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

Peggy Soeldner, M.S. Ed. soeldnerp@ada.org
Manager, Advanced Dental Education
Commission on Dental Accreditation (CODA)

5/3/21

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:

1. Miller CS, Peterson DE. Oral medicine: Today's future can become tomorrow's reality. Oral Surg Oral Med Oral Pathol Oral Radiol. 2018 Nov;126(5):409-414.
2. Tyler MT, Miller CS, Lockhart PB, Patton LL. American Academy of Oral Medicine: 75 years of bringing medicine and dentistry back together. Oral Surg Oral Med Oral Pathol Oral Radiol. 2020 Feb;129(2):91-94.

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 a 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:

1. Whitney EM, Stoopler E, Brennan MT, DeRossi SS, Treister NS. Competencies for the new postdoctoral Oral Medicine graduate in the United States. Oral Surg Oral Med Oral Pathol Oral Radiol. 2015 Sep;120(3):324-8

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

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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

Start of Block: OralMed Curriculum (Q21-25)

Underline indicates addition; ~~Strikethrough~~ indicates deletion

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.

	First Year	Second Year
a. Didactics: conferences/seminars		
b. Clinical activities		
c. Rotation/assignments to other services		
d. Teaching		
e. Research and/or scholarly activity		
f. Other, please specify		
Total		

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.

	First Year Clock Hours	Second Year Clock Hours
~~a. Physical evaluation and medical risk assessment (Standard 2-12a)~~		
a.~~b~~. Detecting and diagnosing patients with complex medical problems that affect various organ systems and/or the orofacial region (Standard 2-10a)		
~~c. Selecting appropriate diagnostic procedures (Standard 2-12b)~~		
b ~~d~~. Suitable preventive and/or management strategies to resolve oral manifestations of medical conditions or orofacial problems (Standard 2-10-b)		
c ~~e~~. Critical evaluation of the scientific literature (Standard 2-10c)		

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)		

~~k. Ameliorating the adverse effects of prescription/over-the-counter products and medical/dental therapy (Standard 2-12e)~~		
i ~~l~~. Principles of nutrition (Standard 2-11f)		
j ~~m~~. Principles of research (Standard 2-11g)		
k ~~n~~. Behavioral science (Standard 2-11h)		

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.

	First Year: Didactic	First Year: Clinical	Second Year: Didactic	Second Year: Clinical
a. Oral mucosal disorders (Standard 2-12c.1)				
b. Medically complex patients (Standard 2-12c.2)				
c. Salivary gland disorders (Standard 2-12c.3)				
d. Acute and chronic orofacial pain (Standard 2-12c.4)				
e. Orofacial neurosensory disorders (Standard 2-12c.5)				

f. Physical evaluation and medical risk assessment (Standard 2-12a)		
g. Selecting appropriate diagnostic procedures (Standard 2-12b)		
h. Ameliorating the adverse effects of prescription/over-the-counter products and medical/dental therapy (Standard 2-12e)		

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)

	First Year: Length in weeks	First Year: Hours per week	Second Year: Length in weeks	Second Year: Hours per week
a. Internal medicine				
b. Cardiology				
c. Hematology				
d. Oncology				
e. Infectious diseases				
f. Dermatology				
g. Nephrology				
h. Hepatology				

i. Endocrinology				
j. Otolaryngology				
k. Oral and maxillofacial radiology/Advanced imaging				
l. Other, please specify				
m. Other, please specify				
n. Other, please specify				

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.

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End of Block: OralMed Curriculum (Q21-25)