

D pain control and F pain management are the same and redundant in my opinion

Nat'l Org

No comments

Program Director-DentAnes

I don't think this is relevant to dental anesthesiology

Program Director-Other

Adequate requirement for development professional skills

Again, acute pain is different from chronic

State Org

No comments

Site Visitor-DentAnes

16.a.: Again, dentist anesthesiologists practice "Anesthesiology," not tooth limited or dental anesthesiology. Eliminate; "...dental..."

Site Visitor-Other

No comments
Questions 17-18 (Standards 2-5 to 2-6)

(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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Dental Anesthesiologist

18.a2-3. The majority of dental anesthesia is utilized for the pediatric and special needs population. Given the unique challenges both demographics may present I do not feel that 15% (pediatric) or 9% (special needs) of total cases is sufficient to provide experience in treating these populations. 300 intubated cases is a low number. 50 nasal intubations is very low as well. At a minimum, these numbers could be doubled.

As stated previously, exposure to management of patients with chronic orofacial pain is not relevant to an anesthesiology program. Time is best spent in the exposure and management of anesthesiology cases.

c. I think we should have exposure to management of patients with chronic pain, but limiting this to orofacial pain I don't believe makes sense.

Cases should be increased to a minimum of 1000 and preferably 1200. minimum of 600 should be intubated.

In my opinion 800 cases is far too low and was probably better suited for times when dental anesthesiology residency programs were two years duration. I think 1000-1200 cases is certainly easily attainable over a three year program.

It is challenging to obtain advanced airway techniques such as fiberoptic intubations.

Minimum number of nasally intubated, pediatric, and special needs cases are too low.

not all residency programs have adequate access to patients with chronic orofacial pain; when I was program director at one of the CODA-accredited institutions, I always found it difficult satisfying this standard

Number of cases should be higher, particularly pediatric cases

The educational program requirements have not included mention, suggestion or requirement for anesthesiology residents to engage in clinical simulation-based training during their residency. This form of education is a foundational aspect of all physician anesthesiology residency programs and is an essential element of training beyond didactic presentation of anesthetic management, perioperative emergencies et cetera. It is the bridge to clinical experiences and without simulation or medical emergencies, there is no way to guarantee that residents gain enough experiences managing emergencies to be deemed "able."

There should be a higher number of pediatric cases required in residency due to the high demand of anesthesia for pediatric patients undergoing dental rehab. This may be biased by my practice, however I feel like most DAs primarily work with pediatric patients and therefore should have more experience in this area.

Upwards of 200 pediatric cases should be required before practicing solo in the private practice without hospital support.
We should be required to do far more than 300 intubated GA's. This is a very low number in my opinion. Same goes for only 50 nasal intubations. As DAs, this is our wheel house. 50 is not enough to develop true expertise. In addition, "advanced airway" management should not include the use of video laryngoscopes. Video laryngoscopes are an important tool and we should have to use them. However, in my opinion, they represent a separate category. Nasal fiberoptic intubations should be mandatory, perhaps 25. These are in important skill for the DA.

**Questions 17-18 (Standards 2-5 to 2-6) - continued**

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**Dean/CAO**

18.c. Same as the response to 14. h. and 14. i.

I believe exposure should be equivalent to that of an MD anesthesiologist

No sure all anesthesia providers would also be experts in orofacial pain.

**Nat'l Org**

*No comments*

**Program Director-DentAnes**

18. a. 3. The requirement for patients with Special Needs should be increased. The Special Needs population is highly variable in terms of co-morbidities, intrinsic anatomic and physiologic deficits as well as negative behavioral presentation. 75 patients over a three year curriculum is too few for residents to reliably achieve competence in the anesthetic management of this patient population. I believe this requirement should be increased to equal the 125 cases required for pediatric patients.

18. c. Exposure to the management of patients with Chronic Orofacial Pain. This is unnecessary as OroFacial Pain is on the verge of becoming a recognized specialty. Having residents observe management of OFP patients does not enhance their anesthesia education and takes up program time that could better utilized in other areas.

exposure to orofacial is not a competency and falls into the scope of an entirely different specialty and therefore should not be included here. The pediatric cases can be challenging because sometimes a patient will be 8 or 9 years of age chronologically but present with medical issues that render them frail compared to a 5 or 6 year old patient. There have been many challenging cases involving children ages 8-12 that "don't count for CODA." A subcategory should be created to allow programs to achieve perhaps a maximum of 25 of the 125 pediatric cases with children in this age category of 8-12.

The advanced airway section should be reevaluated by the new reference committee for dental anesthesiology. The section on chronic orofacial pain should also be evaluated by the reference committee. Since there is a new specialty of orofacial pain this is not needed on dental anesthesiology
We need more requirements.

**Questions 17-18 (Standards 2-5 to 2-6) - continued**

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**Program Director-Other**

18 a 3. They should do more special needs patients. The residents have to get comfortable dealing with this type of patient. A total of 75 means only 25 a year, not an impressive amount.

300 cases for a 3 year period may be too challenging (100 cases/year, 20 cases/week, 4 cases/day) I'd average it at 2 cases/day. Or average the whole year at 75 cases.

criterion is relevant but locking into a specific number may prove very difficult. I know with my residents I am unable to predict the ratio. I tell them I can always give an equivalent experience but the needs and complexity will vary from year to year.

Getting 75 cases of deep sedation/general anesthesia on special needs patients seems daunting. I can't imagine every program could meet that requirement.

I have no way of know what the appropriate # of cases should be in the above standard

Mix of sedation cases should have more nasal intubations, since the bulk of dental anesthesia cases require a nasal intubation also more cases with special needs cases should be performed for the same rational.

Seems like a high number, not sure if there is the demand for such a high number

Special needs patients will comprise many of their future patients therefore the number of completed cases should be higher. More than just exposure to patients with chronic facial pain.

**State Org**

17. Perhaps this can address a reasonable distribution of mobile, surgical center, and hospital based treatment. 18. I love seeing rigorous and specific quantities of various treatments. I just cannot judge the correct number in the given time because I have not attended a DA program.

As stated before, the management of acute and chronic orofacial pain is the purview of all dentists and therefore not relevant to this specialty.

**Site Visitor-DentAnes**

Should have more special needs and better definition.

18.a.2. Pediatric experiences should be increased to a minimum of 200
I recommend a higher number of nasal intubations (18a1), and a defined number (maybe 20?) of management of patients with chronic orofacial pain (18c).

17. Again, dentists do not provide tooth-only services in anesthesiology. The specialty should be iterated as "Anesthesiology," period. Dentists have been providing anesthesiology longer than any other profession, since DEC 1844.

#18. All of the case numbers in "a." should be increased by 50% as minimums.

Questions 17-18 (Standards 2-5 to 2-6) - continued

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Site Visitor-Other

Again qualify "exposure", have 10 patients, one rotation?

c. patients with chronic orofacial pain are not well-served by an anesthesiologist who only has an exposure to them during training. It should be made more demanding or eliminated.

In my opinion, the number of mandatory cases seems excessive.

The use of specific numerical minimum goals to demonstrate proficiency or competence does not address the resident's success or lack of success in an educational clinical experience. It just gives the residents a ceiling for clinical experiences of any quality. Once the numerical goal has been achieved, there is no reason for the resident to continue to attempt to challenge himself or herself with more challenging cases of the same type. And, what is to be done if the program is unable for whatever reason to give the resident enough cases to reach the goal?
Questions 19-24 (Standards 2-7 to 2-11)

(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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Dental Anesthesiologist

100 cases supervised by a dentist anesthesiologist is a very minimal number given the fact the rest of their profession will be dedicated solely to dental cases. We should be doing far more than 100 cases directly with a dentist anesthesiologist seeing as how this is a dental anesthesiology residency.

30 months of GA experience and 18 months in the hospital OR

Designated faculty work with numerous residents each day and who they work with changes on a daily basis. It can make it difficult for them to provide meaningful feedback.

I believe that our resident programs should include was much a a pay-1 internship year as our physician colleagues, meaning they need to have closer to 8+ months of clinical medical rotations and this will include a requirement for residents to complete 4 pgy years to attain specialty certification, an internship year PGY-1 and 3 Clinical Anesthesiology Resident training years (CA1-CA3) [redacted]. We should not be behind our physician colleagues, we should be in step and at the same level as they are. Otherwise, and likely still, there will be contention and discourse between our training pathways and "ability" to be the anesthesiologists that we claim to be.

One month is not necessary in some fields. Focus should be on pediatrics, cardiology and internal medicine.

Possible difficulty in finding hospital support for trauma anesthesia

Supervision of care does not beee to be performed by dentist anesthesiologists, physician anesthesiologist are acceptable

The educational value of certain rotations will vary by hospital and by department. Some rotations will not have any added value after 2 weeks. It should be left to the head of the residency program to determine the best utilization of the institutional resources, based on resident feedback, to best determine how long each rotation should be. A 4 week rotation may be suggested but I wouldnt advise making it a minimum length of rotation

There should be minimum months devoted specifically to the private practice models. There should be a minimum 1 month intensive care required.

with the expansion of training programs to 36 months, it would have been reasonable to expand the hospital-based anesthesia exposure to 18 months

Why is this less than the requirement for Oral and Maxillofacial Surgery resident education? There can only be one standard / requirement for competency.
Questions 19-24 (Standards 2-7 to 2-11) - continued

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Dean/CAO

20 FT is too demanding don't see why it cant be part-time 21B what is "experience" doesn't say anything 22 Four months not enough 23 two week rotations should be find

Dental anesthesiology rotation should be more than 6 month.

I do know it seems that hospital systems may not allow dentist the opportunities to train. If that becomes an issue, then it becomes a problem and alternate means of medical training will need to be addressed by CODA

Nat'l Org

#22 - good idea, but not relevant for dental anesthesia

Program Director-DentAnes

#22, the maximum of one month on pre-anesthetic assessment clinic should be eliminated #23, the one month minimum should be eliminated. This will allow for a greater experience if so desired by the program

21. a. The vast majority of cases classified as "outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists" are general anesthetics provided in the dental office environment. This is by far the most common clinical setting in which dentist anesthesiologists practice and is the environment in which the vast majority of DA residents will practice upon graduation. The office based environment is very distinct from the hospital based OR or ASU which comprise most of the clinical experience of DA residents. In order to be safe and competent in the remote dental office based setting residents should be required to experience more than a minimum of one hundred of these cases over a three year program. I would raise this requirement to a minimum of two hundred (200) cases.

The length of time on a medical anesthesia service is not the issue. The issue is that many hospital based programs emphasize (rightly so) that patient care comes first, resident education second, and everything else is tertiary. The problem is that there is NO CODA standard to point to in support of protected, academic time for all residents to receive didactic training at once. Several DA programs have accomplished the equivalent of 2 days (or 4 half days) per month of protected time where all residents are pulled from patient care for their education. The [redacted] anesthesia program (Medical) is a pioneering example of this practice that promotes resident wellness but taking 2 full days each month and taking all residents out of the OR, clinics, and rotations for learning.
Questions 19-24 (Standards 2-7 to 2-11) - continued

(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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Program Director-Other

#19 12months not 6 months of Dental Anesthesia

100 OPD cases are not enough.

21a. Supervision specifically by a dentist anesthesiologist may be tough as there aren't a ton of them available I would imagine. Might consider expanding who can provide this specific oversight (CRNA, etc).

22 and 23 My opinion is that setting one month as the standard in the hope that sufficient exposure, knowledge and understanding has been gained leaves too much to chance and the vagaries of patient scheduling. However, I realize it is not possible to cover all possible situations in a rotation. I do not have a solution to offer at this time.

23 rotations of only one month is not sufficient to expose residents to pathology and management of medical conditions

I cannot comment on exact # of procedures or # of hours in a specific discipline

State Org

19. Is six too minimal a demand for DA specific training?

Question 19 - 6 months of dental anesthesiology cases in a program designed to create graduates who can only work in dentistry sounds too little. Question 20 -

Site Visitor-DentAnees

I recommend a higher minimum time devoted to dental anesthesiology, perhaps 8 -12 months (19). I recommend removing maximum time limit for pre-anesthetic assessment clinic (22). I think minimal of 2 weeks is sufficient for some rotations, with the exception of pre-anesthetic assessment clinic, which should be a minimal of 1 month (23).

19. Same issue, "dental anesthesiology" is a non sequitur, it does not follow from what is actually done by anesthesiologists that happen to be dentists. CODA got it right in 21.a.: with: "...anesthesia for dentistry..." But, please, it is not dental or tooth anesthesiology; in fact, one does not even have to specifically anesthetize the teeth if a GA is being run as the entire CNS is the target of the specialty of Anesthesiology.

#21. Should be at least 500. This is what 95% of graduates will be doing.
Questions 19-24 (Standards 2-7 to 2-11) - continued

(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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**Site Visitor-Other**

21.a. See previous comments on specific numerical targets. 21.b. Nebulous. What does this mean in specific terms. 22. This is unclear. Does that mean the resident has to do rotations in all e areas? 23. This clears up #22. Some, b both should be reworked to make the standard understandable.

22, 23; rotations should be proscribed because for instance 4 months of pediatrics will not give adequate training.
Questions 25-32 (Standards 2-12 to 2-19)

(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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Dental Anesthesiologist

30. Time should be allowed for vacation during each year and should allow for informal study time as well.

31. There should not be part-time residents. To become proficient in anesthesiology, one must be immersed in it. In some institutions, 24 months of anesthesia training coupled with a well-structured general practice residency or pediatric dental residency will achieve competency and help satisfy many of the previously cited standards; I believe post-doctoral training beyond the dental school curriculum is more crucial to the development of a competent dentist anesthesiologist than 36 months of training where there was no post-doctoral institutional exposure prior to training.

Part time programs should not be allowed. Period.

Part time residents should not be allowed. This isn't a specialty that can be learned on a part time basis.

There are not and should never be a part time residency to become an anesthesiology. Such a program would not provide the rigor or intensity of all anesthesiology training programs for physicians and dentists in the USA.

Dean/CAO

Is there any other residency, especially one that truly deals with life and death care, that allows part-time training? What justification could there be for a part-time experience? Does the ASA offer such an experience for their medical residency? This seems absurd.

Should occur at a higher frequency.

Nat'l Org

#30 - 36 months is a very long time; a shorter period may be adequate.

Program Director-DentAnes

Residents are continuously evaluated. To demand an artificial timeline is too demanding especially since they are continuously evaluated. You don't let bad habits become ingrained because you only evaluate on a half yearly basis.
Questions 25-32 (Standards 2-12 to 2-19) - continued

(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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**Program Director-Other**

#31 - Length of part-time is too long. Concerned that will reduce effectiveness of learning. #32 - Evaluations should be evenly spaced each quarter.

#31 No part-time program #32a quarterly evaluations

31 32a

32a. evaluations should be at minimum, quarterly to ensure that goals are being met and re-evaluated. Twice a year is not enough.

32a. Evaluations should be at least Quarterly.

At least initially, I believe a review every 6 months is too long. Should be every 3 months at the most during the first year.

I believe evaluations should be more than 2 x per year. After each rotation and quarterly

More frequent assessment should be required

Quarterly reviews

This program should be no more than 2 years or 24 months. I don't see the justification for 3 years.

**State Org**

*No comments*

**Site Visitor-DentAnes**

#31. A part time program is difficult to justify today.

**Site Visitor-Other**

26c-If a resident can do a thorough H & P, it would be assumed that they can interpret one and this standard seems unnecessary. 31- don't see the need for a part-time anesthesia residency

AEGD/GPR programs have evaluations at least 3 times annually. 6 months is a long time to go if someone is not performing adequately.

CQI should include program improvement as well. Resident evals should be done at least 3 times per year, vice 2.
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).

Dental Anesthesiologist

26b should include more than laboratory studies. Include cardiac and pulmonary studies.

A problem exists with respect to the examinations administered by the American Dental Board of Anesthesiology and the current requirements. Dentist anesthesiologists are expected (by the examining board) to have experience and knowledge in areas of anesthesia for major oral and maxillofacial surgical procedures (ie. orthognathic surgery) which is not provided by some of the current residency training programs. Ideally a minimum of 25 cases of major oral and maxillofacial anesthesia would be set to bridge the gap between training programs and what is expected of the board that certifies dentist anesthesiologists.  [Name redacted]

[redacted] I would comment that the concept of a part time Dental Anesthesia residency program would not provide the continuity that the pedagogic/educational process demands specially in such critical and demanding specialty such as it is anesthesiology.

I believe 800 anesthetics and 125 pediatric cases is too few in number for 3 years. The pediatric volume should be increased to 250 and the number of general anesthetics should be a minimum of 1000. Much of our business in the private sector involves pediatric patients. I had done over 500 pediatric patients in my residency.

I think Dental Anesthesiology could really benefit from more medical school exposure, similar to how many oral surgery programs have integrated in with the associated institution medical schools.

It is my opinion that 60-75 “on-site call” experiences should mandatory to achieve CODA standard. On-call experience cannot be replicated and tests the resident’s true anesthesia competence of all aspects of their institutions education program.

rigidly structuring dental anesthesiology residencies as 36 months in duration, potentially creates funding issues in certain institutions if the program prefers first-year residents to have entered the training program after having had some other clinical experience (a GPR, another residency, or multiple years of practice beyond dental school); for example, certain [redacted] DA residencies will not receive full GME funding for a PGY-4 (or beyond) resident when the PGY-1 (and -2) year(s) were spent in a GPR or pediatric dental training program; the conundrum exists because not all dental schools provide adequate knowledge and skills for a recent graduate to thrive as a first-year dental anesthesiology resident

See earlier comments with regard to program length and need for us to match our physician colleagues. We are providing the same level of anesthesia care to our patients while in residency and afterword as attending practitioners. There is no solid argument that I am aware of which can convincingly state that we need less training than they, especially with the amount of pediatric anesthesia care our specialty provides, wherein a physician would require a 5th year of post-graduate training to fellowship in pediatric anesthesiology.
Dean/CAO
This is appropriate.

Nat'I Org
No comments

Standard 2 Comments-continued

(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).*

Program Director-DentAnes

31: Part time residents should be eliminated from this type of specialty training

Program Director-Other

31 part-time residency experience has the potential to dilute the training experience as well as increase drop-out rate of residents

All statements seem very appropriate.

Constant communication with their medical counterparts should be available during their time as residents not only for the purposes of the dental anesthesiologist's education but to better train our medical counterparts in aspects of treatment modalities and patient groups that they might otherwise be unaware of in their medical training.

State Org
No comments

Site Visitor-DentAnes

It is important to publicize that Dentist Anesthesiologists are trained to complete H&P's, just as OMS residents are.

Site Visitor-Other

24 months should be considered for program length.
Standard 3 – Faculty and Staff

Questions 33-42 (Standards 3-1 to 3-9)

(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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Dental Anesthesiologist

Being board certified is not relevant to a program director. A program should support the advancement of a program director should they decide to pursue becoming boarded, however, it should not be a requirement. What is most important is the completion at a CODA approved dental anesthesiology program and job history as it relates to dental anesthesiology as well as their competence in anesthesiology and teaching.

I believe that the program director needs to be a full time faculty employee of the sponsoring or co-sponsoring institution and 40% is insufficient.

No one should be grandfathered in as a program director. Everyone should be board certified. (Furthermore, brand new graduates should not be program directors! but that's a separate issue....) Experience is the most valuable teacher in anesthesia. This is why we require residents to do over 800 cases. To spend 36 months. And still, no one believes a resident is fully formed. We are still new. If you believe Malcolm Gladwell, it takes 10,000 repetitions to become an expert at something. This is roughly a decade of experience as a DA. This is all a way of saying that experience is the most important factor. No one should be given a free pass because of their prior position. Someone who is experienced and qualified should be able to pass a board examination. If they cannot, what business do they have teaching those who are training to become board certified? If they do not WANT to, what business do they have in an academic environment at all? All program directors should be board certified at a minimum.

Physician anesthesiologist are adequate program directors and faculty

Program director should be ADBA certified and no mention of duration of program is necessary. Only that they be ADBA certified.

Program Directors should have a minimum of two years of training, as was available at the time of their training. No one year trained faculty should be Program Director

question 34: program directors must be board certified in dental anesthesiaology... period. program directors appointed prior to January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology as well question 39: not all medical anesthesiology attendings are characterized as faculty within the dental anesthesiology training program, but oftentimes provide consultation, supervision and active teaching when residents are treating patients

The director should be equal to or more than 50% appointed with the institution
Questions 33-42 (Standards 3-1 to 3-9) - continued

(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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Dean/CAO

33. I believe the Program Director must be appointed within the sponsoring or co-sponsoring institution at least sixty percent (60%).

40% time and effort seems inadequate to ensure the quality of the educational program; this time is less than all other accredited programs (within those standards that specify a time commitment)

All faculty more than 50% need to be board certified. In addition to the full time program director, the teaching staff must have at least one full time equivalent dental anesthesiologist as defined by the institution per each authorized senior resident position. One of the teaching staff who is not the program director must be at least half-time faculty as defined by the institution.

Anesthesiology involves daily life and death care. How can a Program Director be part-time yet still be committed and sufficiently involved ith this training and care. There is a huge difference in safety of patient care - the risk of death is real - when compared to General Dentistry, Endodontics, etc.. If OMFS Program Directors are full-time, then Anesthesiology Program Directors should be also.

Calibration? of Boarded dental anesthesiologists?

Q35......for directors who graduated in less than 36mo programs in the past - should there not be a practice requirement since graduation to assure continued competency?

The program director must be full time. There should be specific requirement for other faculty both in total number and percent FTE to the program. Programs should not be run by a bunch of part time people. At the end of the day, Dental Anesthesiology is not ever going to become a meaningful specialty if they do not hire and retain true academic faculty. That means those with full time commitment to academic practice. Not part time private practitioners who drop by to cover cases. Dentistry does not need a specialty of anesthesiology if all we produce are a bunch of practitioners who provide anesthesia care. We have an entire specialty of medical anesthesiology to do that. We need committed educators to move the specialty forward. OR, it will die.

There are many people who could be program directors that are outstanding. The board certification for PD would leave many individuals out that are excellent at administration. Just because you have board certification would not necessary make you a good program director. I do believe that you could have the program director not be board certified but be an excellent administrator and educator. I do believe that some supervision in the clinical area is best served by someone with experience and a preference for those clinical duties would be some board certification based on the same criteria of 36 months, 24 months, and 12 months.
Questions 33-42 (Standards 3-1 to 3-9) - continued

(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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Program Director-DentAnes

34: This statement should specifically state the American Dental Board of Anesthesiology because this is the specific Board that is recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards. 41: This is not relevant to anesthesiology programs because residents do rotate through operating rooms at VA hospital where there is no allied dental personnel and clerical staff.

38. Since a great deal of training is done by MD anesthesiologists outside the pervue of the dental anesthesia program it is too demanding to ask the Anesthesia Department to be subject to the standard. They may or may not have their own evaluation system in their own timeline. 42. Since many of the DA and/or MDs were trained it is hard to calibrate the training. You can only give them the objectives of the training program. How they go about it, is based on their own training.

A program director should be on staff more than 50% of the time. Ideally with protected time to administer the program.

Standard 3-34: There are many people who are not board certified who are qualified to be program directors. There are not many people who want to be in education. I think that we are limiting the number of qualified candidates who may want to be a program director, but will not meet the criteria. With only eight US programs, we should allow as many qualified people as possible to become program directors.

Questions 33-42 (Standards 3-1 to 3-9) - continued

(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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Program Director-Other

#33 - Program director should be 100%. #38 - Faculty should be evaluated two times per year - every 6 months.

2 years with experience should be adequate for qualification as a director of the program. Otherwise the candidates for this position will be limited and with lack of experience.

33. The program director should be available at least 50% of the time, if not more.

33. The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program. *My suggestion is at least 60% to have authority and responsibility for all aspects of the program.

A program director should spend at least 50% of his time with the program.

Director should have > 40%

From my experience, a Director should be onsite a minimum of 50% of the time.

I feel that the program director should have at least a 50% appointment or more due to the fact that instruction becomes too varied without directional leadership presentation for the majority of the treatment time available. This may be offset by more online feedback of daily teaching and evaluation metrics by which content, participation, testing and outcomes may be assessed and reviewed however this still would represent a substantial time involvement of the program director and could not be performed at a 40% or maybe even a 50% level of participation and review

Standard 35. Add “or equivalent”.

The PD needs to be held to the same current standard as residents being trained.

who have not previously served as program directors WHY?

State Org

33. 40% commitment by program directors seems low for proper administration and continuity of education.

Question 33 - A director present only two days a week does not seem sufficient to be in charge of a graduate program.
Questions 33-42 (Standards 3-1 to 3-9) - continued

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Site Visitor-DentAnes

#33. Program directors should be required to be full time (minimum 80%).
33. My opinion is that this should be at least 51%, although I am not privy to the realities of implementing this opinion. 34. Same thing as previously, "dental" is a highly inappropriate descriptor of anesthesiology for dentistry. Even the ADA has the terminology optimized; see the ADA News article about Delta Dental 02 April 2021.
It should be more specific to state that the program direct must be certified by the ADBA. the recognized certifying board

Site Visitor-Other

41. the faculty development standard is problematic across all types of programs. If the faculty are current, credentialed, and meeting State CE requirements, I don't think this standard adds anything other than a burden to the programs.
Residents toward the end of the program and becoming ready to graduate should not need direct oversight
Standard 3 Comments

St3comm (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).*

Dental Anesthesiologist

- Being a board eligible director will suffice

- Creating more restrictions on potential future faculty and staff will only create more staff shortages.

Dean/CAO

- Peculiar expectation of a specialty with high risk of negative outcomes. Faculty time devoted to the education and monitoring of resident progress cannot fulfill obligations with a 40% time commitment.

Nat'l Org

*No comments*

Program Director-DentAnes

*No comments*

Program Director-Other

- The program must be administered by a director with one hundred percent (100%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

- All statements seem very appropriate.

State Org

*No comments*

Site Visitor-DentAnes

*No comments*

Site Visitor-Other

3-1...Program Director should be 100% Appointment at the sponsoring or co-sponsoring institution. PD should be able to practice Den Anes 20% of full time appointment (1 day per week or 2 1/2 days per week...and be involved with research 1 day per week) Basically the PD should be with residents 60% of the time clinically and 40% of the time involved with academic activities that will enhance his/her ability to lead the program.
Standard 4 – Educational Support Services

Questions 43-50 (Standards 4-1 to 4-7)

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Dental Anesthesiologist

Advanced standing should not be allowed

[redacted]. Some of the internationally trained dentists were very well prepared but must were not. Must international graduates do not have the same basic sciences courses nor the academic demand required to level to the required knowledge for such a demanding specialty as it is Dental Anesthesiology. The National Dental Boards used to be a great gauge when there was a numerical score since you could numerically determine the academic level in basic sciences however now days is a pass or fail which makes it difficult to assess. [redacted].

not all dental schools provide adequate knowledge and skills for a recent graduate to directly enter a year dental anesthesiology residency; in certain instances, additional post-doctoral training beyond dental school (such as a GPR or pediatric dental residency) would be desirable

Only domestic/Canadian graduates should be allowed

questions 46 & 47: I have not had experience with residents seeking matriculation into the program with advanced standing question 50: COVID-19 immunization should be a requirement

Resident selection should be at the discretion of the program director, based on the opinions of interviewing faculty. Written criteria are not required.

US and Canada only

Dean/CAO

50. Add COVID-19

It is almost impossible to determine international students real background. This will be another back door to get an USA license.

It is impossible to establish whether an international dental school has provided "equivalent educational background". Most hospital programs make it very difficult to credential those with this type of training and many dental boards will not license dentists with this type of training. To accept someone into a program when there is significant limitations on their ability to ever practice is wrong. Just don't accept them to start with.

Nat'l Org

No comments
Questions 43-50 (Standards 4-1 to 4-7) - continued

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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Program Director-DentAnes

Applicants should be selected from pre-doctoral institutions that are accredited by independent accrediting agencies such as CODA (U.S.) or CODA (Canada). Allowing programs or institutions to independently evaluate the curricula of international dental schools in the resident selection process makes it more likely that poorly prepared applicants will enter DA residency programs.

Should add COVID vaccine and flu shot to this list

Program Director-Other

#44 - Need to have a more thorough process of evaluating graduates of international dental schools.

"Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program" : considering the significant differences of the educational level among the international dental schools (particularly OMFS/anesthesiology), such eligibility should be carefully selected.

50 this should be mandatory

Foreign graduates should be vetted thru accredited US dental schools prior to admission to a dental anesthesiology program.

Graduates from CODA or CDAC only

Graduates from International dental schools should pass a standardized minimal assessment tool

I believe only CODA accreditation is appropriate for this particular specialty in order to serve the intended special needs population in the US.

Immunization should be required for patient safety

Potentially add COVID vaccination?

Require immunizations to be mandatory to protect staff and patients.

Should only accept graduates of ADA accredited schools. My experience has shown that the level of international education varies considerably.

Standard 50. Required, not encouraged

State Org

Questions 43-50 (Standards 4-1 to 4-7)

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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Site Visitor-DentAnes

It is impossible for a program to determine that an international dental school's training is equivalent to a US school.

It would be difficult to admit an advanced standing resident today.

Site Visitor-Other

46. Are there any addition criteria for admission to Advanced Standing? Seems to me there should be. 49. What does "parallel" mean? Shouldn't they be the same? 50. Shouldn't this list other communicable diseases, like Covid-19 that can be immunized against?

International dentists must demonstrate that they have credentials to obtain a license in the USA ie have completed the alternate pathway for licensure in the US.

The international standing should be standardized and not left to the program.
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).

Dental Anesthesiologist

It is my understanding that there is implicit or true bias against advanced standing graduated applicants who are enrolled or have completed prior residency training due to the financial impact this has on GME funding of these residents throughout their 36 months of training. This creates a real problem for advancement of our society as residents with prior post-graduate experience in a hospital-based training program or work will bring significant preparation and value to the program as they integrate with their affiliate hospitals and physician faculty colleagues. To deny them residency or diminish the competitiveness of their application package is unethical and ultimately hurts our specialty in the long run. Such practices need specific policy statements against such bias.

Dean/CAO

No comments

Nat'l Org

No comments

Program Director-DentAnes

No comments

Program Director-Other

Include a requirement for a COVID-19 vaccination.

International Doctors may not be eligible to practice in many states without an US degree.. Needs to be defined well at the beginning. They may train but may not be able to practice

State Org

No comments

Site Visitor-DentAnes

Immunization against SAR-COV-2 should be included in the list on question 50

Site Visitor-Other

What about COVID vaccination?

would ad flu and Covid-19 we are encouraging not requiring so include it.
Standard 5 – Facilities and Resources

Questions 51-60 (Standards 5-1 to 5-7)

(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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Dental Anesthesiologist

52 should say "medical and anesthetic emergencies" not just medical.  53.  Should say "all applicable accrediting bodies AND/OR state rules and regulations" as this is better for mobile practices.

53. All documents state that we must be in compliance with all regulations, yet dental offices and clinic practices often do not adhere to these standards, nor are they taught in training.

All FACULTY should have current ACLS and PALS certification

All instructors MUST be BLS/ACLS/PALS certified.

policies on radiation hygiene? Come on, this is a waste of time. It's important but do we want programs wasting time on nonsense like this?

This should be available and reviewed with enrolled residents, not required to provide to applicants, in my opinion.

Dean/CAO

54. As written, this standard is sufficiently demanding for all enrolled residents. It is too demanding for faculty in that there may be those who specialized in pediatric anesthesia and do not supervise adult anesthesia and vice versa.

PALS is not relevant if the faculty overseeing the particular care is not ever overseeing anesthesia for children.

Nat'I Org

No comments

Program Director-DentAnes

60. Since the implementation of HIPPA regulations nationally , this standard is irrelevant.

Program Director-Other

#55 - Should be ACLS not BLS.

55 ACLS should be minimum
Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients - too demanding to make them available to all applicants and patients.

For this residency, I think all faculty and staff involved in patient care should have ACLS or PALS in addition to BLS.

Ideally at least two auxiliary staff (dental anesthesia assistants, nurses, etc.) should be ACLS certified, two in case one is out on any given day.

**Questions 51-60 (Standards 5-1 to 5-7) - continued**

(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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**State Org**

*No comments*

**Site Visitor-DentAnes**

There may be some attendings that never treat children. They should not be required to have PALS. Wording it as ACLS and/or PALS as appropriate makes sense.

**Site Visitor-Other**

58. What policies? Does this include regulations?
Standard 5 Comments

(Optional) Please use the space below to enter any comments you have related to Standard 5 - Facilities and Resources.

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).

Dental Anesthesiologist
No comments

Dean/CAO

Q55.....is "not included in Q56" correct or should it be Q54?

Nat'l Org
No comments

Program Director-DentAnes

If a. hospital is accredited by the joint commission and/or CMS then this is redundant and assumed to be true. If the program is dental school based, then perhaps compliance must be demonstrated, but for a hospital based program, the entire standard could just be summarized with a joint commission certificate.

Program Director-Other

All statements seem very appropriate.

State Org
No comments

Site Visitor-DentAnes
No comments

Site Visitor-Other
No comments
Standard 6 - Research

Question 61 (Standard 6)

(Optional) You indicated that Question 61 was "Too demanding", "Not demanding", or "Not relevant". Please explain the rating 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).

Dental Anesthesiologist

I month of research should be optional and not required.

Need one month of full time dedicated for the scholarly activity. Not a sufficient time to engage in scholarly activity to present in a scientific journal while fully on schedule

One month of a 36 month program for scholarly activity is too long. It would be better to describe what constitutes qualifying "scholarly activity" without a minimum dedication of time.

One month of scholarly activity that is presented in an educational forum is reasonable. Clinical research with IRB approval leading to publication is not. Not all residents are "researchers" and are of the opinion that "research" is heavily encouraged (mandated) in order to bring certain times of grant dollars to the program. Often research projects take much more time than the 30 day minimum, thus taking time away from much needed study time given the heavier didactic load an anesthesia residency has comparatively to other dental residencies.

Presentation not necessary

There are few actual research opportunities in many residency programs

three to four weeks would work out better for residents.

Dean/CAO

61 one month of research is useless. This is not a well written standard. The idea is the product not the time. Research is a vital component of the program and there ought to be something written re. "sufficient time" to conduct scholarly activity leading to presentation at a scientific forum. If your intent, on the other hand is to guarantee that the programs reserve this time for this purpose, than perhaps not so bad. needs clarification, to ensure programs don't claim that directors cannot say that " patient demand necessitate the resident be in clinical care 100% of the time."

It should be more than one month

One month is too limited a time to produce credible research. It needs to be over many months throughout the program. Saying one month provides excuses for not devoting sufficient time to a research project. It takes time to even put the project together, go through an IRB. And most projects are done throughout the year to patients being treated. It is impossible to do this in a month.

seems minimal

the standard should be directed towards the quality and impact of scholarly activity, not a quantitative measure
This is too minor a requirement. In this field, in particular, a higher level of scholarship than this is essential for the future advancement of the discipline.

**Question 61 (Standard 6) - continued**

(Optional) You indicated that Question 61 was "Too demanding", "Not demanding", or "Not relevant". Please explain the rating 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).*

**Nat'l Org**

*No comments*

**Program Director-DentAnes**

61: This standard needs to be reworded as it is too restrictive. Programs need to have the liberty to have their residents take part in scholarly activity without stipulating 1 month. The standard should state types of scholarly activity that are acceptable, i.e. case reports, senior presentations to the anesthesia department, lectures to predoctoral students, articles in anesthesia journals, etc.

**Program Director-Other**

to vague, one month.

**State Org**

One month does not seem to be adequate to gain experience in evidence-based research, completion of a project and presentation at a meeting. Need more time.

#61 - clinical relevance of a mandatory research period is dubious.

**Site Visitor-DentAnes**

*No comments*

**Site Visitor-Other**

Very vague - is this one continuous month, or a total of one month distributed over the program? What does scholarly activity mean?

In my 2 year residency, I had to publish a Thesis based upon research I conducted, if I wanted my degree. It is unclear whether or nor these residencies will offer degrees or certificates, or both, and what the minimum research Standard would be for each credential.

This is a throw-away unless there is some ongoing or sustained research component
One month of research is inadequate.

6-1...one month is not sufficient for a meaningful research experience. The research experience should be maintained throughout the entire 36 month program culminating in significant results to present/publish.
Standard 6 Comments

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

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).

Dental Anesthesiologist

Research should be not be mandated part of regular curriculum. Opportunity for those residents interested in research should have additional time budgeted from normal schedule/curriculum to achieve desired, qualified research projects as long as all other standards are met. While the language used within this standard is sufficiently demanding, there are programs that do not further define the forum to include presentation at a national meeting or publication in a peer-reviewed journal; simply presenting care reports within the confines of the hospital dental and/or anesthesiology departments does not adequately demonstrate competency in this standard; the term "forum should be more specifically defined to include presentation at a national meeting or publication in a peer-reviewed journal.

Dean/CAO

Each resident should get a masters degree and one publication in the medical or dental literature.

This is too minor a requirement. In this field, in particular, a higher level of scholarship than this is essential for the future advancement of the discipline.

Nat'l Org

No comments

Program Director-DentAnes

No comments

Program Director-Other

A general, if not exclusive commitment to Evidence Based Learning and Peer reviewed article review should govern the research.

A requirement for a literature review research paper on a particular topic of dental anesthesiology would be a good exercise for residents.

#61 research in program should be optional

State Org

No comments

Site Visitor-DentAnes

No comments

Site Visitor-Other

No comments
**Dental Anesthesiologist**

Can’t stress enough the importance of the “On-call” experience. All medical/physician anesthesiologists take call as part of their programs to test and apply their anesthesia knowledge. As true specialists of anesthesia for dentistry, residents what do not participate in 60-75 on-call experiences in their time as dental anesthesia residents are at a disadvantage. They lose respect from other anesthesia professionals and the lacking experience will be a disservice to their future patients.

I never thought anesthesiology would be allowed to be a recognized specialty in dentistry. Dirty politics was finally defeated. I may never live to see it, but I hope for a day when every US dental school has a residency, and dentist anesthesiologists practice with their physician colleagues in every hospital system.

Should have a mobile component and and optional operator anesthesia component.

There is a severe lack of dental anesthesiologists that wish to be faculty and staff in institutions and dental schools due to the severe discrepancy of income and lifestyle. There should be a concerted effort to bring more people to the forefront by decreasing barriers to entry to undertake such a noble task of teaching.

There needs to be a minimum requirement for time spent in the dental office providing anesthesia. In my opinion, it scares me that residents can graduate a dental anesthesia program and never have a mobile aspect to their training! Most DAs after graduation do not work in institutional settings.

We have a bright future ahead, should we take the necessary and important steps not to set ourself up for equality in training and ability of our future graduates. This will require use to keep pressing forward until we are in step and at the same level of post-graduate training as our physician colleagues. Leave no room for argument, perceived or true, in the knowledge, skills, abilities and experiences of our graduates into this incredible specialty of dentistry, anesthesiology.

**Dean/CAO**

Having board certification tied to membership in another organization is problematic as it seems too internal a process. The thought was that once the ADA certified dental anesthesia as a specialty, that all would need to go through some process. This process seemed tied to being a member of a specific group and that seems too self-serving. If grandfathering was to be done, then other historic criteria of equivalent nature should be permitted the grandfathering. People would for various reasons were not in a specific organization left some people would lived through the time when dental anesthesia was a difficult due to various dental board restrictions on dental anesthesia providers. I would suggest that the National Board of Anesthesia members be allowed to grandfathered to clean up some of the historic biases. This would be a very few exceptions and would seem the right thing to do as dental begins a new history of providers of anesthesia.

This survey was much too long!

Why is CODA doing this specialty?
Other comments - continued

Nat'l Org
No comments

Program Director-DentAnes

No comments

Program Director-Other

All statements and proposed requirements seem very appropriate.

Consistent with standards for other accredited programs. Reads well. Unambiguous.

Thank you to CODA for taking the time and effort to put forth standards and guidelines to promote better dental education for the provider and to ultimately provide better treatment outcomes for the patient.

This has been a long time in the making, but is well thought out and formulated. Thanks for the opportunity to participate in the 'genesis' of this specialty area of dentistry.

This program must be held to the same basic CODA standards as any other dental specialty program.

State Org

I am not a DA and have humbly performed only 300 moderate pediatric sedations. A school of thought that I applied every day was something not presented in my sedation courses. Rather, this training came from avalanche safety training. The study of heuristics addresses the pressures that can influence a doctor to start a case despite red flags. Heuristics can help a provider recognize these traps before they get into trouble. I think it is also important to emphasize ethics. There have been occasional concerns about pressure by GP's placed on DA's to start cases that the DA may not be comfortable with. There have also been occasional concerns about the pressure to start another case when the patient recovering may benefit from additional direct monitoring. Thank you for taking the time to review my feedback.

Site Visitor-DentAnes

Thank you for reaching out. "Dental" Anesthesiology should be changed. There are indeed dentists that administer anesthesia for non-dental cases or dental cases in addition to non-dental parameters, such as facial fractures (that may be in an edentulous patient by the way) and a fractured leg. We are simply "Anesthesiologists, as recognized by multiple non-CODA entities. Call me anytime. [Name redacted]

Site Visitor-Other

Great survey - best wishes and thanks for what you do!
Appendix

Survey Instrument
Validity and Reliability Surveys - DentAnes

Start of Block: INTRODUCTION

Q2
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.
Q71 Listed in this survey are the accreditation standards by which the Commission on Dental Accreditation and its 
site visitors evaluate Dental Anesthesiology programs for accreditation purposes. (The complete standards for 
Dental Anesthesiology 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 Dental Anesthesiology educational 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

Start of Block: STANDARD 1 -Q1-12

Q123
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance 
of the criterion to the Dental Anesthesiology educational program.

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

Q128 STANDARD 1 - INSTITUTIONAL AND PROGRAM EFFECTIVENESS
ST1-1.1 1. The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital.

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

ST1-1.2 2. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

ST1-1.3 3. United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization
recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria.

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

ST1-2 4. 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
ST1-3 5. The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

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

ST1-4 6. The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.

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

Q1_6comm (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).

________________________________________________________________
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Q84
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

Q139 STANDARD 1 - INSTITUTIONAL AND PROGRAM EFFECTIVENESS (continued)

ST1-5 7. Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST1-6 8. The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

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<th>Too demanding</th>
<th>Sufficiently demanding</th>
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<th>Not relevant</th>
<th>No opinion</th>
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<tbody>
<tr>
<td>a. Vote and hold office;</td>
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<td>b. Serve on institutional staff committees; and</td>
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<td>c. Admit, manage and discharge patients.</td>
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</table>

ST1-7 9. Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST1-8 10. The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:

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<tbody>
<tr>
<td>a. Anesthesia for dentistry;</td>
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<td>b. Resident education; and</td>
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<td>c. Patient care and include training residents to provide dental anesthesia care in office-based and hospital settings.</td>
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ST1-9 11. The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

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

Q154 **Ethics and Professionalism**
ST1.11 12. The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

Q7_12comm (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).

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St1comm (Optional) Please use the space below to enter any comments you have related to Standard 1 - Institutional and Program 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).

________________________________________________________________
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Q38
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

ST2-1 13. The program must list the written competency requirements that describe the intended outcomes of residents’ education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-
pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-2 14. Upon completion of training, the resident must be:
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<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tr>
<td>a. able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;</td>
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<tr>
<td>b. able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;</td>
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<td>c. competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;</td>
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</table>
d. competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;

e. competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;

f. competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
g. competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

h. competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region;

i. familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and

j. able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

Q13-14comm (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).
Q155
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

Q156 STANDARD 2 - EDUCATIONAL PROGRAM (continued)
Curriculum Content (continued)

ST2-3 15. The program must have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program's written competency requirements.

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

Q126 Didactic Components
Q159 16. Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

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<th>Not relevant</th>
<th>No opinion</th>
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<tr>
<td>a. Applied biomedical sciences foundational to dental anesthesiology,</td>
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<td>b. Physical diagnosis and evaluation;</td>
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<td>c. Behavioral medicine;</td>
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<td>d. Methods of anxiety and pain control;</td>
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<td>e. Complications and emergencies;</td>
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<td>f. Pain management, and</td>
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<td>g. Critical evaluation of literature.</td>
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Q15-16comm (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).
Q124
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

Q160 STANDARD 2 - EDUCATIONAL PROGRAM (continued)

Clinical Components

ST2-5 17. The program must ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program’s stated goals and competency requirements in dental anesthesiology.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-6a 18. The following statements represent the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:
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<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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</thead>
</table>
a. Eight hundred (800) total cases of deep sedation/general anesthesia to include the following: | | | | | |
| 1. Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway techniques can be blind nasal intubations. | | | | | |
| 2. One hundred and twenty five (125) children age seven (7) and under, and | | | | | |
| 3. Seventy-five (75) patients with special needs. | | | | | |
b. Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation;

c. Exposure to the management of patients with chronic orofacial pain.

Q17_18comm (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).
Q162
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

Q163 STANDARD 2 - EDUCATIONAL PROGRAM (continued)
General Anesthesia Experience/Anesthesia Service

ST2-7 19. At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period must be devoted exclusively to clinical training in anesthesia, of which a minimum of six (6) months are devoted to dental anesthesia.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-8 20. Residents must be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

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

Q167 Outpatient Anesthesia for Dentistry

ST2-9 21. At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

<table>
<thead>
<tr>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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</thead>
<tbody>
<tr>
<td>a. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.</td>
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<tr>
<td>b. Experience as the provider of supervised anesthesia care.</td>
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Q127 Medicine Rotations

ST2-10.1 22. Residents must participate in at least four (4) months of clinical rotations from the following list: Cardiology, Emergency medicine, General/internal medicine, Intensive care, Pain medicine, Pediatrics, Pre-anesthetic assessment clinic (max. one [1] month), Pulmonary medicine.

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

ST2-10.2 23. If more than one rotation is selected [from the list in Question 24], each must be at least one month in length.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
Q173 24. Each assigned rotation or experience must have:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<td>a. Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;</td>
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<td>b. Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and</td>
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<td>c. Evaluations performed by designated faculty.</td>
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Q21-24comm (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).
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

Q172 STANDARD 2 - EDUCATIONAL PROGRAM (continued)

ST2-12 25. Residents must be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-13 26. The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:
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<thead>
<tr>
<th></th>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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</thead>
<tbody>
<tr>
<td>a. Taking, recording, and interpreting a complete medical history;</td>
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<td>b. Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;</td>
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<tr>
<td>c. Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and</td>
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</table>
d. Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

Q179 Other Components

ST2-14 27. The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST2-15 28. Residents must be given assignments that require critical review of relevant scientific literature.

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

ST2-16 29. The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.

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

Q182 Program Length
ST2-17 30. The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

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

ST2-18 31. Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

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

Q185 Evaluation
ST2-19 32. The program's resident evaluation system must assure that, through the director and faculty, each program:
<table>
<thead>
<tr>
<th></th>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tbody>
<tr>
<td>a. Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;</td>
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<td>b. Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and</td>
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</table>
c. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Q25-32comm (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).

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St2comm (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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Q46
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

ST3-1 33. The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-2.1 34. The program director must be board certified in dental anesthesiology; program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology.

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

ST3-2.2 35. The program director must have completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. (A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.)

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-3 36. All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.

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

ST3-4 37. The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

☐ Too demanding
☐ Sufficiently demanding
☐ Not demanding
☐ Not relevant
☐ No opinion
ST3-5 38. A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

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

ST3-6 39. A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-7 40. The program must show evidence of an ongoing faculty development process.

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

ST3-8 41. At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for efficient administration of the program.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST3-9 42. The program must provide ongoing faculty calibration at all sites where educational activity occurs.

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

Q33_42comm (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).

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St3comm (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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End of Block: STANDARD 3 - Q33-42

Start of Block: STANDARD 4 - Q43-50

Q73
For each "must" statement, please select the option that most closely reflects your opinion in terms of the relevance of the criterion to the Dental Anesthesiology educational program.

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

Q142 STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

ST4-1 43. The sponsoring institution must provide adequate learning resources to support the goals and objectives of the program.

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

Q192 Selection of Residents
ST4-2 44. Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology: Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation; Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation of Canada; and Graduates from an International dental school with equivalent educational background and standing as determined by the institution and program.

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

Q44 comm (Optional) Please specify the element(s) of Question 44 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).

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ST4-3 45. Specific written criteria, policies and procedures must be followed when admitting residents.

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

---

ST4-4.1 46. Admission of students/residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program.

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

---
ST4-4.2 47. Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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

ST4-5 48. The program’s description of the educational experience to be provided must be available to program applicants and include:

<table>
<thead>
<tr>
<th></th>
<th>Too demanding</th>
<th>Sufficiently demanding</th>
<th>Not demanding</th>
<th>Not relevant</th>
<th>No opinion</th>
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<tbody>
<tr>
<td>a. A description of the educational experience to be provided;</td>
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<tr>
<td>b. A list of competencies of residency training; and</td>
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<tr>
<td>c. A description of the nature of assignments to other departments or institutions.</td>
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</table>
Q276 Due Process

X

ST4-6 49. There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

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

Q194 Health Services

X

ST4-7 50. Resident, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
Q43Q45-50comm (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).

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St4comm (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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End of Block: STANDARD 4 - Q43-50

Start of Block: STANDARD 5 - Q51-60

Q268

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

Too demanding = Criterion is relevant to type of program but too demanding for programs and/or residents
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Not demanding = Criterion is relevant but not demanding enough for programs and/or residents
Not relevant = Criterion not relevant to type of program, regardless of how demanding it is for programs and/or residents
No opinion = No opinion on this criterion
Q118 STANDARD 5 - FACILITIES AND RESOURCES

ST5-1.1 51. Institutional facilities and resources must be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards.

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

ST5-1.2 52. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-2 53. In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies must be available in accord with all applicable accrediting bodies and state rules and regulations.

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

ST5-3 54. All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care must be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-4 55. All other faculty (not included in Question 56) and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support for health care providers.

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

---

ST5-5 56. Secretarial and clerical assistance must be sufficient to permit efficient operation of the program.

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

---
ST5-6.1 57. The program must document its compliance with the institution's policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases.

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

ST5-6.2 58. Policies must be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance.

- Too demanding
- Sufficiently demanding
- Not demanding
- Not relevant
- No opinion
ST5-6.3 59. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients.

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

ST5-7 60. The program’s policies 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

Q51-60comm (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).
St5comm (Optional) Please use the space below to enter any comments you have related to Standard 5 - Facilities and Resources.

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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End of Block: STANDARD 5 - Q51-60

Start of Block: STANDARD 6 - Q61

Q143

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

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

Q143 STANDARD 6 - RESEARCH

X+
ST6 61. Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

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

Q61 (Optional) You indicated that Question 61 was "Too demanding", "Not demanding", or "Not relevant". Please explain the rating 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).

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St6comm (Optional) Please use the space below to enter any comments you have related to Standard 6 - Research.

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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Q114 (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)._  

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Q115 Thank you for your assistance with this research project.

_Please click "Finish" to complete the survey._
CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN DENTAL ANESTHESIOLOGY RELATED TO PATIENTS WITH SPECIAL NEEDS

**Background:** 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 graduates to be competent in treating patients with special needs. The Council on Dental Education and Licensure’s request is found in Appendix 1.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) considered the request for proposed revision to the Accreditation Standards for Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, and Orofacial Pain submitted by the Council on Dental Education and Licensure. The AGDOO RC believed that the Accreditation Standards for each of the disciplines under its purview should be further studied to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted. Further, the AGDOO RC recommended that the new Review Committees on Dental Anesthesiology, which will conduct its first meeting in Winter 2022, further study its specific Accreditation Standards with a report to the Commission at its Winter 2022 meeting. At its August 5, 2021 meeting, the Commission agreed and directed the new Dental Anesthesiology Review Committee to further study the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted with a report to the Commission at its Winter 2022 meeting.

**Summary:** The Dental Anesthesiology Review Committee (DentAnes RC) is requested to further study the proposed revision to the Accreditation Standards (Appendix 1) submitted by the Council on Dental Education and Licensure. 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: Ms. Peggy Soeldner
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 Tooks, director, Commission on Dental Accreditation
    Ms. Karen M. Hart, director, Council on Dental Education and Licensure
REPORT ON DENTAL ANESTHESIOLOGY ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for dental anesthesiology programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020.

At its Summer 2020 meeting, the Commission on Dental Accreditation approved revisions to the Annual Survey Curriculum Section for implementation in Fall 2022. The approved Curriculum Section of the Annual Survey for dental anesthesiology programs can be found in Appendix 1.

**Summary:** The Review Committee on Dental Anesthesiology (DentAnes RC) is requested to review the draft Curriculum Section of the Annual Survey of its discipline-specific Annual Survey (Appendix 1).

**Recommendation:**

Prepared by: Ms. Peggy Soeldner
Underline indicates addition; Strikethrough indicates deletion

Start of Block: DentAnes Curriculum (Q21-26)

Part II - Dental Anesthesiology Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did residents spend in each of the following areas during the 2017-18 2021-22 residency year? Column must add up to 100%. Do not enter percent signs.
<table>
<thead>
<tr>
<th>First Year</th>
<th>Second Year</th>
<th>Third Year</th>
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<tbody>
<tr>
<td>a. Anesthesia for ambulatory dental procedures provided in a dental clinic or in a facility outside the hospital operating rooms including office-based venues (Standards 2-6; 2-7; and 2-9)</td>
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<tr>
<td>b. Anesthesia for dental inpatient or same-day surgery within the hospital operating rooms</td>
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<td>c. Rotation/assignments to other services (Standard 2-10)</td>
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<td>d. Didactics: conferences/seminars (Standards 2-1; 2-2; 2-3; 2-4)</td>
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<td>e. Teaching (Standard 2-15)</td>
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<tr>
<td>f. Investigative work (Standard 6-1)</td>
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<td>g. Other, please specify (Standards 2-12 and 2-13)</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

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22. Please indicate the number of clock hours residents spent in lectures, seminars or formal courses when on the medical/dental service during the 2017-18 2021-22 residency year. (Standards 2-2 and 2-3)
<table>
<thead>
<tr>
<th>First Year Clock Hours</th>
<th>Second Year Clock Hours</th>
<th>Third Year Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Applied biomedical sciences <em>(Standard 2-4 a)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Physical diagnosis and evaluation <em>(Standard 2-4 b)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Behavioral medicine <em>(Standard 2-4 c)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Techniques of anxiety and pain control <em>(Standard 2-4 d)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Complications and emergencies <em>(Standard 2-4 e)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Pain management <em>(Standard 2-4 f)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
g. Critical evaluation of literature
(Standard 2-4 g)
23. Please indicate the number of weeks residents spent on the following clinical rotations/assignments during the 2017-18 2021-22 residency year.
<table>
<thead>
<tr>
<th>First Year: Number of weeks</th>
<th>Second Year: Number of weeks</th>
<th>Third Year: Number of weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cardiology (Standard 2-10 a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Emergency medicine (Standard 2-10 b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. General/Internal medicine (Standard 2-10 c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Intensive care (Standard 2-10 d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Pain clinic/service (Standard 2-10 e)</td>
<td></td>
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<tr>
<td>f. Pediatrics (Standard 2-10 f)</td>
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<tr>
<td>g. Other, please specify (Standard 2-10 g)</td>
<td></td>
<td></td>
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<tr>
<td>h. Other, please specify (Standard 2-10 h)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Other, please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use this space to enter comments or clarifications for your answers on this page.

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Page Break
Part II - Dental Anesthesiology Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

24. Please provide the number of cases/procedures the 2018-2022 graduates completed/performed throughout the entire three-year residency program.
<table>
<thead>
<tr>
<th>Highest number</th>
<th>Lowest number</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Deep sedation/general anesthesia cases <em>(Standard 2-6 a)</em></td>
<td></td>
</tr>
<tr>
<td>b. Intubated general anesthetics cases <em>(Standard 2-6 a.1)</em></td>
<td></td>
</tr>
<tr>
<td>c. Nasal intubations <em>(Standard 2-6 a.1)</em></td>
<td></td>
</tr>
<tr>
<td>d. Advanced airway management techniques <em>(Standard 2-6 a.1)</em></td>
<td></td>
</tr>
<tr>
<td>e. Cases of children age 7 and under <em>(Standard 2-6 a.2)</em></td>
<td></td>
</tr>
<tr>
<td>f. Patients with special needs <em>(Standard 2-6 a.3)</em></td>
<td></td>
</tr>
<tr>
<td>g. Ambulatory patients</td>
<td></td>
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<td></td>
<td></td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>h. Patients over age 65</td>
<td>(Standard 2-6 b)</td>
</tr>
<tr>
<td>i. Patients with physical status ASA III or greater</td>
<td>(Standard 2-6 b)</td>
</tr>
<tr>
<td>j. Patients requiring moderate sedation</td>
<td>(Standard 2-6 b)</td>
</tr>
<tr>
<td>k. Patients with chronic orofacial pain</td>
<td>(Standard 2-6 c)</td>
</tr>
</tbody>
</table>

25. How many months, over their entire three-year residency, do the residents devote exclusively to clinical training in anesthesiology?  **(Standard 2-7)**

26. How many months, over their entire three-year residency, are the residents assigned to a hospital anesthesia service that provides trauma and/or emergency surgical care?  **(Standard 2-8)**
Use this space to enter comments or clarifications for your answers on this page. 

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End of Block: DentAnes Curriculum (Q21-26)
CONSIDERATION OF PROPOSED REVISION TO STANDARD 3-1 OF THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ORAL MEDICINE

**Background:** On May 4, 2021, the Commission on Dental Accreditation received correspondence from the faculty at the University of Rochester, Eastman Institute for Oral Health (Appendix 1) requesting a revision to Standard 3-1 of the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine. Oral Medicine Standard 3-1 states “The program must be administered by an appointed director who is full-time faculty and who is board certified in oral medicine.” The University requests that individuals with “equivalent educational qualifications in oral medicine” also be eligible to serve as program directors of CODA-accredited oral medicine programs.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) considered the request for proposed revision to Standard 3-1 of the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine. The AGDOO RC noted the rationale for the request included the desire to develop future oral medicine faculty and increase the number of oral medicine programs. However, as noted in the request, identifying adequately trained individuals qualified to serve as program directors for new programs is challenging due to the accreditation requirement that program directors be board certified. The request noted that many oral medicine faculty are internationally trained and internationally boarded, which also presents a barrier to initiating new programs.

Through discussion, the AGDOO RC expressed concern that the language “equivalent educational qualifications in oral medicine” could present challenges in verifying program director qualifications because of the potential need for review by a discipline-specific oral medicine review committee member or Commissioner at the time a new program director is appointed, especially if the applicant is foreign-trained. The AGDOO RC agreed this level of review and verification could create a delay in verifying program director qualifications. Additionally, the Commission does not determine the equivalence of educational preparedness or educational qualifications of individuals within its role as an accrediting agency. The AGDOO RC also noted that, while the specific request is that individuals with “equivalent educational qualifications in oral medicine” be eligible to serve as program director, the request also noted that Orofacial Pain Standards include “educationally qualified” as a possible alternative to board certification for an Orofacial Pain program director. Orofacial Pain defines “educationally qualified” as “Board eligible in orofacial pain or successful completion of an orofacial pain program of at least two years in length.” The AGDOO RC believed this may be more appropriate language, but that careful attention would have to be given to defining “educationally qualified” due to the potential complexities in determining “educationally qualified,” especially for foreign-trained faculty.
Following lengthy discussion, the AGDOO RC concluded this request should be further studied, through referral to the newly formed Review Committee on Oral Medicine, which will conduct its first meeting in Winter 2022, to determine if revision to Standard 3-1 is warranted. At its August 5, 2021 meeting, the Commission agreed and directed the new Review Committee on Oral Medicine further study the request to revise Standard 3-1 of the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine, with a report for consideration by the Commission in Winter 2022.

**Summary:** The Oral Medicine Review Committee (OM RC) is requested to further study the request to revise Standard 3-1 of the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine (*Appendix 1*) submitted by the faculty at the University of Rochester, Eastman Institute for Oral Health. 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: Ms. Peggy Soeldner
Dear Ms. Soeldner,

We are writing to you to request a change in the Oral Medicine program director standard to be considered by the Review Committee and Commission at their Summer 2021 meetings. Specifically, we request the standard 3-1 be changed from:

“The program must be administered by an appointed director who is full-time faculty and who is board certified in oral medicine.”

to

“The program must be administered by an appointed director who is full-time faculty and who is board certified in oral medicine or has equivalent educational qualifications in oral medicine”.

This replicates the model that exists in the CODA standards for Orofacial Pain programs.

We recognize that a change in standard requires substantial justification and will be subject to the endorsement of the communities of interest. We shall provide background and rationale for this change, a summary statement and attempt to identify and answer questions that might arise in the consideration of this request.

Background and Rationale

Oral Medicine is an important field in dentistry that interfaces closely with medicine. This has been acknowledged recently by the profession with the recognition of Oral Medicine as a specialty. Moreover, the American Board of Oral Medicine was recognized by the National Commission, during their meeting on April 2021, as the official board of the Oral Medicine specialty. Oral Medicine professionals provide unique specialized service for their patients. A recent publication regarding the history of Oral Medicine in the US suggests that the number of Oral Medicine programs and specialists is at a plateau, with no likely increase without some intervention.¹ A recent Editorial outlined the achievements of the American Academy of Oral Medicine during since its establishment 75 years ago, and identified the training of the next generation as a cornerstone for the success of this profession: ²

“Our future must consist of clinicians who are well trained to provide novel biologic therapies, regardless of whether the delivery of these therapies is currently practiced. Innovation dictates
the training of practitioners who have expertise to treat oral cancer; who are involved in wellness management; whose clinics employ nurse practitioners; whose practices have strong referral linkages to primary care providers, pharmacists, physicians, physical therapists, and alternative medicine providers; and who endorse alternative practice models, including telemedicine and integrated care models.”

While there are no readily available data regarding the reasons that limit institutions from opening new Oral Medicine programs, based on our experience, we believe that financial barriers may be an important factor. Similarly, lack of fiscal viability post-graduation is likely a factor in limiting the number of applicants to programs. Clearly, these are important issues to address but increasing the number of programs is likely a multifactorial problem and all possibilities should be considered. Post-graduate programs in Oral Medicine remain key in generating the future professionals. Currently there are 9 CODA-approved Oral Medicine programs, 6 in the US and 3 in Canada. NIH supported research in Oral Medicine has decreased in the last decades\(^1\). This may be a result of Oral Medicine programs lacking the capacity for research and training with an academic focus.

Efforts to advocate recognizing Oral Medicine as a specialty in the US achieved success with the American Board of Dental Specialties recognizing Oral Medicine as a specialty.\(^2\) Furthermore, ADA recognition of Oral Medicine as a specialty was granted in early 2020. These, as well as other successes, are outlined in the Editorial celebrating the 75 years of the AAOM.\(^2\)

These successes are encouraging. They emphasize the importance of increasing the number of Oral Medicine programs, in order to increase the number of Oral Medicine specialists to meet the needs for Oral Medicine in the community. There are many barriers to achieving this goal, as mentioned previously, and innovative approaches to address these, should be explored. One barrier is finding adequately trained academic oriented Oral Medicine program directors given the CODA requirement for American certified program directors.

Clearly, all Oral Medicine programs need to be at the highest standards of education, and CODA standards play an important role in defining the requirements for these programs. This includes the standard that program directors be board certified. While this is a perfectly reasonable approach to ensure high-quality programs, it might be restrictive as some institutions already have highly qualified faculty who could fulfill this role. These faculty, including potential Oral Medicine program directors, have graduated from excellent international programs, are not board certified in the US, yet meet these certification standards in their own countries.

The current CODA standard for program director is phrased in very specific language relative to other programs that were accredited by CODA in the last decade. For example, the Orofacial Pain program defines the program director requirements as being board-certified or educationally qualified in orofacial pain. This approach, and possibly others, might provide some flexibility in judging and then including Oral Medicine faculty, trained in countries with high standards and requirements for Oral Medicine specialists, as possible directors of programs.
Please note the attached addendum which provides answers to potential questions on this proposal.

Summary statement

The recent recognition of Oral Medicine as a specialty and the ABOM as the certifying board, signals potential significant growth and achievements in clinical service, education and research of the discipline. More than ever before, Oral Medicine depends on training programs to develop the next generation of Oral Medicine specialists. While CODA has provided clear standards assuring high quality in Oral Medicine residency program, the standard for program director bears examining. Currently that standard requires that program directors are board certified by a professional board. While this standard for a program director is a perfectly appropriate requirement, it limits the potential to open Oral Medicine residency programs in some US academic institutions. Given the need to increase the research capacity of Oral Medicine, those institutions that are research intensive are of note. There are US academic institutions that have all the necessary elements for an Oral Medicine residency program, including research resources, and who have excellent Oral Medicine faculty who are board certified in their country of origin and leaders in academic oral medicine, but who don’t meet the CODA standard for a program director. A change in the standard for program director would allow these institutions to take advantage of the presence of these faculty to develop Oral Medicine residency programs in accomplished academic environments.

A change in the program director standard, as suggested, can allow available high-quality international faculty, to assume leadership positions in programs.

Sincerely,

Eli Eliav, DMD MSc PhD
Professor and Director,
EIOH
Vice President for Oral Health
URMC

Cyril Meyerowitz, DDS MS,
Professor and past Director,
EIOH

Sharon Elad, DMD MSc,
Professor and Chair Oral Medicine,
EIOH

References:
Addendum: Questions and Answers

1. Is there a prior precedent of a CODA-approved program using the educational equivalency option for the program director?

Yes, the most recent is the CODA standard for program director in an Orofacial Pain program which permits a program director to be qualified for the position based on Board-certification equivalent education.

2. Will this change in standards reduce the quality of Oral Medicine programs?

It is highly unlikely. Currently, recruitment and retention of high performing international faculty to academic dental institutions has sustained dental education in all general and specialty programs. The individuals recruited provide a rich resource in dental education and research, particularly needed given the low percentage of dental graduates who choose to make dental academics a career. Similarly, in Oral Medicine, the international faculty currently present in the US, come from countries with a long and excellent history in Oral Medicine. These faculty are board certified, or the equivalent, in their countries of origin and include research and scholarly individuals, some with NIH funding and experience as NIH reviewers. In addition, research and academic collaborations between the US and international Oral Medicine programs and faculty has a long history. The presence of these faculty is likely to enhance the quality of these institutions or programs.

3. Will this change in standards reduce the value of Oral Medicine board certification?

The Oral Medicine Board certification has very high standards, and those are highly unlikely to be influenced by the change in the CODA standard.

Oral Medicine programs in the US have produced a steady number of excellent graduates, fully equipped to practice their specialty. The recent approval of Oral Medicine as a specialty by the American Dental Association has further solidified the status and role of Oral Medicine. In addition, the recognition of ABOM by the ADA National Commission as the certifying board for Oral Medicine has established the American Board of Oral Medicine (ABOM) as the responsible entity for board recognition. Board certification remains the desirable outcome of training programs and most of graduates seek to attain this privilege. Specialty status approval has further increased the value of certification. The number of international professions seeking, or in, positions in Oral Medicine programs in the US is relatively small compared to the number of graduates of US Oral Medicine programs. Furthermore, if the change of the program director standard is adopted, the equivalence language will set a very high bar for international professionals to qualify to be program directors.
4. What is the potential impact of this change in standard on the number and diversity of programs?

The plateau in the number of US Oral Medicine Programs have not increased beyond 6 since the advent of CODA standards for Oral Medicine Programs. Therefore, there appears to be a need to reduce the barriers to the establishment of new programs to encourage increased in the number of programs. A change in the program director standard will allow institutions with already present well qualified international Oral Medicine faculty to consider starting a program. Of note, some institutions with these faculty are in research intensive institutions, offering an opportunity not only to increase the number of programs, but also their academic and geographic diversity.

5. What limits institutions with international well-known oral medicine academics from recruiting individuals from US Oral Medicine programs who could achieve board certification and be program directors?

While the number of Oral Medicine graduates who are board-eligible in the US has increased, the financial and geographic barriers to their recruitment to academic institutions remain. It is often the well-established Oral Medicine departments in institutions that already have a residency program, that have the financial infrastructure to support new faculty. Less developed departments, particularly in institutions within medical academic centers that are not tuition driven, are faced with the challenge of securing large enough initial financial packages that allow time for faculty to develop clinical revenue adequate to support their salaries. This might require the new faculty to practice outside their specialty to generate income. If these institutions already have existing well qualified international faculty, additional financial resources to support further recruitment might be limited. For these institutions an appropriate strategy is to rely on the existing academic human resources and to add new faculty, in a gradual manner.

Additional factors include attractiveness of the institute location, requirement for scholarly performance willingness to contribute financially to the institute in other ways through research or clinical performance:

- Location may be a factor in limiting recruitment and institutions, because of individual’s personal preference of proximity to family, community vibrance, urban size and weather.
- Some institutions require significant scholarly production and set a high bar for academic performance and the securing of research grants that can be daunting for a young recently qualified professional.
- Furthermore, institutional demands to produce significant clinical revenue can discourage new faculty hires.

6. Will institutions preferentially recruit international faculty as program directors?
This is highly unlikely as recruitment of international faculty from their countries of origin is a costly and complicated process. There might be limited recruitment in the case of superbly qualified individuals with strong academic credentials but, in general, the equivalency requirement will limit the number of potential candidates. It is more likely that already established international faculty who are able to qualify under the equivalency requirements and already within the institution, will be tapped for the program director role.

7. If the standard is changed, can it be changed back to the current language?

Yes. There is an established process for changing accreditation standards within CODA.

8. How will CODA judge equivalency in the standard?

The establishment of equivalence to board certification in the program director standard could have the following elements:

- Training - Completion of a formal Oral Medicine program of at least 2 years that provides eligibility for board certification in that country.
- Exam - Completion of an exam process for certification, such as a written exam and case presentations combined with verbal exam.
- Content - The requirements for board certification in the other countries should be consistent with the US competencies. ¹
- The certification qualifies them for specialty status recognized by the national professional society or government.
- Consideration of scholarly activity including research funding and/or publications.

Reference:

CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION
STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ORAL
MEDICINE RELATED TO PATIENTS WITH SPECIAL NEEDS

Background: 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 graduates to be competent in treating patients with special needs. The Council on Dental Education and Licensure’s request is found in Appendix 1.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) considered the request for proposed revision to the Accreditation Standards for Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, and Orofacial Pain submitted by the Council on Dental Education and Licensure. The AGDOO RC noted that the request did not include review of the Oral Medicine Standards which do not address patients with special needs. The AGDOO RC recommended that the Accreditation Standards for each of the disciplines under its purview, including Oral Medicine, should be further studied to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted. Further, the AGDOO RC recommended that the new Review Committee on Oral Medicine, which will conduct its first meeting in Winter 2022, further study its specific Accreditation Standards. At its August 5, 2021 meeting, the Commission agreed and directed the new Oral Medicine Review Committee further study the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted with a report to the Commission at its Winter 2022 meeting.

Summary: The Oral Medicine Review Committee (OM RC) is requested to further study the proposed revision to the Accreditation Standards (Appendix 1) submitted by the Council on Dental Education and Licensure. 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: Ms. Peggy Soeldner
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 Tooks, director, Commission on Dental Accreditation
    Ms. Karen M. Hart, director, Council on Dental Education and Licensure
REPORT ON ORAL MEDICINE ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for oral medicine programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020.

At its Summer 2020 meeting, the Commission on Dental Accreditation approved revisions to the Annual Survey Curriculum Section for implementation in Fall 2022. The approved Curriculum Section of the Annual Survey for oral medicine programs can be found in **Appendix 1**.

**Summary:** The Review Committee on Oral Medicine (OM RC) is requested to review the draft Curriculum Section of the Annual Survey of its discipline-specific Annual Survey (**Appendix 1**).

**Recommendation:**

Prepared by: Ms. Peggy Soeldner
Part II - Oral Medicine Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did residents spend in each of the following areas during the 2017-18 2021-22 residency year?
Column must add up to 100%. Do not enter percent signs.

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<thead>
<tr>
<th></th>
<th>First Year</th>
<th>Second Year</th>
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<tbody>
<tr>
<td>a. Didactics:</td>
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<td>conferences/seminars</td>
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<td>b. Clinical activities</td>
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<td>c. Rotation/assignments to other services</td>
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<td>d. Teaching</td>
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<td>e. Research and/or scholarly activity</td>
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<td>f. Other, please specify</td>
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<td>Total</td>
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22. Please indicate the number of clock hours residents spent in formal courses, lectures, and seminars receiving instruction in the following subject areas during the 2017-18 2021-22 residency
year.
If none, enter zero.
<table>
<thead>
<tr>
<th>First Year Clock Hours</th>
<th>Second Year Clock Hours</th>
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</thead>
<tbody>
<tr>
<td>a. Physical evaluation and medical risk assessment (Standard 2-12a)</td>
<td></td>
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<tr>
<td>a, b. Detecting and diagnosing patients with complex medical problems that affect various organ systems and/or the orofacial region (Standard 2-10a)</td>
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</tr>
<tr>
<td>c. Selecting appropriate diagnostic procedures (Standard 2-12b)</td>
<td></td>
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<tr>
<td>b. Suitable preventive and/or management strategies to resolve oral manifestations of medical conditions or orofacial problems (Standard 2-10-b)</td>
<td></td>
</tr>
<tr>
<td>c. Critical evaluation of the scientific literature (Standard 2-10c)</td>
<td></td>
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</tbody>
</table>
d f. Anatomy, physiology, microbiology, immunology, biochemistry, neuroscience and pathology
   (Standard 2-11a)

e g. Pathogenesis and epidemiology of orofacial diseases and disorders
   (Standard 2-11b)

f h. Concepts of molecular biology and molecular basis of genetics
   (Standard 2-11c)

g i. Aspects of internal medicine and pathology
   (Standard 2-11d)

h j. Concepts of pharmacology mechanisms, actions, interactions and effects of prescription and over-the-counter drugs
   (Standard 2-11e)
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<tbody>
<tr>
<td>k.</td>
<td>Ameliorating the adverse effects of prescription/over-the-counter products and medical/dental therapy (Standard 2-12e)</td>
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<tr>
<td>j l.</td>
<td>Principles of nutrition (Standard 2-11f)</td>
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<td>j m.</td>
<td>Principles of research (Standard 2-11g)</td>
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<tr>
<td>k n.</td>
<td>Behavioral science (Standard 2-11h)</td>
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23. Please indicate the number of clock hours the residents spent in didactic instruction and clinical training during the 2017-18 **2021-22** residency year related to establishing a differential
diagnosis and formulating a working diagnosis prognosis and management plan pertaining to each of the following.
<table>
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<tr>
<th></th>
<th>First Year: Didactic</th>
<th>First Year: Clinical</th>
<th>Second Year: Didactic</th>
<th>Second Year: Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Oral mucosal disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Standard 2-12c.1)</td>
<td></td>
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<tr>
<td>b. Medically complex patients</td>
<td></td>
<td></td>
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<tr>
<td>(Standard 2-12c.2)</td>
<td></td>
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<tr>
<td>c. Salivary gland disorders</td>
<td></td>
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<tr>
<td>(Standard 2-12c.3)</td>
<td></td>
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<tr>
<td>d. Acute and chronic orofacial pain</td>
<td></td>
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<tr>
<td>(Standard 2-12c.4)</td>
<td></td>
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<tr>
<td>e. Orofacial neurosensory disorders</td>
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</tr>
<tr>
<td>(Standard 2-12c.5)</td>
<td></td>
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<tr>
<td></td>
<td>f. Physical evaluation and medical risk assessment (Standard 2-12a)</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td></td>
<td>g. Selecting appropriate diagnostic procedures (Standard 2-12b)</td>
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<tr>
<td></td>
<td>h. Ameliorating the adverse effects of prescription/over-the-counter products and medical/dental therapy (Standard 2-12e)</td>
<td></td>
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</tr>
</tbody>
</table>
24. Please indicate the clinical rotations/assignment, length in weeks and number of hours per week where the residents gained clinical medical experiences during the 2017-18 2021-22 residency year. (Standard 2-17)
<table>
<thead>
<tr>
<th></th>
<th>First Year: Length in weeks</th>
<th>First Year: Hours per week</th>
<th>Second Year: Length in weeks</th>
<th>Second Year: Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Internal medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Cardiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Hematology</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d. Oncology</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>e. Infectious diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Dermatology</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. Nephrology</td>
<td></td>
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<tr>
<td>h. Hepatology</td>
<td></td>
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</tr>
<tr>
<td>i. Endocrinology</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>j. Otolaryngology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Oral and maxillofacial radiology/Advanced imaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Other, please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Other, please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Other, please specify</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

25. If applicable, please indicate the number of hours students/residents participated in teaching activities during the 2017-18 2021-22 residency year. *(Standard 2-18)*

_________________________________________________________________________________________________________________________________ 

Use this space to enter comments or clarifications for your answers on this page.

_________________________________________________________________________________________________________________________________
CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN OROFACIAL PAIN RELATED TO PATIENTS WITH SPECIAL NEEDS

Background: 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 graduates to be competent in treating patients with special needs. The Council on Dental Education and Licensure’s request is found in Appendix 1.

At its Summer 2021 meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain (AGDOO RC) considered the request for proposed revision to the Accreditation Standards for Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, and Orofacial Pain submitted by the Council on Dental Education and Licensure. The AGDOO RC noted the Accreditation Standards for Advanced Education in Orofacial Pain do not directly address patients with special needs beyond providing a definition for this term. The AGDOO RC recommended that the Accreditation Standards should be further studied to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted. Further, the AGDOO RC recommended that the new Review Committee on Orofacial Pain, which will conduct its first meeting in Winter 2022, further study its specific Accreditation Standards. At its August 5, 2021 meeting, the Commission agreed and directed the new Orofacial Pain Review Committee further study the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain to determine whether modification of existing Standards or development of new Standard(s) related to patients with special needs is warranted with a report to the Commission at its Winter 2022 meeting.

Summary: The Orofacial Pain Review Committee (OFP RC) is requested to further study the proposed revision to the Accreditation Standards (Appendix 1) submitted by the Council on Dental Education and Licensure. 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: Ms. Peggy Soeldner
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 Tooks, director, Commission on Dental Accreditation  
    Ms. Karen M. Hart, director, Council on Dental Education and Licensure
REPORT ON OROFACIAL PAIN ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for orofacial pain programs in alternate years. The most recent Curriculum Section was conducted in August/September 2020.

At its Summer 2020 meeting, the Commission on Dental Accreditation approved revisions to the Annual Survey Curriculum Section for implementation in Fall 2022. The approved Curriculum Section of the Annual Survey for orofacial pain programs can be found in Appendix 1.

**Summary:** The Review Committee on Orofacial Pain (OFP RC) is requested to review the draft Curriculum Section of the Annual Survey of its discipline-specific Annual Survey (Appendix 1).

**Recommendation:**

Prepared by: Ms. Peggy Soeldner
Part II - Orofacial Pain Curriculum Section

Underline indicates addition; Strikethrough indicates deletion

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. A majority of the total program time must be devoted to providing orofacial pain patient services, including direct patient care and clinical rotation. What percentage of time did residents spend in each of
the following areas during the **2017-18 residency year** entire program? Columns must add up to 100%. Do not enter percent signs.

<table>
<thead>
<tr>
<th>Didactics: conferences/seminars</th>
<th>Percent total time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Activities: Orofacial pain</td>
<td></td>
</tr>
<tr>
<td>Clinical Activities: Other (please specify)</td>
<td></td>
</tr>
<tr>
<td>Rotations/assignment to other services</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td></td>
</tr>
<tr>
<td>Other, please specify</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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<tr>
<td></td>
<td>First Year</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>a. Didactics:</strong></td>
<td>conferences/seminars</td>
</tr>
<tr>
<td><strong>b. Clinical Activities:</strong></td>
<td>Orofacial pain</td>
</tr>
<tr>
<td><strong>c. Clinical Activities:</strong></td>
<td>Other (please specify)</td>
</tr>
<tr>
<td><strong>d. Rotations/assignment to other services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>e. Teaching</strong></td>
<td></td>
</tr>
<tr>
<td><strong>f. Research</strong></td>
<td></td>
</tr>
<tr>
<td><strong>g. Other, please specify</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
22. **Formal instruction must be provided in each of the following biomedical sciences areas.** Please indicate the number of clock hours resident spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the 2017-18 residency entire program. *(Standard 2-5)*

<table>
<thead>
<tr>
<th></th>
<th>Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Gross and functional anatomy and physiology including the musculoskeletal and articular system of the orofacial, head, and cervical structures;</td>
</tr>
<tr>
<td>b.</td>
<td>Growth, development, and aging of the masticatory system;</td>
</tr>
<tr>
<td>c.</td>
<td>Head and neck pathology and pathophysiology with an emphasis on pain;</td>
</tr>
<tr>
<td>d.</td>
<td>Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures;</td>
</tr>
<tr>
<td>e.</td>
<td>Sleep physiology and dysfunction;</td>
</tr>
<tr>
<td>f.</td>
<td>Oromotor disorders including dystonias, dyskinesias, and bruxism;</td>
</tr>
<tr>
<td>g.</td>
<td>Epidemiology of orofacial pain disorders;</td>
</tr>
<tr>
<td>h.</td>
<td>Pharmacology and pharmacotherapeutics; and</td>
</tr>
<tr>
<td>i.</td>
<td>Principals of biostatistics, research design and methodology, scientific writing, and critique of literature.</td>
</tr>
<tr>
<td>First Year Clock Hours</td>
<td>Second Year Clock Hours</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>a. Gross and functional anatomy and physiology including the musculoskeletal and articular systems of the orofacial, cranio/orofacial, and cervical structures</td>
<td></td>
</tr>
<tr>
<td>b. Growth, development, and aging of the masticatory system</td>
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</tr>
<tr>
<td>c. Head and neck pathology and pathophysiology with an emphasis on pain</td>
<td></td>
</tr>
<tr>
<td>d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures</td>
<td></td>
</tr>
<tr>
<td>e. Sleep physiology and dysfunction</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **f.** Oromotor disorders  
   including dystonias,  
dyskinesias, and bruxism |   |
| **g.** Epidemiology of orofacial  
pain disorders |   |
| **h.** Pharmacology and  
pharmacotherapeutics |   |
| **i.** Principles of biostatistics,  
research design and  
methodology, scientific  
writing, and critique of  
literature |   |
| **j.** The neurobiology of pain  
transmission and pain  
mechanisms in the central  
and peripheral nervous  
systems |   |
| **k.** Mechanisms associated  
with pain referral to and from  
the orofacial region |   |
<table>
<thead>
<tr>
<th>l. Pharmacotherapeutic principles related to sites of neuronal receptor-specific action pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>m. Pain classification systems</td>
</tr>
<tr>
<td>n. Psychoneuroimmunology and its relation to chronic pain syndromes</td>
</tr>
<tr>
<td>o. Primary and secondary headache mechanisms</td>
</tr>
<tr>
<td>p. Pain of odontogenic origin and pain that mimics odontogenic pain</td>
</tr>
<tr>
<td>q. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction</td>
</tr>
</tbody>
</table>
r. Cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors

s. The recognition of pain behavior and secondary gain behavior

t. Psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain disorders

u. Conducting and applying the results of psychometric tests

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Use this space to enter comments or clarifications for your answers on this page.

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Page 8 of 17
Part II - Orofacial Pain Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

23. Please indicate the number of clock hours the residents spent in didactic instruction and clinical training addressing the following areas during the 2017-18 residency year.

23. The program must provide a foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain. Please indicate the method of instruction (courses, lectures, seminars) and the number of clock hours resident spend receiving instruction in the following subject areas during the entire program. (Standard 2-6)

<table>
<thead>
<tr>
<th>Method of Instruction</th>
<th>Clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong></td>
<td>The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems;</td>
</tr>
<tr>
<td><strong>b.</strong></td>
<td>Mechanisms associated with pain referral to and from the orofacial region;</td>
</tr>
<tr>
<td><strong>c.</strong></td>
<td>Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain;</td>
</tr>
<tr>
<td><strong>d.</strong></td>
<td>Pain classification systems;</td>
</tr>
<tr>
<td><strong>e.</strong></td>
<td>Psychoneuroimmunology and its relation to chronic pain syndromes;</td>
</tr>
<tr>
<td><strong>f.</strong></td>
<td>Primary and secondary headache mechanisms;</td>
</tr>
<tr>
<td><strong>g.</strong></td>
<td>Pain of odontogenic origin and pain that mimics odontogenic pain; and</td>
</tr>
<tr>
<td><strong>h.</strong></td>
<td>The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction.</td>
</tr>
<tr>
<td></td>
<td>First Year: Didactic</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>First Year:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Didactic</strong></td>
<td></td>
</tr>
<tr>
<td>a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits</td>
<td></td>
</tr>
<tr>
<td>b. Obtain informed consent</td>
<td></td>
</tr>
<tr>
<td><strong>Second Year:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Didactic</strong></td>
<td></td>
</tr>
<tr>
<td>d. Physical medicine modalities</td>
<td></td>
</tr>
<tr>
<td>e. Sleep-related breathing disorder intraoral appliances</td>
<td></td>
</tr>
</tbody>
</table>
24. Please indicate the clinical rotations/assignment, length in weeks and number of hours per week where the residents gained clinical experiences in other healthcare services during the 2017-18 residency year.
24. Formal instruction must be provided in each of the following behavioral sciences areas as it relates to orofacial pain disorders and pain behavior. Please indicate the number of clock hours resident spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the entire program. (Standard 2-7)

<table>
<thead>
<tr>
<th>Clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors;</td>
</tr>
<tr>
<td>b. the recognition of pain behavior and secondary gain behavior;</td>
</tr>
<tr>
<td>c. psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain, sleep disorders, and sleep medicine; and</td>
</tr>
<tr>
<td>d. conducting and applying the results of psychometric tests.</td>
</tr>
<tr>
<td>First Year: Length in weeks</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>a. Oral and maxillofacial surgery</td>
</tr>
<tr>
<td>b. Oral and maxillofacial surgery for intracapsular TMJ disorders</td>
</tr>
<tr>
<td>c. Outpatient anesthesia pain service</td>
</tr>
<tr>
<td>d. Rheumatology</td>
</tr>
<tr>
<td>e. Neurology</td>
</tr>
<tr>
<td>f. Oncology</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>g. Otolaryngology</td>
</tr>
<tr>
<td>h. Rehabilitation medicine</td>
</tr>
<tr>
<td>i. Headache clinic</td>
</tr>
<tr>
<td>j. Radiology</td>
</tr>
<tr>
<td>k. Oral Medicine</td>
</tr>
<tr>
<td>l. Sleep Disorder clinic</td>
</tr>
<tr>
<td>m. Other, please specify</td>
</tr>
<tr>
<td>n. Other, please specify</td>
</tr>
</tbody>
</table>
25. The program must provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders. Please indicate the number of clock hours the residents spent in didactic instruction and clinical training addressing the following areas during the entire program. (Standard 2-9)

<table>
<thead>
<tr>
<th>Area</th>
<th>Clinical Clock hours</th>
<th>Didactic Clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Conduct a comprehensive pain history interview;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient’s orofacial pain and/or sleep disorder complaints;</td>
<td></td>
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</tr>
<tr>
<td>c. Perform clinical examinations and tests and interpret the significance of the data;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Establish a differential diagnosis and a prioritized problem list.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. The program must provide instruction and clinical training in multidisciplinary pain management for the orofacial pain patient. Please indicate the number of clock hours the residents spent in didactic instruction and clinical training addressing the following areas during the entire program. (Standard 2-10)

<table>
<thead>
<tr>
<th>Area</th>
<th>Clinical clock hours</th>
<th>Didactic Clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care;</td>
<td></td>
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</tr>
</tbody>
</table>
c. Obtain informed consent;

d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient’s treatment responsibilities;

e. intraoral appliance therapy;

physical medicine modalities;

sleep-related breathing disorder intraoral appliances;

non-surgical management of orofacial trauma;

behavioral therapies beneficial to orofacial pain; and

pharmacotherapeutic treatment of orofacial pain including systemic and topical medications and diagnostic/therapeutic injections.

27. Residents must participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period). Please indicate the clinical rotations/assignment, length in weeks and number of hours per week where the residents gained clinical experiences in other healthcare services during the entire program. (Standard 2-11)

<table>
<thead>
<tr>
<th>Rotation/Service/Assignment</th>
<th>Number of weeks</th>
<th>Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral and maxillofacial surgery (to include procedures for intracapsular TMJ disorders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient anesthesia pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-patient pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology</td>
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<td>Otolaryngology</td>
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<td>Rehabilitation medicine</td>
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<td>Headache</td>
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<td>Radiology</td>
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<td>Oral medicine</td>
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<td>Sleep disorder clinics</td>
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<td>Other, please specify</td>
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<tr>
<td>Other, please specify</td>
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</tbody>
</table>
25-28. If applicable, please indicate the number of hours residents participated in teaching orofacial pain during the 2017-18 residency year entire program.

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Use this space to enter comments or clarifications for your answers on this page.

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End of Block: OrofacPain Curriculum (Q21-25)
INFORMATIONAL REPORT ON THE CONDUCT OF A VALIDITY AND RELIABILITY STUDY FOR THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN OROFACIAL PAIN

Background: The Accreditation Standards for Advanced Education Programs in Orofacial Pain were adopted by the Commission on Dental Accreditation at its August 5, 2015 meeting for implementation on July 1, 2017.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1), the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula:

_The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years._

Thus, the validity and reliability of the new standards for a one-year program will be assessed after four years, while standards applying to programs two years in length will be assessed five years after implementation.

According to the Commission’s timetable for validity and reliability studies the study for Advanced Dental Education Programs in Orofacial Pain will be initiated in the spring of 2022. Survey results will be considered at the Summer 2022 meetings of the OFP RC and the Commission on Dental Accreditation. The communities will be surveyed to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

Methodology and Survey Design for Orofacial Pain: In cooperation with the ADA’s HPI, a timetable will be developed, surveys will be distributed to the audiences, and responses will be due to the HPI within two weeks of receipt of the survey. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2022. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2022 meeting.

A survey instrument will be developed to obtain evaluations of each of the requirements in the current standards. Respondents will be asked to indicate the relevance of each criterion to the orofacial pain curriculum:
• Relevant/Too demanding: Criterion relevant but too demanding
• Retain as is: Retain criterion as is
• Relevant/Not demanding: Criterion relevant but not sufficiently demanding
• Not relevant: Criterion not relevant
• No opinion: No opinion on this criterion

In addition, they will be asked to add and provide a rationale for any issues that they believe should be added to the standards. A sample format of the survey is presented in Appendix 2.

The following alternatives might result from the assessment of the adequacy of the standards:
• Authorization of a comprehensive revision of the standards;
• Revision of specific sections of the standards;
• Refinement/clarification of portions of the standards; and
• No changes in the standards but use of the results of this assessment during the next revision.

If it is determined that revisions to the accreditation standards is warranted, further analysis of the data obtained in the validity and reliability study would be conducted to provide more in-depth information for the revision process. In addition, other resources could provide further information, including:
• The annual Frequency of Citings Reports of Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain.
• Data identifying trends in accredited orofacial pain programs.
• Issues related to orofacial pain.
• Requests for standards revisions received but postponed until the regular validity and reliability study.
• Relevant reports from the higher education and practice communities, e.g., Institute of Medicine Report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce.”

When a comprehensive revision of an accreditation standards document is required, the new document is developed with input from the communities of interest in accordance with Commission policies. The document is drafted using resources such as those noted above. When the document is finalized, it is shared with the communities of interest and hearings are held, as appropriate. Written and oral comments from the hearings and written comments received during the comment period are reviewed when considering the document for adoption. An implementation date is specified when the document is adopted.

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

Prepared by: Ms. Peggy Soeldner
POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of standards are made to reflect significant changes in disease and practice patterns, scientific or technological advances, or in response to changing professional needs for which the Commission has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year after the validity and reliability of the standards has been assessed, the Commission will conduct a study to determine whether the accreditation standards continue to be appropriate to the discipline. This study will include input from the broad communities of interest. The communities will be surveyed and invited to participate in some national forum, such as an
invitational conference, to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

The following alternatives, resulting in a set of new standards, might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with Commission policies. An implementation date is specified and copyright privileges are sought when the document is adopted. Assessment of the validity and reliability of these new standards will be scheduled in accord with the policy specified above. Exceptions to the prescribed schedule may be approved to ensure a consistent timetable for similar disciplines (e.g. advanced dental education programs and/or allied dental education programs).

Revised: 8/18; 7/07, 07/00; Reaffirmed: 8/12, 8/10, 7/06; Adopted: 12/88
SAMPLE ADVANCED DENTAL EDUCATION PROGRAM IN OROFACIAL PAIN VALIDITY AND
RELIABILITY SURVEY

Listed below are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate orofacial pain programs for accreditation purposes. For each standard, please circle the appropriate number that corresponds to your rating in terms of its relevance of the criterion to the curriculum. Please note that certain standards have multiple items to be rated.

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>For each of the five-point rating scales use:</th>
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<tbody>
<tr>
<td>Advanced Dental Education Program in Orofacial Pain – a postgraduate program designed to provide training beyond the level of predoctoral education in oral health care, using applied basic and behavioral sciences to treat patients with orofacial pain. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates' knowledge and skills to enable them to provide care for individuals with orofacial pain.</td>
<td>1 = criterion relevant but too demanding</td>
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<td>2 = retain criterion as is</td>
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<td>3 = criterion relevant but not sufficiently demanding</td>
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<td></td>
<td>4 = criterion not relevant</td>
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<td>5 = no opinion</td>
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</tbody>
</table>

STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1. List Standards in this column 1 2 3 4 5

List comments related to Standard 1 – Institutional and Program Effectiveness.

STANDARD 2 – EDUCATIONAL PROGRAM

1. List Standards in this column 1 2 3 4 5

List comments related to Standard 2 – Educational Program.

STANDARD 3 – FACULTY AND STAFF

1. List Standards in this column 1 2 3 4 5

List comments related to Standard 3 – Faculty and Staff.
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

1. List Standards in this column

List comments related to Standard 4 – Educational Support Services

STANDARD 5 – PATIENT CARE SERVICES

1. List Standards in this column

List comments related to Standard 5 – Patient Care Services

STANDARD 6 – RESEARCH

1. List Standards in this column

List comments related to Standard 6 – Research
INFORMATIONAL REPORT ON REVIEW COMMITTEE AND COMMISSION MEETING DATES

Background: Below is the meeting schedule for all Review Committees and the Commission through Summer 2023. Review Committees meet at least two (2) weeks prior to the Commission meeting.

**Review Committee and Commission Meeting Dates**

<table>
<thead>
<tr>
<th></th>
<th>Winter 2022</th>
<th>Summer 2022**</th>
<th>Winter 2023**</th>
<th>Summer 2023**</th>
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<tr>
<td>PREDOC RC</td>
<td>Jan 10-11</td>
<td>July 11-12</td>
<td>Jan 9-10</td>
<td>July 10-11</td>
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<td>PGD RC</td>
<td>Jan 13-14</td>
<td>July 14-15</td>
<td>Jan 12-13</td>
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<td>DA RC</td>
<td>Jan 13-14</td>
<td>July 14-15</td>
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<td>DH RC</td>
<td>Jan 11-12</td>
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<td>DLT RC</td>
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<td>DPH RC</td>
<td>Jan 14</td>
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<td>ENDO RC</td>
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<td>OMP RC</td>
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<td>OMR RC</td>
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<td>OMS RC</td>
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<td>ORTHO RC</td>
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<td>PED RC</td>
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<td>PERIO RC</td>
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<td>PROS RC</td>
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<td>DENTANES RC</td>
<td>Jan 12</td>
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<td>OM RC</td>
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<td>OFP RC</td>
<td>Jan 10</td>
<td>July 11</td>
<td>Jan 9</td>
<td>July 10</td>
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<tr>
<td>Closed Session</td>
<td>Feb. 10</td>
<td>Aug. 4</td>
<td>Feb. 9</td>
<td>Aug. 10</td>
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<tr>
<td>Commission</td>
<td>10:00 a.m.</td>
<td>10:00 a.m.</td>
<td>10:00 a.m.</td>
<td>10:00 a.m.</td>
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<tr>
<td>Open Session</td>
<td>Feb. 11</td>
<td>Aug. 5</td>
<td>Feb. 10</td>
<td>Aug. 11</td>
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<tr>
<td>Commission</td>
<td>8:30 a.m.</td>
<td>8:30 a.m.</td>
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**Summer 2022 and 2023 meeting dates are tentative, pending final room availability.**

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

Prepared by: Dr. Sherin Tooks
REMINDER OF PROFESSIONAL CONDUCT POLICY AND PROHIBITION AGAINST HARASSMENT

**Background:** Members of the Commission, as well as members of the Commission’s committees, are reminded that the Commission supports the American Dental Association’s policy on professional conduct and prohibition against harassment (*Appendix 1*).

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

Prepared by: Dr. Sherin Tooks
POLICY ON PROFESSIONAL CONDUCT AND PROHIBITION AGAINST HARASSMENT

All staff members and volunteers must treat each other and all others with whom we work on behalf of the ADA with integrity, courtesy and professionalism. It is ADA policy that all staff members and volunteers are responsible for assuring that the work place is free from improper harassment. With this policy, the ADA prohibits not only unlawful harassment, but also other unprofessional and discourteous actions. For example, rude, insulting, disrespectful, disruptive, uncivil and unprofessional comments or conduct will also not be tolerated.

Workplace harassment isn’t limited to sexual harassment, and doesn’t preclude same-gender harassment; it can occur between any two people - co-workers, managers, or even non-employees like clients, contractors, or vendors.

The ADA absolutely prohibits sexual harassment and harassment on the basis of one’s status as a member of a legally-protected class, such as race, color, religion, sex (including pregnancy, childbirth and related medical conditions), gender, gender identity, national origin, age (40 or older), disability (mental or physical), sexual orientation, military status, genetic information, and marital status. These types of discriminatory harassment are prohibited by state and federal laws and may subject the ADA and/or the individual harasser to liability for any such unlawful conduct.

Offensive conduct may include, but is not limited to, offensive jokes, slurs, epithets or name calling, physical assaults or threats, intimidation, ridicule or mockery, insults or put-downs, offensive objects or pictures, unwelcome sexual advances, unwanted physical contact (including touching), and all other verbal, or physical conduct directed at an individual because of their status as a member of a protected class that is unwelcome and interferes with work performance. Such conduct constitutes unlawful harassment when:

- Submission to such conduct is made either implicitly or explicitly a condition of the individual’s employment;
- Submission to or rejection of such conduct is used as the basis for decisions affecting an individual’s employment; or
- Such conduct is sufficiently severe or pervasive to alter the conditions of employment and to create a hostile or abusive working environment.

To Report a Potential Incident
If you believe you have experienced or have become aware of an incident of harassment or a violation of our professional conduct policy, report it as soon as possible to your supervisor and/or Human Resources at (312) 440-2005.

1 For purposes of these HR protocols ‘the ADA’ collectively refers to the American Dental Association and its two affiliated organizations, the for-profit company ADA Business Enterprises, Inc. (ADABEI) and the not-for-profit educational and research focused ADA Foundation (ADAF).
Each staff member and volunteer must exercise his or her own good judgment to avoid engaging in conduct that may be perceived by others as harassment. As an ADA staff member or volunteer, you are responsible for keeping our work environment free of all such harassment. If you believe that you have been harassed, or if you become aware of an incident of harassment, whether by an employee, a member, or a non-employee or non-member, you should report it as soon as possible to your supervisor, a volunteer leader, and/or to the Human Resources, (312-440-2005).

If the incident is reported to an employee’s supervisor or a volunteer leader, the supervisor or volunteer leader must then report the incident to the head of ADA Human Resources. Do not allow an inappropriate situation to continue by not reporting it, regardless of who is creating that situation.

No staff member or volunteer in this organization is exempt from this policy. This policy applies to the immediate work place as well as to ADA related activity outside the ordinary work place, such as travel on ADA business, meetings outside the ADA building, email and telephone communications, and ADA-sponsored social or recreational events.

In response to every complaint, the ADA will take prompt investigatory actions and corrective and preventative actions where necessary. A staff member who brings such a complaint to the ADA in good faith will not be adversely affected as a result of reporting the harassment or objectionable conduct. All staff members should be aware that the privacy of the charging party and the person accused of the harassment will be protected to the extent consistent with effective enforcement of this policy.

The ADA will retain confidential documentation of all allegations and investigations. Any staff member or volunteer found to have violated this policy may be subject to disciplinary action up to and including discharge from employment with the ADA or removal from a volunteer position. Any memoranda regarding a determination that a violation of the Professional Conduct Policy and Prohibition against Harassment has occurred shall be placed in a staff member’s personnel file. Effective: January 1, 2015

**Procedures Applicable to Professional Conduct Policy and Prohibition against Harassment**

a. If you believe that there has been a violation of the ADA’s Professional Conduct Policy and Prohibition against Harassment (ADA’s Policy) immediately contact your supervisor, or Human Resources.

b. If an incident is reported to a supervisor or volunteer leader, the supervisor or volunteer leader must then notify Human Resources of the incident.

c. In a timely and confidential manner, the ADA will conduct an investigation of any complaint that is made pursuant to the ADA’s Policy. Human Resources will conduct an
Professional Conduct Policy
All Review Committees
CODA Winter 2022

investigation, which includes interviewing witnesses with potential knowledge of the objectionable conduct.

d. It is the obligation of each staff member and volunteer to cooperate in these investigations by providing truthful, thorough information.

e. The alleged harasser is given an opportunity to relate his/her version of the events and to provide any information that the ADA should consider before it finalizes its investigation. If the alleged harasser refuses to participate, the ADA will base its decision on the other information gathered during the investigation, the inferences drawn from that evidence and the alleged harasser’s unwillingness to cooperate in the interview.

f. Information obtained pursuant to the investigation is confidential and will be reported to those within the ADA on a “need to know” basis. The privacy of the complaining party and the person accused of the harassment will be protected to the extent consistent with effective enforcement of this Policy.

g. Attempting to influence the investigation or to disclose confidential information by discussing it with others can be cause for disciplinary action, up to and including discharge, except to the extent such disclosure may be legally permissible.

h. Human Resources, in consultation with legal counsel, will make a recommendation to the Executive Director as to whether there has been a violation of the ADA’s Policy and whether corrective action, if any, should be taken.

i. Any staff member found to have violated the Professional Conduct Policy and Prohibition against Harassment will be subject to disciplinary action up to and including discharge. Any memoranda regarding violation of the Professional Conduct Policy and Prohibition against Harassment will be placed in the staff member’s personnel file.

The ADA prohibits managers and supervisors from taking adverse job consequences against staff who engage in protected activities such as: 1) lodging a discrimination complaint or concern, 2) participating in an investigation of such a discrimination complaint or concern or 3) opposing employment practices that an employee reasonably believes discriminate against the employee or another staff member.

The ADA prohibits any form of retaliation against any staff member for making a bona fide complaint under this policy or for assisting in a complaint investigation. Any individual, however, whose complaint is determined to be false or made in bad faith, or supported by false information, may be subject to disciplinary action.

The ADA specifically reserves its right to change, modify or eliminate any of the provisions of its Procedures Applicable to the Professional Conduct Policy and Prohibition against Harassment Policy at any time with or without notice. Effective: January 1, 2015

Revised: 8/15; 8/14; 7/09; 1/03, 7/97; Reaffirmed: 8/18; 8/13; 8/10; CODA: 01/95:11
CONSIDERATION OF RESOLUTIONS ADOPTED BY THE ADA HOUSE OF DELEGATES AND THE ADA BOARD OF TRUSTEES RELATED TO THE COMMISSION ON DENTAL ACCREDITATION AND DENTAL EDUCATION

**Background:** The American Dental Association’s (ADA) House of Delegates met October 13-16, 2021 in Las Vegas, Nevada. Several of the resolutions adopted by the House of Delegates are related to education, accreditation and the Commission on Dental Accreditation (CODA). A summary of those resolutions is provided in Appendix 1. Some of the resolutions are considered informational in nature; others may require action.

The ADA’s Board of Trustees met on July 16-18, 2021 and September 12-14, 2021 in Chicago, Illinois. The Board of Trustees adopted resolutions pertaining to education, accreditation and the Commission on Dental Accreditation (CODA). A summary of those resolutions is provided in Appendix 2. Some of the resolutions are considered informational in nature; others may require action.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
### UNOFFICIAL REPORT OF ACTIONS
AMERICAN DENTAL ASSOCIATION HOUSE OF DELEGATES
Las Vegas, Nevada: October 13-16, 2021

<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>House Action</th>
<th>Resolution</th>
<th>Notes</th>
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<tbody>
<tr>
<td>31H.</td>
<td>Adopted</td>
<td><strong>Commission for Continuing Education Provider Recognition Resolution</strong></td>
<td>CCEPR</td>
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<td>31—Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association</td>
<td>CEBJA</td>
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<td><strong>Resolved</strong>, that Chapter IX. Section A.3 of the <em>Governance and Organizational Manual of the American Dental Association</em> be amended as shown below (additions underscored; deletions stricken):</td>
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<td>Commission for Continuing Education Provider Recognition. The number of and the method of selection of members of the Commission for Continuing Education Provider Recognition shall be governed by the Rules of the Commission for Continuing Education Provider Recognition, except that six (6) members shall be selected as follows:</td>
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<tr>
<td></td>
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<td>a. Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. At least two (2) of the members appointed shall be general dentists.</td>
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<tr>
<td>HOD &amp; BOT Resolutions</td>
<td>All Review Committees</td>
<td>CODA Winter 2022</td>
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<td><strong>32H.</strong></td>
<td><strong>Adopted—Consent Calendar Action</strong></td>
<td><strong>Reference Committee C (Dental Education, Science and Related Matters)</strong></td>
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<td>Resolution 32RC adopted in lieu of Council on Dental Education and Licensure Resolution 32—Amendment of the Policy: Review of ADA Definition: Continuing Competency</td>
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<td><strong>Resolved</strong>, that the ADA definition of Continuing Competency (*Trans.*1999:939) be amended as follows (additions underscored; deletions stricken):</td>
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<td>Continuing Competency: The continuance of the appropriate knowledge and skills appropriateness, necessity and quality of the care provided by the dentists in order to maintain and improve the dental, oral, and craniofacial health care of his or her patients in accordance with the ethical principles of dentistry.</td>
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<tr>
<td><strong>41H.</strong></td>
<td><strong>Adopted—Consent Calendar Action</strong></td>
<td><strong>Council on Advocacy for Access and Prevention Resolution 41—Amendment of the Policy, Encouraging the Development of Oral Health Literacy Continuing Education Programs</strong></td>
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<td><strong>Resolved</strong>, that the policy titled Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans.*2006:316) be amended as follows (additions are underscored; deletions are stricken):</td>
<td></td>
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<tr>
<td>Resolution</td>
<td>Action</td>
<td>Description</td>
<td>Date of Action</td>
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<td><strong>46H.</strong></td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Dental Education and Licensure Report 1—Special Care Dentistry Association</td>
<td>CDEL</td>
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<td><strong>Resolved</strong>, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in special needs dentistry by the Commission on Dental Accreditation, and be if further</td>
<td></td>
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<td><strong>Resolved</strong>, that the Special Care Dentistry Association be urged to collaborate with advanced dental education programs and their sponsoring institutions to enhance the current scope and depth of instruction related to special needs dentistry and to encourage the establishment of more training programs in special needs dentistry.</td>
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<tr>
<td><strong>47H.</strong></td>
<td>Adopted—Consent Calendar Action</td>
<td>Council on Dental Education and Licensure Resolution 47—Continuing Education Market Research</td>
<td>Department of Continuing Education. CDEL</td>
</tr>
<tr>
<td></td>
<td><strong>Resolved</strong>, that market research be conducted to learn more about the continuing education interests of practicing dentists related to managing and treating patients with special needs, i.e., people with developmental disabilities, cognitive</td>
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</tr>
</tbody>
</table>
impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

<table>
<thead>
<tr>
<th>Resolution</th>
<th>Calendar Action</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>48H.</td>
<td>Adopted—Consent</td>
<td>Council on Dental Education and Licensure Resolution 48—Developing Continuing Education Activities</td>
</tr>
<tr>
<td></td>
<td>Calendar Action</td>
<td>Resolved that a variety of continuing education activities related to special needs dentistry be developed by the appropriate ADA agency.</td>
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<td></td>
<td>Calendar Action</td>
<td>Resolved, that the following policy be adopted:</td>
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<tr>
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<td></td>
<td><strong>Patients with Special Needs</strong></td>
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<td></td>
<td></td>
<td>The dental profession’s continued ability to effectively provide dental care for America’s special needs population is dependent on sustaining a strong educational foundation in this area. The ADA encourages efforts to maintain and expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that support practitioners in providing dental treatment to patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The ADA encourages dental practitioners to regularly participate in continuing education in this area.</td>
</tr>
</tbody>
</table>
81H. Adopted—Consent Calendar Action

Reference Committee C (Dental Education, Science and Related Matters)
Resolution 81RC adopted in lieu of Board of Trustees Resolution 81 and
Third Trustee District Resolution 81S-1—Response to Resolution 74-2020 –
Elder Care Strategies for Continuing Education

Resolved, that in order to prepare the profession for the increased demographic
shift to an older population, the appropriate ADA agencies should consider
integrating the following elder care strategies on both the oral-systemic
connection and the dental management of the medically complex older adult as
priority projects, and be it further

Resolved, elevate the importance of both the oral-systemic connection and the
dental management of the medically complex older adult, to both members and
the public the dental community and medical communities, as appropriate, by:

1. providing educational opportunities for the profession on the oral-
   systemic connection.
2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual
   Meeting or other ADA meetings.
3. developing and maintaining a roster of qualified speakers both the oral-
   systemic connection and the dental management of the medically
   complex older adult.

1. developing and delivering dental continuing education on both the oral-
   systemic connection and the dental management of the medically
   complex older adult through ADA online CE, SmileCon programs,
   ADA conferences and other ADA meetings, publications and
   programming as appropriate.
4. Developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals with an increased emphasis on the need for a more active collaboration and consultation between dental and medical providers when managing medically complex older adults.

3. The development of continuing educational curricula for the delivery of preventive and quality of life dental care for institutional, long-term care and home-bound individuals to allow for greater access in their respective environments.

<table>
<thead>
<tr>
<th>85H.</th>
<th>Adopted</th>
</tr>
</thead>
</table>
| **Reference Committee B (Dental Benefits, Practice and Related Matters)**  
Resolution 85RC adopted in lieu of Indiana Dental Association Resolution 85, Third Trustee District Resolution 85S-1 and Indiana Dental Association Resolution 85S-2—Addressing the Dental Team Workforce Shortage |

**Resolved**, that the appropriate ADA agency distribute existing print and social media communications materials to state and local dental societies to use to promote and encourage middle and high school students to consider careers in dentistry, dental hygiene and dental assisting, and be it further

**Resolved**, that the appropriate ADA agency study the issue of dental hygienist and dental assistant employment tenure to determine variables that lead to attrition and high employee turnover, as well as variables that encourage long term employees. The research will be used to develop a toolkit that dentists can use to help increase the tenure of dental team members, and be it further

| CDP  
HPI  
CDEL  
CGA |
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<tr>
<th>Resolution</th>
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<th>Text</th>
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<tbody>
<tr>
<td>108H.</td>
<td>Adopted—Consent Calendar Action</td>
<td><strong>Resolved,</strong> that the appropriate ADA agency request ADEA to collaborate in conducting a study of accredited dental hygiene and assisting programs and formulate ideal enrollment recommendations by state and or region and make this information available to state and local dental societies, as well as dentistry, hygiene and assisting education administrators, and be it further <strong>Resolved,</strong> that the appropriate ADA agency investigate financial incentives, such as possible tax abatements and grants, to motivate educational institutions to create, or expand existing, dental hygiene and dental assisting programs in order to expedite the resolution of the workforce issue.</td>
</tr>
<tr>
<td>111H.</td>
<td>Adopted</td>
<td><strong>Resolved,</strong> that the recommendations of Reference Committee C on the following resolutions be accepted by the House of Delegates.</td>
</tr>
</tbody>
</table>

**Fifth Trustee District and Sixteenth Trustee District Resolution 108—National Commission On Recognition Of Dental Specialties And Certifying Boards Requirements For Recognition Review**

**Resolved,** that the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, currently used by the National Commission on Recognition of Dental Specialties and Certifying Boards, be reviewed by the ADA Council on Dental Education and Licensure in 2022, rather than 2023, and be it further **Resolved,** that CDEL report its findings and any proposed revisions to the Requirements for Recognition to the National Commission and to the 2022 ADA House of Delegates.

**Reference Committee C (Dental Education, Science and Related Matters) Resolution 111—as amended—Consent Calendar**

**111. Resolved,** that the recommendations of Reference Committee C on the following resolutions be accepted by the House of Delegates.
<table>
<thead>
<tr>
<th>Resolution</th>
<th>Description</th>
<th>Recommendation</th>
</tr>
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<tbody>
<tr>
<td>Resolution 31</td>
<td><strong>Adopt—Amendment of Chapter IX, Section A of the Governance and Organizational Manual of the American Dental Association (Worksheet:4001)</strong> $: None</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
<tr>
<td>Resolution 32RC</td>
<td><strong>Adopt Resolution 32RC in lieu of Resolutions 32—Amendment of the Policy: Review of ADA Definition: Continuing Competency (Worksheet:4005)</strong> $: None</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
<tr>
<td>Resolution 46</td>
<td><strong>Adopt—Special Care Dentistry Association (Worksheet:4057)</strong> $: None</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
<tr>
<td>Resolution 47</td>
<td><strong>Adopt—Continuing Education Market Research (Worksheet:4058)</strong> $: 35,000</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
<tr>
<td>Resolution 48</td>
<td><strong>Adopt—Developing Continuing Education Activities (Worksheet:4059)</strong> $: 7,500</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
<tr>
<td>Resolution 49</td>
<td><strong>Adopt—Proposed Policy: Patients With Special Needs (Worksheet:4060)</strong> $: None</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
<tr>
<td>Resolution 64</td>
<td><strong>Adopt—Amendment of the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (Worksheet:4065)</strong> $: None</td>
<td><strong>Committee Recommendation:</strong> Vote Yes</td>
</tr>
</tbody>
</table>
COMMITTEE RECOMMENDATION: Vote Yes

8. Resolution 65RC—Adopt Resolution 65RC in lieu of Resolution 65—Amendment of the Policy, Research Funds (Worksheet:4066) $: None

COMMITTEE RECOMMENDATION: Vote Yes

9. Resolution 66—Adopt—Rescission of the Policy, Comparative Effectiveness Research and Patient-Centered Outcomes Research (Worksheet:4069) $: None

COMMITTEE RECOMMENDATION: Vote Yes

10. Resolution 80—Adopt—Electronic Archiving of State and Component Dental Publications (Worksheet:4099) $: 5,000

COMMITTEE RECOMMENDATION: Vote Yes

11. Resolution 81RC—Adopt Resolution 81RC in lieu of Resolution 81 and Resolution 81S-1—Response to Resolution 74-2020 - Elder Care Work Group—Elder Care Strategies for Continuing Education (Worksheet:4101) $: 10,000

COMMITTEE RECOMMENDATION: Vote Yes

12. Resolution 96RC—Adopt Resolution 96RC in lieu of Resolution 96 and Resolution 96S-1—The Practice of Dentistry and Cannabis (Worksheet:4108) $: None

COMMITTEE RECOMMENDATION: Vote Yes


COMMITTEE RECOMMENDATION: Vote No
<table>
<thead>
<tr>
<th>Resolution</th>
<th>Description</th>
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<tbody>
<tr>
<td>14. <strong>Resolution 104RC</strong></td>
<td>Adopt Resolution 104RC in lieu of Resolution 104—Financial Literacy Among New Dentists and Dental Students (Worksheet:4110) $: None</td>
</tr>
<tr>
<td>COMMITTEE RECOMMENDATION:</td>
<td>Vote Yes</td>
</tr>
<tr>
<td>15. <strong>Resolution 108</strong></td>
<td>Adopt—National Commission on Recognition of Dental Specialties and Certifying Boards Requirements for Recognition Review (Worksheet:4111) $: None</td>
</tr>
<tr>
<td>COMMITTEE RECOMMENDATION:</td>
<td>Vote Yes</td>
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<tr>
<td>COMMITTEE RECOMMENDATION:</td>
<td>Vote Yes</td>
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</tbody>
</table>
## HOD & BOT Resolutions

**AMERICAN DENTAL ASSOCIATION**  
**BOARD OF TRUSTEES**  
*July 16-18, 2021 and September 12-14, 2021*  
*Chicago, Illinois*

<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>Board Action</th>
<th>Resolution</th>
<th>Notes</th>
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</thead>
</table>
| B-74, July 2021   | Adopted      | **Resolved,** that the following two general dentist commissioners be appointed to serve on the Commission for Continuing Education Provider Recognition for the 2021-2025 term.  
Dr. Mark Nuger, Maryland  
Dr. Susan Zelazo-Smith, Illinois |       |
| B-75, July 2021   | Adopted      | **Resolved,** that the following commissioner be appointed to serve on the Commission on Dental Accreditation for the 2022-2026 term.  
Dr. Deborah Weisfuse, New York |       |
| B-76, July 2021   | Adopted      | **Resolved,** that Dr. Frank Schiano be appointed to serve on the Joint Commission on National Dental Examinations for the 2021-2025 term. |       |
| B-77, July 2021   | Adopted      | **Resolved,** that the following three general dentist commissioners be appointed to serve on the National Commission on Recognition of Dental Specialties and Certifying Boards for the 2021-2025 term.  
Dr. Len Aste, Utah  
Dr. Michele Beeler, Kentucky  
Dr. Ned Murphy, Wisconsin |       |
<table>
<thead>
<tr>
<th>Resolution No.</th>
<th>Date</th>
<th>Action</th>
<th>Resolution Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-90</td>
<td>September 2021</td>
<td>Adopted</td>
<td>Resolved, that the ADA enter a negotiation with the University of Illinois-Chicago College of Dentistry in order to explore the possibility of a CODA-accredited Advanced Education Program in Dental Public Health, where ADA would provide an educational experience up to two days per week as part of the academic school year in areas of dental public health research and/or dental public health policy advocacy, and be it further.</td>
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<td>Resolved, that the ADA contribute $100,000 per year for three years to support the establishment of the Advanced Education Program in Dental Public Health in collaboration with the University of Illinois-Chicago College of Dentistry, Department of Public Health upon the successful completion of a negotiated agreement.</td>
</tr>
<tr>
<td>B-91</td>
<td>September 2021</td>
<td>Adopted</td>
<td>Resolved, that a steering committee be reauthorized for the 2022 term to oversee the launch and validation of the ADA Admission Test for Dental Hygiene (ATDH), and be it further.</td>
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<td>Resolved, that the following individuals be reappointed to the Steering Committee for the 2022 term to oversee the launch and validation of the ADA Admission Test for Dental Hygiene (ATDH):</td>
</tr>
</tbody>
</table>
|               |            |        | • Dr. Paul Leary, Trustee, Steering Committee Chair  
• Dr. Stephen M. Lepowsky (CDEL Member)  
• Dr. Uri Hangorsky (CDEL Member)  
• Donna Warren Morris, RDH, MEd (Dental Hygiene Program Director)  
• Wanda Cloet, RDH, DHS (Dental Hygiene Program Director)  
• Joyce C. Hudson, RDH, MS (Dental Hygiene Program Director)  |
<table>
<thead>
<tr>
<th>Director</th>
<th>Michelle R. Roman, EdD, MSM, MPH (Dental Hygiene Program Director)</th>
<th>Ebony M. Thomas-Butler, MS, BS (Admissions Officer)</th>
</tr>
</thead>
</table>

HOD & BOT Resolutions
All Review Committees
CODA Winter 2022