MINUTES

COMMISSION ON DENTAL ACCREDITATION
AMERICAN DENTAL ASSOCIATION
ADA HEADQUARTERS BUILDING, CHICAGO

August 5 and 6, 2010

Call To Order: The Chair, Dr. Bryan Edgar, called a regular meeting of the Commission on Dental Accreditation to order at 1:00 P.M. on Thursday, August 5, 2010, in the 22nd Floor Board room of the ADA Headquarters Building, Chicago, in closed session for the purpose of reviewing educational programs.

Roll Call: Dr. Michael Biermann, Dr. Richard Buchanan, Dr. Eric Carlson, Ms. Elizabeth Curran, Dr. Bryan Edgar, Dr. Andy Elliot, Dr. W. Stan Hardesty, Dr. Vincent Iacono, Dr. Janice Jackson (for Dr. Paul Casamassimo), Dr. Donald Joondeph, Dr. Laura Joseph, Dr. Mel Kantor, Dr. Karen Kershenstein, Dr. Kent Knoernschild, Dr. Lee Koppelman, Dr. Charles Marinelli, Dr. Judith Messura, Ms. Anna Nelson, Dr. Reuben Pelot, Dr. Robert Ray, Dr. Michael Reed, Dr. Yilda Rivera-Nazario, Mr. Kenneth Thomalla, Dr. Christopher Wenckus, Dr. Alexander White and Dr. John Wright.

Mr. Ryan Dulde, Ms. Mary Kay Richter and Dr. Steven Tonelli were unable to attend.

In addition to the staff of the Commission, Dr. Dr. Russ Webb, ADA Trustee Liaison and representatives of the Commission on Dental Accreditation of Canada (CDAC), Dr. Claude Lamarche and Ms. Susan Matheson, attended.

Adoption of the Agenda: The agenda of the meeting was adopted.

Consideration of Matters Relating to Accreditation Status: The Chair read statements reminding the Commission of the confidentiality of its materials and deliberations related to the accreditation of programs, as well as conflict of interest policies related to the determination of accreditation status of programs. The Commission reviewed site visit evaluations, progress and other requested reports on predoctoral dental education programs, advanced general dental education programs, advanced specialty education programs and allied dental education programs.

> **Commission Action**: Accreditation status was granted to programs evaluated since the February 2010 meeting. Accreditation actions are summarized in the "Report on the Accreditation Statuses of Educational Programs" (Appendix 1).

Presentation of Plaque: Dr Vincent Iacono and Dr. John Wright received a plaque acknowledging their service on the Commission.

Adjournment: The Commission adjourned the closed session at 4:30 P.M.

Call To Order: The Chair, Dr. Bryan Edgar, called the regular open meeting of the Commission on Dental Accreditation to order at 8:30 A.M. on Friday, August 6, 2010, in the 22nd Floor Board room of the ADA Headquarters Building, Chicago.

Roll Call: Dr. Michael Biermann, Dr. Eric Carlson, Ms. Elizabeth Curran, Mr. Ryan Dulde, Dr. Bryan Edgar, Dr. Andy Elliot, Dr. W. Stan Hardesty, Dr. Janice Jackson (for Dr. Paul Casamassimo), Dr. Donald Joondeph, Dr. Laura Joseph, Dr. Mel Kantor, Dr. Karen Kershenstein, Dr. Kent Knoernschild, Dr. Lee Koppelman, Dr. Charles Marinelli, Dr. Judith Messura, Ms. Anna Nelson, Dr. Reuben Pelot, Dr. Robert Ray, Dr. Michael Reed, Dr. Yilda Rivera-Nazario, Mr. Kenneth Thomalla, Dr. Christopher Wenckus, and Dr. Alexander White.

Dr. Richard Buchanan, Dr. Vincent Iacono, Ms. Mary Kay Richter, Dr. Steven Tonelli and Dr. John Wright were unable to attend.

In addition to the staff of the Commission, Dr. Russ Webb, ADA Trustee Liaison and representatives of the Commission on Dental Accreditation of Canada (CDAC), Dr. Claude Lamarche and Ms. Susan Matheson, attended.

Adoption of Agenda: The agenda of the meeting was adopted.

Reminder of Professional Conduct: The Commission reviewed the Association's policy on professional conduct.

Approval of Minutes from February 2010 Meeting: The minutes of the February 2010 Commission meeting were amended and adopted.

Consent Calendar: The following reports in their entirety were placed on the consent calendar and adopted as received:

- Mail Ballots Approved since the February 2010 Meeting (Appendix 2)
- Report of the Review Committee on Dental Assisting Education (Appendix 3)
- Report of the Review Committee on Dental Hygiene Education (Appendix 4)
- Report of the Review Committee on Dental Laboratory Technology Education (Appendix 5)
- Report of the Review Committee on Dental Public Health Education (Appendix 6)
- Report on the Review Committee on Oral and Maxillofacial Pathology Education (Appendix 7)

- Report on the Review Committee on Oral and Maxillofacial Radiology Education (Appendix 8)
- Report of the Review Committee on Pediatric Dentistry Education (Appendix 9)
- Report of the Review Committee on Periodontics Education (Appendix 10)
- Report of the Review Committee on Prosthodontic Education (Appendix 11)

Report of the Review Committee on Predoctoral Dental Education: Chair**:** Dr. Michael Reed. Committee Members: Dr. Stephen Campbell, Dr. Cecile Feldman, Dr. Gerald Ferretti, Dr. Karen Kershenstein, Dr. Charles Massler, and Dr. Ann McCann; Dr. Bryan Edgar, chair, Commission on Dental Accreditation, *ex officio*. Staff Members: Dr. Lorraine C. Lewis, manager, Predoctoral Dental Education, Dr. Anthony J. Ziebert, director, CODA, and Dr. Laura M. Neumann, ADA senior vice president, Education/Professional Affairs. Guests: Dr. Eugene Anderson, American Dental Education Association, Dr. Gary M. Heir, American Academy of Orofacial Pain, and Mr. Michael Kalutkiewicz and Dr. Frank Scannapieco, American Association for Dental Research were present for the policy portion of the meeting.

The meeting of the Review Committee on Predoctoral Dental Education was held on July 12, 2010 at ADA Headquarters, Chicago, Illinois.

*Frequency of Citings of Accreditation Standards for Dental Education Programs***:** Dr. Kantor observed that in the latest report of the frequency of citings of accreditation standards for dental education programs encompassing 27 program site visits, there has not been a citation for the research standards. Dr. Kantor also reported that in the previous compilation of citings from 1998 through 2006, encompassing 78 program site visits, the research standards had been cited only twice. He noted that this trend can also be quantified in the advanced specialty research standards. He offered several possible explanations for this, including a lack of training of the site visitors; a low threshold for research standards compliance; or incorrect judgments made by the Review Committee. He stated that it begs the question: "are the standards meaningful?" He maintained that the need for robust scholarly activities is critical because it separates the profession from a trade. Dr. Reed responded that at the 20 site visits he has chaired, the research standards have never been cited because each school presented sufficient documentation that it complied with the standards. Dr. Reed stated that he concurred with Dr. Kantor's concerns; however, he did not believe that site visitors are not prepared, nor did he believe they are not doing their job. Further, he stated that there is no evidence to suggest that research in dental schools is not being done, and while there is broad-based research in dental-related areas in competition with dental schools, the new dental schools opening in "non-traditional settings" will also have to meet the research standards. Finally, Dr. Reed noted there are many other standards have also not been cited in this latest frequency of citings. Dr. Kantor reiterated his concern that the standard threshold is so low that every program can achieve it. He wondered whether this trend is worth the Commission's attention.

Commission action: This report was informational in nature; no action was taken.

*Report of the Joint Advisory Committee on International Accreditation***:** There was no discussion of the report of the Joint Advisory Committee on International Accreditation.

Commission action: This report was informational in nature, no action was taken.

*Consideration of Proposed Revision to Accreditation Standards for Dental Education Programs***:** The PREDOC RC reviewed proposed revisions to the accreditation standards at its 2008, 2009 and 2010 Summer meetings. The original proposal for change originated from the ADEA-CODA Task Force on Predoctoral Dental Education Standards which was appointed jointly in 2007 by the Commission on Dental Accreditation (CODA) and the American Dental Education Association (ADEA) Board of Directors. At the Summer 2009 meeting, the PREDOC RC carefully considered each of the comments submitted, and made revisions to the proposed standards. Proposed revisions related to diversity included additions to the principles contained in the Educational Environment; an additional Standard 1-4 related to institutional policies and practices to promote diversity; and revision of intent statements throughout the document. Additionally, revisions to Standard 2-23 were made to update required areas of competency in clinical sciences and editorial changes were made throughout the document related to the comments received. At the Summer 2009 meeting, the Commission determined that the additional changes were substantial and directed that the proposed accreditation standards be circulated to the communities of interest for review and comment through May 1, 2010. In addition, the Commission directed that open hearings be conducted during the October 2009 American Dental Association (ADA) Annual Session and the February 2010 American Dental Education Association (ADEA) Annual Session.

At its July 12, 2010 meeting, the PREDOC RC carefully reviewed comments received. A total of twenty-three (23) comments were received in writing and during open hearings from September 23, 2009 through June 16, 2010. Comments were related to every standard as well as to the Educational Environment and the Definitions section of the proposed standards document. Most comments were editorial in nature, and many included support for the proposed revised standards. Revisions to Dental Education Standards 1-2, 1-3, 2-4, 2-5, 2-17, 2-20 (and intent statement), 4-3, and 5-1 are proposed to simplify language and provide clarity. Following review of the Frequency of Citings Report, the PREDOC RC believed that revision of Dental Education Standard 5-3 related to quality assurance in the patient care program was warranted to provide additional guidance to predoctoral programs and site visitors. Additionally, the PREDOC RC proposed revisions to Dental Education Standard 2-9 and added an intent statement to Standard 6-3 to provide clarity and support the role of scientific discovery and the integration of knowledge in predoctoral programs.

Since the proposed standards will require that programs develop new policies and practices and determine new measures of student competency, the PREDOC RC believed that significant changes will be needed at the institutional level and that time is needed for programs to come into compliance with the new standards. To this end, the PREDOC RC recommends that

programs may elect to be evaluated under the new standards from January 1, 2012 through June 30, 2013. After July 1, 2013, programs will be required to be evaluated under the new standards. Dr. Kantor noted that the language of the intent statement added to Standard 6-3 connotes a very limiting notion of research. Dr. Kantor proposed an amendment to the intent statement (addition is underlined) to broaden the scope of research that could be used to demonstrate compliance with the standard:

> **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.*

Commission action: The Commission amends the intent statement of Standard 6-3 of the revised Predoctoral Dental Education Accreditation Standards as outlined in Appendix 12.

Commission action: The Commission adopts the proposed revisions to the Accreditation Standards for Dental Education Programs, as amended (Appendix 13). Further, the Commission directs that programs may elect to implement the new standards from January 1, 2012 through June 30, 2013, with a required implementation date of July 1, 2013.

Implementation of New Predoctoral Standards: The PREDOC RC reviewed data from the Survey of Dental Education, the Frequency of Citings for Predoctoral Programs and from post site visit surveys conducted from October 2009 through March 2010, representing six (6) comprehensive dental school visits. The purpose of the review was to consider how program personnel, site visitor/consultants and other members of communities of interest would best be informed and/or trained on the use of the new standards, and to consider the ways that evidence can be presented as part of the self-study and collected during an on-site visit under the new standards. Following the review of the information presented, the PREDOC RC believed that the process of writing the self-study and conducting the on-site visit is going smoothly, although additional ways to streamline the process should continue to be explored. Additionally, the Committee found that there is little benchmarking data collected on new areas within the proposed standards, and believed that the predoctoral portion of the Survey of Dental Education should be reviewed. The new areas to be considered include, but are not limited to, diversity, opportunities for service learning and research, and development of student competency in

critical thinking, collaboration with other health care professionals, and skill in functioning in a multicultural work environment.

> **Commission action:** The Commission directs that the ADA/ADEA/CODA Liaison Committee on Surveys and Reports review the predoctoral portion of the Survey of Dental Education so that benchmarking data is collected relative to the revised predoctoral standards. The Liaison Committee should report back to the Commission through the PREDOC RC prior to the required implementation date of the new standards.

Report of the Review Committee on Postdoctoral Dental Education: Chair: Dr. Judith Messura. Committee Members: Dr. Tracy Dellinger, Dr. Steven Ganzberg, Dr. H. Garland Hershey, Dr. Jeffery Hicks, Dr. Agnes Lau, Dr. Dara Rosenberg, Ms. Mary Richter and Dr. Miriam Robbins. Dr. Michael Siegel was unable to attend. Staff Members: Dr. Anthony J. Ziebert, director and Ms. Peggy Soeldner, manager, Postdoctoral General Dentistry Education, CODA. Guests: (open portion only): Ms. Kate Martinez, American Association of Hospital Dentistry; Ms. Jane Kantor, American Academy of Oral Medicine, Dr. Mark Malterud, Academy of General Dentistry.

The meeting of the Postdoctoral General Dentistry Review Committee (PGD RC) was held July 15-16, 2010 at ADA Headquarters, Chicago, Illinois.

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Education Programs in General Dentistry; Advanced Education Programs in General Practice Residency; Advanced General Dentistry Education Programs in Dental Anesthesiology;and Advanced General Dentistry Education Programs in Oral Medicine: There was no discussion on the reports of frequency of citings.

> **Commission action**: These reports were informational in nature, no action was taken.

Consideration of Proposed Revision to Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology: At its January 2010 meeting, the Review Committee on Postdoctoral General Dentistry Education (PGD RC) reviewed a request to consider whether someone who gained the required two years of relevant dental anesthesiology experience prior to the formal training would meet the relevant experience requirement of the Standards and could be considered qualified to be a program director, according to Accreditation Standard 3-2. Following careful consideration, the PGD RC recommended that Standard 3-2 of the Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology be revised to accurately reflect the intent of the standard and to ensure that programs and CODA consultants understand the requirement of Standard 3-2. The PGD RC recommended that the proposed revisions be circulated to the communities of interest for review and comment through May 15, 2010.

At its February 2010 meeting, the Commission on Dental Accreditation agreed with the PGD RC and directed that the proposed revision be circulated to the communities of interest for review

and comment through May 15, 2010 and that an open hearing be conducted at the February-March 2010 American Dental Education Association (ADEA) Annual Session.

At the July 2010 meeting, the PGD RC carefully considered the comments received on the proposed revision to the Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology. The PGD RC believes one rationale for the Standards revision is to make the Standard more flexible, possibly resulting in an expanded pool of qualified program directors. To that end, the PGD RC further revised the standard and recommends the revised standard be circulated to the communities of interest with comments accepted until October 1, 2010, with review of comments at the Winter 2011 meeting of the PGD RC and Commission.

Dr. Kantor expressed concern with how the term "recent" will be applied in the proposed revised standard: "The program director **must…**have had at least two years of recent additional continuous significant practice of general anesthesia." Dr. Messura replied that the combination of the words "recent" and "significant" implies that techniques have changed, and that "recent" and "continuous" would cover the qualitative question. She stated the Review Committee relied on the dental anesthesia content expert for the wording of the standard and the intent is to expand the potential pool of program directors. As the criteria is specifically about the credentials to be program director, an oral surgeon, for instance, would either have to complete a two-year dental anesthesia residency, or its equivalent, as outlined in the standard in order to qualified to be a program director. She reiterated that this standard is not about the ability to deliver general anesthesia in a practice setting.

> **Commission action:** The Commission directs that the proposed revision to Standard 3-2 of the Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology be circulated to the communities for review and comment until October 1, 2010 for consideration at the Winter 2011 meetings of the PGD RC and Commission.

*Consideration of Request to Review General Practice Residency Standard 3-2***:** The PGD RC received a request to review and consider revision to General Practice Residency Standard 3-2. This standard requires program directors appointed after January 1, 2000, who have not previously served as program directors, to have completed an accredited General Practice Residency program or Advanced Education in General Dentistry program. The request contends that there are a number of individuals with significant experience in general dentistry, hospital-based care, and education that have functioned for years in hospital dentistry programs who could serve as successful program directors. However, since these individuals have not completed a general practice residency or advanced education in general dentistry program, they are not qualified to serve as program director because of the requirement set forth in Standard 3-2.

Following discussion, the PGD RC determined that completion of an advanced education program in General Practice Residency or Advanced Education in General Dentistry is essential

to the administration of a General Practice Residency program. Therefore, the PGD RC believed that Accreditation Standard 3-2 should not be revised at this time.

Commission action: This report was information in nature, no action was taken.

Consideration of Request to Revision to Postdoctoral General Dentistry Standards: The PGD RC received the request from the American Academy of Pediatric Dentistry (AAPD) to consider revising the Accreditation Standards for Postdoctoral General Dentistry Education Programs to include peri-natal oral health care and treatment of women before, during and after pregnancy and include language related to this population in the Standards when possible.

The PGD RC noted that the Accreditation Standards for General Practice Residency (GPR) and Advanced Education in General Dentistry (AEGD) currently contain standards related to providing patient-focused care to a wide variety of patients, including patients with special needs The PGD RC believed this patient population includes women during the peri-natal period. Therefore, the PGD RC believed revision of the Standards is not warranted at this time.

Commission action: This report was informational in nature, no action was taken.

Report of the Review Committee on Endodontics Education: Chair: Dr. Christopher Wenckus. Committee Members: Drs. Stephen Clark, Benjamin P. Graham, M. Lamar Hicks, Keith Krell, and James R. Sherrard. Dr. Bryan Edgar, chairman, Commission on Dental Accreditation (CODA), *ex officio*.). Staff member: Catherine A. Horan, manager, Advanced Specialty Education, CODA. Guest: Ms. Beverly Albert, American Association of Endodontists (AAE).

The meeting of the Review Committee on Endodontics Education was conducted on July 12, 2009 at ADA Headquarters, Chicago Illinois.

*Informational Report on Frequency of Citings of Accreditation Standards for Advanced Specialty Education Programs in Endodontics***:** The Review Committee on Endodontics Education (ENDO RC) considered the first annual report on the frequency of citings based upon Accreditation Standards for Advanced Specialty Education Programs in Endodontics, adopted July 2008 and implemented January 1, 2009. The ENDO RC found that the most frequently cited area of noncompliance, cited more than once is the second part of Standard 2-1.b, specifically regarding the program director's time commitment to the program. The ENDO RC further found that there were no citings in Standards 1, 5 and 6, and 14 (9.28%) of the 130 required areas of compliance have been cited at least once. Six (6) of the nine (9) programs of this study received no citings. One program was responsible for 11 of the total 15 citations.

Commission action: This report was informational; no action was taken.

*Re-Consideration of Proposed Revision of Intent Statement to Accreditation Standard 2-4.1 of the Accreditation Standards for Advanced Speciality Education Programs in Endodontics***:** The ENDO RC considered proposals from the American Association of Endodontists (AAE), on a

proposed revision to Standard 2-4 and the statement of intent to that Standard, regarding the attending faculty responsible for clinical activities in an advanced specialty education program in endodontics. The ENDO RC noted that the intent statement was originally developed to ensure supervision of endodontic students/residents in patient care by qualified endodontists, but that the intent has evolved to indicate that only American- and Canadian-trained endodontists qualify to supervise endodontic clinical procedures for endodontic students/residents. At its Winter 2010 meetings, the Commission approved a revision of the intent statement and directed an immediate implementation due to the clarifying nature of the proposal. The purpose of the revision to the statement of intent to Standards 2-4, 2-4.1, was to broaden interpretation of these Standards by not restricting interpretation to those that would fall under a specific category still used by the American Board of Endodontics, thus allowing internationally-trained endodontists to be eligible for teaching/supervising endodontic students/residents, based upon equivalency of experience as determined by the institution/program. Upon consideration of the AAE proposals, the RC maintained that the language of Accreditation Standards 2-4, 2-4.1 should not be revised at this time, but that the statement of intent should be further clarified. To that end, the Committee noted that the revised intent statement, originally proposed by the AAE in its November 24, 2009 submission, would provide the needed clarification. While the Committee discussed limiting clinical practice at remote sites to no more than a percentage of their overall time in the program, similar to the 10% of time allowed for teaching, it believed that a requirement on attending faculty at affiliated sites could be considered in future revision of endodontic accreditation standards.

Based upon significant feedback received on the previous revision to the statement of intent, the ENDO RC recommends that the proposed revision to the statement of intent be circulated for review and comment, with Open Hearings at the annual meetings of the American Dental Association (ADA), the American Dental Education Association (ADEA), and the American Association of Endodontists (AAE), with consideration of final adoption by the Commission at its Summer 2011 meeting. Dr. White expressed concern that the term "educationally equivalent" is not well-defined. Dr. Wenkus responded that programs traditionally know the qualifications of the people supervising their residents and the programs make the evaluations of equivalency in a timely and fair manner.

> **Commission action:** The Commission directs the revision of the intent statement to Standards 2-4, 2-4.1 of the Accreditation Standards for Advanced Specialty Education Programs in Endodontics, as presented in Appendix 14, for circulation to the communities of interest for review and comment; with a "preamble" to the call for comment on the proposal, to explain that the second revision is contained to the intent statement only, and that the standard is not proposed for change; with Open Hearings to be conducted at the Annual Sessions of the American Dental Association (ADA), the American Dental Education Association (ADEA) and the American Association of Endodontists (AAE); and review of comment and consideration of final adoption by the Commission at its Summer 2011 meetings.

Consideration of CODA-American Association of Endodontists (AAE) sponsored training: The RC discussed plans for a CODA calibration training workshop, funded by the American Association of Endodontists (AAE), to be held on February 26, 2011, for endodontic

consultants/site visitors. The ENDO RC noted that program directors preparing for site visits during the next year to year-and-a-half, are also invited as observers. The ENDO RC learned that approximately 27 people have been invited by the AAE for the one-day training program.

Commission action: This report was informational in nature; no action was taken.

Report of the Review Committee on Oral and Maxillofacial Surgery Education: Chair: Dr. Eric R. Carlson. Committee Members: Drs. Richard Burton, Bryan C. Edgar, Ghali E. Ghali, Mr. Paul Lemont, Esquire, and Dr. Paul S. Tiwana. Staff Member: Dr. Catherine A. Horan, manager, Advanced Specialty Education, Commission on Dental Accreditation. Guests: Drs. Ira D. Cheifetz, president, Larry Moore, president-elect, and Arthur C. Jee, vice-president, the American Association of Oral and Maxillofacial Surgeons (AAOMS); Ms. Randi V. Andresen, associate executive director, Advanced Education and Professional Affairs, and Ms. Mary Allaire-Schnitzer, manager, Advanced Education and Resident Affairs, AAOMS; and Dr. Stuart Lieblich, president and Ms. Cheryl E. Mounts, executive director, the American Board of Oral and Maxillofacial Surgery (ABOMS).

The meeting of the Review Committee on Oral and Maxillofacial Surgery Education was conducted on July 13, 2010 at ADA Headquarters in Chicago, Illinois.

*Re-Consideration of a Revision to the Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery***:** The OMS RC discussed an alleged conflict between Standard 4-16.3 (adopted by the Commission at its Winter 2010 meetings and implemented July 1, 2010) and Connecticut law. The OMS RC noted that the list of cosmetic procedures in Accreditation Standard 4-16.3 is in a "should" statement, which indicates a method to achieve the standards, not a requirement. The committee reviewed the Connecticut statutes regarding the scope of practice dentistry. The practice of dentistry does not include: 1. treatment of dermatologic diseases or disorders of skin or face; 2. performance of microvascular free tissue transfer; 3. treatment of diseases or disorders of the eyes; 4. ocular procedures; and 5. performance of cosmetic surgery or other cosmetic procedures, other than those related to oral procedures, its contents or jaws. The OMS RC noted however, that subsection (c) provides less restrictive language for a person "who has successfully completed a postdoctoral training program that is accredited by the Commission…in the specialty area of dentistry in which such person practices." This is beyond the general scope of practice (subsection (a) of the Connecticut state statute) restricting the performance of cosmetic surgery or other cosmetic procedures to those related to the oral cavity, its contents, or the jaws. The Committee further noted that, for oral and maxillofacial surgery residents, under a subsection (e.3), "a person who holds the degree of doctor of dental medicine or doctor of dental surgery or its equivalent… and receive[s] practical training under the supervision of a licensed dentist or physician in an advanced dental education program conducted by a dental or medical school in the state or by a hospital operated by the federal government" is an exception to the previous rule.

As a result of this discussion, the OMS RC concluded that there is no conflict between Accreditation Standard 4-16.3 and Connecticut law, as alleged. Dr. White asked if a legal opinion on this interpretation had been obtained, and whether interpretation of the Board of Dentistry of Connecticut had been obtained. Dr. Carlson replied that the OMS RC felt the

regulations were self-evident and did not require additional interpretation. The OMS RC requested that an acknowledgment be sent to the person who brought the possible conflict to the attention of the Commission, explaining the conclusion of the OMS RC.

> **Commission action:** The Commission directs a letter of acknowledgment be sent to the person who brought the possible conflict between Accreditation Standard 4-16.3 of the Oral and Maxillofacial Surgery Accreditation Standards and Connecticut law to the attention of the Commission, explaining the results of the review.

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery and Informational Report on Frequency of Citings of Accreditation Standards for Clinical Fellowship Training Programs in Oral And Maxillofacial Surgery: There was no discussion on the two reports of Frequency of Citings.

> **Commission action**: This report was informational in nature, no action was taken.

Consideration of the Development of a Policy on Resident Duty Hour Restrictions: Dr. Carlson gave a brief background on the development of resident duty hour restrictions by the Accreditation Council for Graduate Medical Education (ACGME), the accrediting agency for graduate medical education and hospitals. He reported that in 2003, the following guidelines on resident duty hours took effect for medical residents in hospital settings: 1. duty hours must not exceed an 80 hour week average over a four week period of time, not to exceed 320 hours over the month; 2.duty hours must not exceed a 30 hour call period of time, for 24 hours of duty time, only an additional six hours of time for academic activities are allowed; 3. residents must observe one day off in seven; 4. residents must be provided a full weekend off per month; and 5. there must at least be a ten hour period of time observed between shifts. While oral surgery programs and other hospital-based dental programs are not accredited by ACGME, nonetheless the medical centers are accredited by ACGME. It is very difficult for oral surgery programs to adhere to these guidelines in certain medical centers. The RC discussed the new recommendations on resident duty hours from the Task Force of the ACGME, published in the online edition of the *New England Journal of Medicine* (June 22, 2010). The OMS RC noted that the new guidelines: 1. specify more detailed directives for levels of supervision necessary for a first-year resident (known as a PGY-1). A PGY-1 cannot exceed a 16 hour workday and faculty are will have to provide direct supervision to all PGY-1 activities, including on-call activities; 2. reduce duty periods of a PGY-1 to no more than 16 hours a day; and 3. set stricter requirements for duty hour exceptions. Since oral and maxillofacial surgery is a hospital-based discipline, these proposed restrictions have the potential to impact oral and maxillofacial surgery programs, both educationally and fiscally, even though CODA Accreditation Standards do not include any requirement(s) restricting resident duty hours. Dr. Carlson reported that there is support for the new guidelines in the medical community.

The OMS RC believes that CODA should develop a policy regarding the educational and fiscal impact of the proposed resident duty hour restrictions on CODA-accredited oral and maxillofacial surgery programs. In particular, the OMS RC believes the guidelines do not serve

the best interests of oral surgery and other hospital-based dental residency programs. From an educational perspective, for example, training of oral and maxillofacial surgeons may have to be extended as a result of implementation of the proposed resident duty hour restrictions. The OMS RC noted that a study by an outside agency on the economic impact of these proposals is expected soon. The RC recommends that a Task Force composed of stakeholders be formed to study the educational and financial impact that the resident duty hour restrictions proposed by the ACGME, may have on Commission-accredited oral and maxillofacial surgery programs, with the intent of developing a policy for Commission endorsement. Dr. Carlson quoted a perspective recently published in the aforementioned paper in the *New England Journal of Medicine*: "…our results suggest that although the majority of program directors agree with the overall workload recommendations, they disagree regarding limiting duty hours to 16 hours for first-year residents." Dr. Carlson characterized the first year in oral surgery education as "a right of passage," in other words, much education goes on in the first year, and putting restrictions on the first-year residents would be detrimental to resident education and detrimental to patient care and patient safety. Dr. White asked how two disparate policies could be reconciled if CODA formulated a policy in direct contradiction to ACGME policy. Dr. Carlson responded that it is CODA that accredits and reaccredits oral surgery programs, it is not ACGME. As ACGME accredits medical centers also, some oral surgery programs located in those medical centers have been required to abide by the resident duty-hour guidelines. He suggested that CODA could develop a policy that points out this equivocal existence and through presentation to medical centers and deans, the case would be made that CODA policy should override ACGME policy. Dr. Carlson reported that ACGME already looks at two sets of documents when visiting medical centers-one with the oral surgery programs included and one without, so ACGME is aware that oral surgery programs exist with the medical centers. Dr. White expressed further concern that ACGME will cite hospitals if the oral surgery programs are not in compliance with ACGME policies; in addition, he noted that oral surgery programs residents do receive GME money. He wondered how CODA policy could circumvent ACGME policy. Dr. Carlson responded that he thought this is a great opportunity to make a statement and that other oral surgery program directors agree that an 80 hour work-week is appropriate.

Dr. Messura stated that an additional community of interest for this issue is GPR programs. In discussing this issue with her peers, she found that none have been mandated to follow the policy, although some programs comply electively. Further, as the ACGME understands that dental programs are accredited by a different process, it might be better to look at this issue proactively and make sure CODA is on the same page across all hospital-based disciplines. She noted that to come into compliance with these guidelines means expanding manpower, and it has been problematic for medical departments in some medical centers to come into compliance. She concurred that it is worth studying, as it may impact multiple hospital programs. Dr. Neumann suggested gathering more information, especially determining what is within the ACGME purview, being careful to fully understand who is responsible for what and where dental programs fit in. Dr. Elliott recommended to not only study the economic and educational effects of the proposed guidelines, but also the patient safety issues. Dr. Carlson maintained that being proactive is essential, and reminded the Commission that the term "patient safety" is a buzzword today. However, patient safety is discipline independent and there are no differences between oral surgery residents and GPR residents in this regard. The implementation of the revised guidelines is scheduled for July 2011.

Commission action: The Commission directs that a Commission Task Force be formed to study the educational and financial impact the proposed ACGME resident duty hour restrictions have on Commission-accredited oral and maxillofacial surgery programs, with the intent of developing a policy for Commission endorsement.

Report of the Review Committee on Orthodontics and Dentofacial Orthopedics Education: Chair: Dr. Donald Joondeph. Committee Members: Dr. Eladio DeLeon, Mr. Robert Giasolli, and Drs. Virginia Merchant, P. Lionel Sadowsky, and James L. Vaden. Staff Member: Dr. Catherine A. Horan, manager, Advanced Specialty Education, CODA. Guests: (via telephone conference call) Ms. Anita Craig, director, Education and Member Services, American Association of Orthodontists (AAO).

The meeting of the Review Committee on Orthodontics and Dentofacial Orthopedics Education was conducted on July 9, 2010 at ADA Headquarters in Chicago, Illinois.

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics: January 2000 – June 2009 and Informational Report on Frequency of Citings of Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics: July – October 2009: There was no discussion on the two reports of Frequency of Citings.

Commission action: These reports were informational in nature, no action was taken.

*Consideration of a Standard for Monitoring Board Certification of Students/Residents for the Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics***:** The Review Committee on Orthodontics Education (ORTHO RC) reviewed comments received as a result of circulation of two (2) proposed standards, with complementary intent statement and examples of evidence, with regard to monitoring board certification of students/residents**.** The ORTHO RC noted that some comments were contentious and that there may have been a misunderstanding as to the intent of the proposed standards. Nevertheless, the ORTHO RC maintained that orthodontic accreditation standards should include language that addresses preparation and monitoring of board certification, as do several other specialty standards. In reviewing the language related to this topic in other specialty standards, the ORTHO RC identified that the periodontics accreditation standards came the closest to what would work for advanced specialty education programs in orthodontics.

To address the contentious feedback received on the previous proposals, the ORTHO RC recommended that the new proposals, as presented in Appendix 15, be circulated for review and comment, with Open Hearings at the annual meetings of the American Dental Association (ADA), the American Dental Education Association (ADEA), and the American Association of Orthodontists (AAO), and review of comment and consideration of final adoption by the Commission at its Summer 2011 meetings.

Further, the ORTHO RC noted that, due to misunderstanding, the original proposals were perceived as requiring orthodontics programs to teach to the board examinations, and to be accountable for having their students/residents take/pass the boards. Accordingly, the ORTHO RC recommended a "preamble" (to be crafted) to the call for comment on the proposal to explain that the new proposals are simple, broad in scope, and provide flexibility for compliance to the programs.

> **Commission Action:** The Commission directs the new proposals of Standards 2-11, 2-11.a of the Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics, as presented in Appendix 15, be circulated to the communities of interest for review and comment; with a "preamble" to explain that the new proposals are simple, broad in scope, and provide flexibility for compliance to the programs; with Open Hearings to be conducted at the Annual Sessions of the American Dental Association (ADA), the American Dental Education Association (ADEA) and the American Association of Orthodontists (AAO); and review of comment and consideration of final adoption by the Commission at its Summer 2011 meetings.

Consideration of Proposals for Revised and New Accreditation Standards of the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics: The ORTHO RC reviewed feedback from the first fellowship accreditation site visit in craniofacial and special care orthodontics. The Committee noted that feedback was from both the site visitors and the program director. As a result of the review, the ORTHO RC believed that there was merit to the proposals, and recommended the proposals (with amendment) for revision to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (adopted, January 30, 2009; implemented, July 1, 2009), as presented in Appendix 16. The Committee believed that the revisions are editorial in nature, and do not need circulation for comment. Dr. Carlson proposed an amendment to Standard 6-2.2, subpoint "I", on the order of exposure to various subspecialty dental and medical disciplines. He proposed that in the listing, the dental specialties be placed before plastic surgery and craniofacial surgery, with the knowledge that there are many of these cases being performed by oral and maxillofacial surgeons. He suggested that listing the dental specialties at the beginning sends a message of loyalty, both clinically and educationally, to dental specialists.

> **Commission action**: The Commission amends the Standard 6.2-2, subpoint "I", in the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics, to list the dental specialties ahead of the medical specialties.

Dr. Kantor proposed an amendment to the intent statement of Standard 3-9, eliminating the last phrase "…if the equipment is convenient" and adds the phrase "…are acceptable if clinically indicated." He asked the Commission to consider whether the "convenience" of equipment is an appropriate selection criteria for the use of relatively high tech imaging technology.

> **Commission action**: The Commission amends the intent statement of Standard 3-9 in the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and

Special Care Orthodontics, to eliminate the phrase "…if the equipment is convenient.", and add the phrase "…are acceptable if clinically indicated."

Commission action: The Commission directs that proposals for revision to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (adopted, January 30, 2009; implemented, July 1, 2009), as amended in Appendix 17, be adopted with immediate implementation due to the clarifying nature of the proposals.

Consideration of CODA Sessions during Annual Meeting of the American Association of Orthodontists (AAO): The ORTHO RC reviewed previous training opportunities during the annual session of the American Association of Orthodontists (AAO) for orthodontic consultants/site visitors, and orthodontic program directors who are preparing to undergo a site visit. The ORTHO RC believed that similar training should be planned for next year's AAO annual session when it is held in Chicago.

The ORTHO RC believed an information/discussion session should be held on these proposed standards and other new items from CODA's recent meeting agendas, that specifically impact orthodontic programs, such as an anticipated revised Policy on Enrollment Increases in Dental Specialty Programs. The ORTHO RC noted that this information/discussion session could occur as a separate update session as part of the program at the Educators' Conference or as a lead-in to the Open Hearing, as has been the case during recent Open Hearings held during last year's annual sessions of the American Dental Association and the American Dental Education Association. Following its discussion, the ORTHO RC concluded CODA staff should collaborate with AAO staff in ensuring that the above events are scheduled and advertised for next year's AAO annual session.

Commission action: This report was informational only, no action was taken.

Miscellaneous Affairs-Consideration of Matters Relating to More than One Review Committee

Report of the Standing Committee on Documentation: Chair: Dr. Michael Reed. Committee Members: Ms. Elizabeth Curran, Dr. Reuben Pelot, III, Dr. Christopher Wenckus, and Mr. Kenneth Thomalla. Dr. Bryan Edgar, chair, Commission on Dental Accreditation (CODA) participated as ex-officio members of the Committee. Staff member: Ms. Sherin Tooks.

At the Winter 2009 meeting, the Commission on Dental Accreditation (CODA) directed the Standing Committee on Documentation to study two new business items. The first item related to a request from the ADA's Councils on Dental Education and Licensure (CDEL) and Ethics, Bylaws and Judicial Affairs (CEBJA) to consider strengthening current standards, or including a new standard, on ethics and professionalism within the accreditation standards documents. The second item presented by the Review Committee on Postdoctoral General Dentistry Education (PGD RC), related to review of the accreditation standard that requires accreditation of hospital-

based programs by The Joint Commission or its equivalent in the advanced general dentistry education standards.

As a result of its review, the Standing Committee on Documentation proposed a new standard be developed on Ethics and Professionalism for circulation to the communities of interest for period of one year. Similarly, the Documentation Committee proposed circulation of a public notice of potential action related to the elimination of "or its equivalent" from Standard 1, Institutional Commitment/Program Effectiveness of the Accreditation Standards documents in advanced general dentistry education and advanced specialty education and to seek comment, for a period of one year. The Commission concurred with the Documentation Committee's recommendations and directed circulation of these two items from July 2009 through June 2010.

The Standing Committee on Documentation met via conference call on Monday, June 7, 2010 and on Monday, July 26, 2010. Following review of the comments received and discussion, the Documentation Committee concluded that a standard on ethics and professionalism should be added to all accreditation standards documents. However, it was determined that the proposed standard should be placed in Standard 1, Institutional Commitment/Program Effectiveness rather than in the curriculum section of the standards. It was believed that the application of ethical and professional responsibility should be an institution/program-wide initiative. Additionally, in response to comments received, which identified that the "must" statement was unclear, the Committee determined that an intent statement should be included. The final proposed standard on Ethics and Professionalism, to be included in Standard 1 is presented as follows:

Ethics and Professionalism

Graduates **must** be competent in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

> ***Intent:*** *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.*

At the July 2010 meetings, all review committees of the Commission considered the Documentation Committee's report on the proposed addition of a standard and intent statement on Ethics and Professionalism to be placed in Standard 1, Institutional Commitment/Program Effectiveness of all Accreditation Standards documents. The Committee noted that comments varied among review committees, although all review committees agreed that ethics and professionalism is an important topic and should be addressed within the Accreditation Standards documents of each discipline. For example, some committees believed that the proposed Ethics and Professionalism standard was best suited in Institutional Support/Program Effectiveness, while others believed that this standard would be best placed in Curriculum. It was believed that the placement and wording of the proposals put forth by the review committees was based on review committees' assessment of the current standards that address ethics and professionalism as well as the specific needs and educational requirements of the discipline. Most of the review committees believed that measuring competence in ethics and professionalism would be a

difficult task and therefore, suggested revision to the proposed standard on Ethics and Professionalism. These committees include the Dental Assisting Review Committee (DA RC), Predoctoral Dental Education Review Committee (Predoc RC), Postdoctoral General Dentistry Review Committee (PGD RC), Endodontic Review Committee (ENDO RC), Oral and Maxillofacial Pathology Review Committee (OMP RC), Oral and Maxillofacial Radiology Review Committee (OMR RC), Oral and Maxillofacial Surgery Review Committee (OMS RC), Orthodontic and Dentofacial Orthopedic Review Committee (ORTHO RC), Pediatric Dentistry Review Committee (PED RC), Periodontic Review Committee (PERIO RC) and Prosthodontic Review Committee (PROS RC). The Dental Laboratory Technology Review Committee (DLT RC) believed that this proposed standard will be difficult to implement but concurred that it is important and should be adopted. The DLT RC had no suggested revisions for modification but requested that any further proposed changes be re-circulated to all review committees for consideration. The Dental Public Health Review Committee (DPH RC) also concurred with the proposed standard but noted that it would be difficult to implement measures without guidance and criteria which, the committee believes, should be made available to programs and site visitors. The DH RC believed that Standard 2-22 of the Dental Hygiene Standards is comparable to the proposed new standard; therefore, an additional standard is not needed. All except three review committees agreed with placement of the Ethics and Professionalism standard within Standard 1, Institutional Support/Program Effectiveness. As stated, the DH RC believed the proposed standard is already addressed in Standard 2 of the Dental Hygiene Accreditation Standards. Additionally, the Predoc RC believed that the proposed standard should be placed in Standard 2, Educational Program, of the predoctoral standards, not Standard 1. The PED RC believed the proposed standard should be placed in the curriculum section of all standards documents. With regard to implementation, those committees that offered comment recommended various periods of implementation. The ENDO RC, OMS RC, ORTHO RC, and PERIO RC recommended immediate implementation. The PED RC recommended implementation on January 1, 2011. The PGD RC, DPH RC, OMP RC, OMR RC, and PROS RC recommended implementation on July 1, 2011. The DA RC recommended an implementation date of January 1, 2012. Finally, the Predoc RC recommended implementation on July 1, 2013. Following review of the comments received and the Documentation Committee's discussion, the Committee determined that each review committee should review the proposed Ethics and Professionalism standard and its own comments in Winter 2011 and develop a standard on Ethics and Professionalism that suits the needs of the discipline it represents. If a review committee believes this concept is already addressed within its Accreditation Standards, it should notify the Commission and provide rationale for this decision. The Commission could review the proposed standards for each review committee at the Winter 2011 Commission meeting. Dr. Elliott asked why one standard was not developed that each of the review committees could agree on. Dr. Reed responded that was the original intent, but each review committee wanted to be comfortable with what they had in their own standards. Dr. Edgar reiterated that there were very diverse opinions expressed by each review committee regarding the language and placement of the proposed standard.

Commission action: The Commission directs the 14 education review committees to consider the proposed standard and comments received on Ethics and Professionalism and develop a discipline-specific standard on Ethics and Professionalism for review at the Commission's Winter 2011 meeting. The Commission further directs that if a review

committee chooses not to develop a new standard on Ethics and Professionalism, it must provide a rationale for this decision.

The Documentation Committee reviewed the comments received on the proposed deletion of "or its equivalent" from Standard 1 of the advanced dental education Accreditation Standards. Following discussion, the Documentation Committee recommended that the Commission retain the language "or its equivalent" in Standard 1 of the accreditation standards for all advanced education programs. The Committee recognized the need for guidance as to what accrediting bodies would offer institutional accreditation "equivalent" to that of The Joint Commission for anticipated future challenge and, additionally, recommended that the Commission establish an ad hoc committee to further study this issue and identify which agencies could be considered equivalent to The Joint Commission. The Documentation Committee believed that representation on the ad hoc committee should be provided to all stakeholder groups who have a vested interest in this issue. The Documentation Committee believed that the following seven disciplines should have representation on the ad hoc committee: oral and maxillofacial pathology, oral and maxillofacial radiology, pediatric dentistry, prosthodontics, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, and postdoctoral general dentistry. It was noted that other communities interested may be identified by the Commission.

Commission action: The Commission directs that the words "or its equivalent" within the advanced education accreditation standards be retained. The Commission on Dental Accreditation also directs the formation of an ad hoc committee to study Joint Commission equivalency in the advanced education standards. The ad hoc committee will include membership from oral and maxillofacial pathology, oral and maxillofacial radiology, pediatric dentistry, prosthodontics, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, and postdoctoral general dentistry.

Miscellaneous Affairs-Matters for the Commission as a Whole

Report of the Standing Committee on Outcomes Assessment: Chair: Dr. Sharon Turner. Committee Members: Dr. Donald Joondeph, Dr. Karen Kershenstein, Dr. Robert Ray and Dr. Steven Tonelli. Dr. Bryan Edgar, chair, Commission on Dental Accreditation (CODA) participated as ex-officio member of the Committee. Staff Member: Dr. Lorraine Lewis.

Commission Meeting Assessment and Commission Self-Assessment: At its June 17 meeting, the OA Committee learned that an evaluation of each Commission meeting will be conducted and that the results of that evaluation will be incorporated into the 2010 OEAP. Additionally, the Committee reviewed the self-assessment of the Commission which is required of all ADA Councils and Commissions by Resolution 118H-2002 and 119H-2002. The self-assessment consisted of twelve (12) questions that reviewed the Commissions' relevance, mission, duties, processes and structure. The OA Committee determined that the self-assessment was thorough and complete, and included evidence collected as part of the annual review of the OEAP.

Commission action: This report was informational in nature; no action was taken.

Evaluation and Impact of the New Review Committee Structure, CODA Review Committee Survey Report*:* At the Winter 2007 meeting, the Commission implemented the revised Review Committee (RC) composition, and directed that the new structures be evaluated to assess the impact on the RC process. To that end, the OA Committee developed a survey for distribution to all Commissioners, RC members and CODA staff. The initial data collection occurred in fall 2008. At the Summer 2009 meeting, the Commission directed that the survey be repeated in 2009, 2010, and 2011 to provide longitudinal data to evaluate the impact of the new RC structure. A summary of the 2009 survey data and an analysis of the longitudinal data obtained to date were reviewed at the OA Committee's February 3, 2010 meeting. During their review of the OEAP and survey results, the OA Committee discussed current training of RC members and Commissioners. The OA Committee determined that efforts to enhance training of new RC members and Commissioners should continue to be pursued, especially improving information provided during the nomination process. The OA Committee also discussed a possible additional year where nominated RC members and Commissioners would serve as a "trainee" or "designate" and attend meetings, observe a site visit and receive additional training prior to the official start of their term. The OA Committee recommends further investigation into the feasibility of implementing a six months to a year of training for nominated RC members and Commissioners. The CODA Task Force has a similar recommendation, although it is not exactly the same as the OA recommendation. Dr. Joondeph clarified that the difference between the two recommendations is just whether a year or less than a year of training is desired by the Commission. Dr. Kershenstein stated that the Subcommittee was very strong in support for the one year training period and she made a motion to amend the OA recommendations to one year training instead of six to twelve months. Dr. Joseph stated that there is a cost factor involved for travel and the Commission should look at the feasibility of both the six month and one year training period. The amendment failed.

> **Commission action**: The Commission directs that the feasibility of implementing six (6) months to a year of training for nominated Review Committee members and Commissioners prior to the official start of their term be investigated.

Revision of Evaluation Policy and Procedures (EPP) and Operational Policy and Procedures (OPP) Manuals: In 2009, discussion occurred between the OA Committee and staff regarding reorganization of the Operational Policies and Procedures (OPP) and Evaluation Policies and Procedures (EPP) manuals into a single manual. Currently, only the EPP is on the Commission web site, and the OA Committee determined that it would be beneficial to have a combined manual where all Commission policies and procedures would be available to the public and communities of interest. Additionally, there are numerous redundancies throughout the two manuals, and the current organization of the manuals makes it difficult to locate specific policies and/or procedures. The OA Committee directed staff to continue to refine the manual and present it to the Committee for their review in 2010. Staff combined the two manuals, and at its February 3, 2010 meeting, the OA Committee reviewed the new combined manual in its entirety, making revisions based on clarity of information, elimination of redundancy and uniformity of policy and procedures. In addition, policy and procedures were evaluated to determine whether they reflected established U. S. Department of Education (USDE) requirements. The OA Committee

determined that the proposed combined manual, to be called *Evaluation and Operational Policies and Procedures* (EOPP)**,** would be available to Commissioners beginning March 1. Commissioners were asked to provide comment until May 1, 2010. At its June 17 and July 29, 2010 conference call, the OA Committee reviewed all comments and also reviewed revision of policies related to recommendations of the ADA Task Force on CODA. Most revisions to the EOPP were editorial in nature; however, the Committee did consider substantive changes to the following policies:

1. Rules of the Commission on Dental Accreditation. Changes to Rules of the Commission, Articles 2, 3, 4, and 5 are proposed to update the name change to American Association of Dental Boards; provide clarification of the composition of the Commission and who should preside in the absence of the Chair; and clarify language on the appeals process and bring the Rules into alignment with the Higher Education Opportunity Act.
2. Conflict of Interest Policy. The Committee determined that the differentiation between direct and indirect conflicts of interest is confusing and unnecessary. To that end, the Conflict of Interest Policy redefines what constitutes a conflict of interest and carries that definition through to all policies and procedures that are impacted by conflict of interest, such as the Protocol for Review of Report on Accreditation Status of Educational Programs.
3. Criteria for Granting Accreditation. The current time period that a dean or program director must be employed prior to an initial accreditation site visit is three (3) months. The Committee determined that this time period is too short to ensure that the newly hired administrator is familiar with the program and has been involved in writing the application for initial accreditation. The proposed revision to this policy extends the employment period to at least six (6) months prior to the anticipated date of the site visit.
4. Policy Statement on Consultant/Site Visitor Training. Revised policy to require site visitors/consultants who have not been on a site visit during the previous two (2) years to receive additional training. This is in response to ADA Task Force on CODA recommendations #18 and 19.
5. Role of Observers on a Site Visit. The Committee determined that current policy language does not include all the types of observers that can attend site visits. In addition, a description of the role of observer was added so that all individuals who may attend a site visit are included in this section of the manual.
6. Post site visit evaluation. Revised language includes the current practice of using electronic post site visit surveys of both program personnel and consultants, and includes evaluation of all consultants. This is in response to ADA Task Force on CODA recommendation #20.
7. Review Committee Structure. Revised policy to require that all Review committee members who have not been on a site visit within the last two (2) years observe a site visit prior to taking their position. This is in response to ADA Task Force on CODA recommendation #17. Additionally, revised the policy to require that the chairperson of the Review Committee reschedule the meeting if an adequate number of content experts are not present at the meeting. This is in response to ADA Task Force on CODA recommendation #10.

8. Nomination Criteria for Review Committee Members. The OA Committee determined that current language on the total length of terms for those individuals who serve on Review Committees and then serve as Commissioners, or vice versa, is unclear. The Committee determined that individuals may serve a maximum of eight (8) years on any combination of Review Committee and/or Commission without a hiatus. Rules related to the appointment term on Review Committees and the Commission apply. At its July 29, 2010 meeting the Committee determined that the policy on Nomination Criteria for Review Committee Members be implemented immediately. The rationale for immediate implementation of this policy is to allow the Nominating Committee to use the revised policy to fill vacancies on Review Committees prior to the Winter 2011 meetings.
9. Policy on Enrollment Increases in Advanced Dental Specialty Programs. At its Summer 2009 meeting, Commissioners expressed concern regarding the common practice of Commission approval via mail ballot of requests for retroactive enrollment increases for advanced specialty education programs. The Commission referred the Policy on Enrollment Increases in Dental Specialty Programs to the Specialty Review Committees for consideration at the Winter 2010 Commission meeting.

   At its Winter 2010 meeting, the Commission reviewed the discussion that had taken place during the January 2010 Specialty Review Committee meetings, and adopted a resolution directing that the OA Committee review and consider proposed changes to the Policy on Enrollment Increases in Dental Specialty Programs as discussed at the Specialty Review Committee meetings. The OA Committee was also directed to consider revisions to the policy that would eliminate the possibility of Commission approval of retroactive increases in enrollment; match deadlines in the policy to Commission meeting deadlines; and consider logical and practical consequences to violation of policy. Specifically, the OA Committee was asked to consider what happens to the student and what happens to the programs when an unauthorized enrollment increase is reported.

   At its May 2010 conference call, the OA Committee reviewed current Commission policy on Enrollment Increases in Dental Specialty Programs, policies on enrollment increases from other specialty accrediting agencies, and data summarizing the requests for enrollment increases from January 2007 to February 2010. The OA Committee found that retroactive requests peaked in 2009, and dropped by February 2010. The OA Committee determined that the language contained in the policy on Reporting Major Changes in Accredited Programs is too broad to apply to enrollment increases in dental specialty programs. The OA Committee also determined that the Policy on Enrollment Increases in Dental Specialty Programs does not contain logical and practical consequences to violation of the policy and should be revised. To that end, the OA Committee reviewed language recommended by several Specialty Review Committees at their January 2010 meetings, and reviewed policy on substantive changes from other specialty accrediting agencies to modify the existing policy. The OA Committee requested that the advanced specialty review committees consider the proposed modifications to the Policy on Enrollment Increases in Dental Specialty Programs at their July 2010 meetings and provide comment back to the OA Committee.

At its July 29, 2010 conference call the OA Committee carefully considered all comments from the advanced specialty review committees. All advanced specialty review committees felt that the proposed language addresses many of the Commission's prior concerns regarding this policy, and supported revision of the policy. The Review Committees on Dental Public Health (DPH RC), Oral and Maxillofacial Radiology (OMR RC), Orthodontics and Dentofacial Orthopedics (ORTHO RC), and Periodontics (PERIO RC) supported the policy as proposed by the OA Committee. The Committee determined that comments on revisions to the OA Committee's proposal were related to two components of the policy, the notification deadline and the penalties for non-compliance with the policy. The Committee recommends adoption of the following revised policy on Enrollment Increases in Dental Specialty Programs (additions are underlined, deletions indicated as strikethrough):

Policy on Enrollment Increases in Dental Specialty Programs. ~~The Commission on Dental Accreditation monitors increases in enrollment. The purpose for monitoring increases in enrollment through review of existing and projected program resources (faculty, patient availability, and variety of procedures, physical/clinical resources, and allied support services) is to ensure that program resources exist to support the intended enrollment increase.~~ A program considering or planning an enrollment increase, or any other substantive change, should notify the Commission early in the program's planning. Such notification will provide an opportunity for the program to seek consultation from Commission staff regarding the potential effect of the proposed change on the accreditation status and the procedures to be followed.

A request for an increase in enrollment with all supporting documentation must be ~~reported~~ submitted in writing to the Commission ~~at least six (6)~~ one (1) month prior to ~~publishing requests for applications to fill an enrollment increase for consideration at a regularly scheduled Commission meeting.~~ a regularly scheduled semiannual Review Committee/Commission meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents. The Commission will not retroactively approve enrollment increases without a special focused site visit. Special circumstances may be considered on a case-by-case basis, including, but not limited to, temporary enrollment increases due to:

- Student/Resident extending program length due to illness, incomplete projects/clinical assignments, or concurrent enrollment in another program;
- Unexpected loss of an enrollee and need to maintain balance of manpower needs;
- Urgent manpower needs demanded by U.S. armed forces; and
- Natural disasters.

Failure to comply with this policy will jeopardize the program's accreditation status, up to and including withdrawal of accreditation. If a program has enrolled beyond the approved number of students/residents without ~~notifying~~ prior approval by the

Commission, a special focused site visit will be required at the program's expense. If the focused visit determines that the program does not have the resources to support the additional student(s)/resident(s), the program will be placed on "intent to withdraw" status and no more additional student(s)/resident(s) beyond the previously approved number may be admitted to the program until the deficiencies have been rectified and approved by the Commission. Student(s)/Resident(s) who have already been formally accepted or enrolled in the program will be allowed to continue.

10. Policy on Accreditation of Off-Campus Sites. At the Winter 2010 meeting, the Commission considered the Review Committees' discussion and adopted a resolution for the OA Committee to consider whether twenty (20) percent is the proper threshold to trigger a site visit to an off-campus site as contained in the Policy Statement on Accreditation of Off-Campus Sites. The Commission requested that the OA Committee provide a report and recommendation to the Commission at the Summer 2010 meeting.

    At the June 2010 conference call, the OA Committee reviewed the summary of the Winter 2010 Review Committee's discussion and policies on accreditation of off-campus sites from other specialty accrediting agencies**.** The Committee determined that the Review Committees emphasized the value of maintaining flexibility in the policy, and of broadening the scope of the policy to include all educational experiences. The 20% rule was an arbitrary number which had nothing to do with either the quality or quantity of information. The education at a site less than 20% of the time could be vitally important to the students' education. Additionally, several Review Committees felt that the term "clinical instruction" in the policy was unclear and could be confusing. The Committee recommends adoption of the following Policy on Accreditation of Off-Campus Sites (additions are underlined, deletions indicated as strikethrough):

    Policy Statement On Accreditation Of Off-Campus Sites The Commission on Dental Accreditation must be informed when ~~an institution, which has~~ a program accredited by the Commission, plans to initiate an off-campus site (distance site and/or additional training site not located on the main campus). ~~in which all or the majority of the instruction occurs. In accordance with the Policy on Reporting Major Changes in Accredited Programs, t~~The Commission must be informed in writing six (6) months ~~thirty (30) days~~ prior to the anticipated ~~implementation~~ initiation of educational experiences at ~~of~~ the ~~change~~ off-campus site.

    Generally, only programs without reporting requirements will be approved to initiate educational experiences at off-campus sites. The Commission ~~on Dental Accreditation~~ must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all students/residents enrolled in an accredited program. When the Commission has received notification that an institution plans to offer its accredited program at an off-campus site, the Commission will conduct a special focused site visit to each of the off-campus

locations where a significant portion of each student's/resident's educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, ~~20% or more of the clinical instruction occurs for each student/resident~~ or if other cause exists for such a visit as determined by the Commission. After ~~its~~ the initial visit, each site will continue to be visited during the regularly scheduled site visits to the program.

The Commission recognizes that dental assisting and dental laboratory technology programs utilize numerous extramural dental offices and laboratories to provide students with clinical/laboratory practice experience. In this instance, the Commission will randomly select and visit several facilities during the site visit to a program. All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to on and off-campus locations. The Commission office should be contacted for current information on fees.

Dr. Joondeph reported that preference of the review committees was that the determination of visiting a distance site should be based on a qualitative evaluation, not a quantitative evaluation of the curriculum provided at that distance site. Dr. White asked how much flexibility the review committees would have in determining which distance sites to visit. Dr. Joondeph replied that most review committees wanted flexibility to visit any distance sites at which the program delivered its curriculum. The review committees need to accept the responsibility to make this determination, so it is conceivable that sites with less than 20% of the curriculum will trigger a site visit. Dr. Reed asked these if these proposed changes could be circulated to the communities of interest before implementation, as many of the changes being suggested could have an effect on curriculum and have an effect on other educational components of dental schools. Dr. Edgar replied that accreditation policy is solely under the purview of the Commission, and that Commission is ultimately responsible for its own policy.

Dr. Carlson expressed concern that the proposed revised policy on enrollment increase in specialty programs requires only a six month notice for notification of changes in enrollment. However, specialty programs that participate in a match need at least a thirteen month planning period prior to the intended enrollment increase in order to meet the legal obligations of the match. He stated that what seems to missing in this revised policy is the chronology associated with the match and that some enrollment increases would be denied after the legally binding match is announced. Dr. Joondeph responded that the programs need to be aware that they must apply earlier for enrollment increases in these types of situations. As this is a general policy for all programs that utilize the match and programs that do not utilize the match, scheduling and timing is different for each specialty. Specialty specific requirements for major change would be the only solution to this problem. Dr. Edgar stated that at the point in time a program wants an enrollment increase, the program should be aware of the time–frame that applies. Dr. Joondeph also made the point that there is no limit on how early the request can be put in, just how late. Dr. Carlson responded that in a perfect world, the program director will know the policy, but he was not certain it will be done in all cases. He was concerned that the Commission will see program directors not planning properly. Dr. Edgar stated there are exceptions for expedited requests, plus a violation triggers a special focus site visit, which may find that everything is fine. Dr. White

brought up a possible difficulty with applying for HRSA monies. The ability to enroll students depends on the institutions ability to get a grant and he asked whether a program would apply for enrollment increases along with the grant application. Usually notification of the availability of the grants happens late in the year, with a quick turnaround time. Dr. Joondeph responded the feedback from review committees was clear. The review committees want a steadfast, rigid rule. There was consensus that the granting of a retroactive increase was just a rubber stamp of what was already done. In particular, the charge to the OA in formulating the revised policy was that there must be consequences for programs that do not follow the policy. The revised policy also provides for a streamlined process if necessary, as review committees can act on requests within six months of an application. Conceivably, the process could be much shorter. Dr. Joondeph cited the instance where programs could have approval by the February Commission meeting for an enrollment increase request made in the preceding December. The policy is written so that programs must get approval first before accepting students. This is to protect the students. Review committee flexibility to make the decision is the key to the revised policy.

> **Commission action**: The Commission adopts the revised *Evaluation and Operational Policies and Procedures Manual*.

Revised Rules of the Commission: Changes to Rules of the Commission, Articles 2, 3, 4, and 5 are proposed to update the name change to American Association of Dental Boards; provide clarification of the composition of the Commission and who should preside in the absence of the Chair; and clarify language on the appeals process and bring the Rules into alignment with the higher education act.

> **Commission action**: The Commission adopts revised *Rules* of the Commission on Dental Accreditation and per ADA *Bylaws*, sends the revised *Rules* to the Council on Dental Education and Licensure and the Council on Ethics, Bylaws and Judicial Affairs for support and to the 2010 ADA House of Delegates meeting for approval.

Consideration of Monitoring of Programs: At its Summer 2009 meeting, several Commissioners expressed concern that the Commission needs to take a more proactive approach in the monitoring of educational programs, especially those programs that have an unusually high number of recommendations or those programs that have severe deficiencies. It was suggested that the Commission investigate initiating a policy and procedures to identify "triggers" that would require programs to report to the Commission more often or to report more in-depth information. To that end, the Commission directed the OA Committee to review the Major Change policy regarding possible triggers that would require interim reporting by programs, for review at the Commission's Winter 2010 meeting. Following review, the OA Committee determined that policies and procedures are in place to provide flexibility to both review committees and the Commission in making accreditation determinations. Review committees can and have recommended that a program be put on "approval with reporting requirements-intent to withdraw" prior to their deadline date if it deems the deficiencies severe. The Commission, during its review of programs, can likewise place a program on "approval with reporting requirements-intent to withdraw," even if the review committee has recommended a different accreditation status. The OA Committee determined that training and calibration of Commissioners and review committee members should be reviewed to make certain that training

emphasizes all of the options available when making accreditation recommendations and decisions.

> **Commission action**: The Commission directs that training and calibration of Commissioners and review committee members be reviewed to make certain that training emphasizes all of the options available when making accreditation recommendations and decisions.

ADA Policies: Each division within the American Dental Association (ADA) routinely reviews relevant policies and makes recommendations to the ADA House of Delegates. To that end, policies related to the accreditation of education programs under the purview of the Commission on Dental Accreditation must be reviewed and recommendations made to the ADA House. At its July 29, 2010 meeting, the OA committee considered ADA policies related to the accreditation of educational programs.

> **Commission action**: The Commission recommends that the ADA House of Delegates retain as written the following ADA policies related to the accreditation of educational programs: State Board and Commission on Dental Accreditation Roles in Candidate Evaluation for Licensure (2003:367); Dental Accreditation and Specialty Recognition (2003:375); Encouraging the Commission on Dental Accreditation to Adopt Rigorous Standards (2003:374); Sponsorship of Accreditation Programs (1972:697;2003:367); Participation in International Higher Education Collaborative Networks (2003:368).

> **Commission action**: The Commission recommends that the ADA House of Delegates revise the following ADA policies related to the accreditation of educational programs: Urging the Commission on Dental Accreditation to Communicate with Local Communities of Interest (2003:367) and Single Accreditation Program (1996:696).

> **Commission action**: The Commission recommends that the ADA House of Delegates rescind the following ADA policies related to the accreditation of educational programs: Advanced Educational Programs in General Dentistry (1979:613).

Report on Appointment of Commissioners and Appeal Board Members: The Commission received information on the replacement of Commissioners and Appeal Board Members.

Commission

Former Member		**Current Member**	
Dr. Leo Rouse	(ADEA)	Dr. Yilda Rivera-Nazario	(ADEA)
Dr. Michael Reed	(ADEA)	Dr. John Williams	(ADEA)
Dr. John Wright	(AAOMP)	Dr. Brad Neville	(AAOMP)
Dr. Bryan Edgar	(AADB)	Dr. Paul G. Sims	(AADB)
Dr. Logan Nalley	(AADB)	Dr. W. Stan Hardesty	(AADB)

Dr. Vincent Iacono	(AAP)	Dr. Henry Greenwell	(AAP)
Dr. Kathleen Leonard	(ADHA)	Dr. Laura Joseph	(ADHA)
Mr. Corwyn Hopke	(ASDA)	Mr. Ryan Dulde	(ASDA)
Ms. Mary K. Richter	(Public)	TBA	(Public)
Mr. Kenneth Thomalla	(Public)	TBA	(Public)
Dr. Sharon Turner	(ADEA)	TBA	(ADEA)

Appeals Board

Former Member		**Current Member**	
Dr. Harold Seigel	(AADB)	Dr. Bruce P. Kinney	(AADB)
Dr. Steven Schonfeld	(ADA)	Dr. Stanwood H. Kanna	(ADA)
Dr. J. Terrell Hoffeld	(DPH)	Dr. James N. Sutherland	(DPH)
Dr. Thomas W. Braun	(OMS)	TBA	(OMS)
Ms. Camille Kostelac-Cherry	(Public)	TBA	(Public)
Vacant	(OMR)	TBA	(OMR)
Mr. Dennis Lanier	(NADL)	TBA	(NADL)
Dr. Mike Salkin	(Perio)	TBA	(Perio)
Dr. Gayle Glenn	(Ortho)	TBA	(Ortho)
Dr. Chuck Cunningham	(Endo)	TBA	(Endo)

Commission Action: This report was informational in nature; no action was taken.

Report of the Standing Committee on Nominations of Review Committee Members and Public Members: Chair: Dr. Alex White. Committee Members: Dr. Vincent Iacono; Dr. Kent Knoernschild; Dr. Ruben Pelot; and Ms. Mary Kay Richter. Dr. Bryan Edgar, chair of the Commission participated in the conference call in an *ex officio* capacity. Staff: Ms. Gwen Welling.

An ongoing responsibility of the Standing Committee on Nominations of Review Committee and Public Member's (Nomination Committee) includes recommendations for qualified consumer/public members for the Commission on Dental Accreditation (CODA) and nominations to vacant positions on Review Committees. The committee reviewed the membership roster for the Commission board as well as selection criteria for nominees and noted that the term of two Public Members will expire in October 2010 and require replacements. Based on its review of the *Commission and Review Committee Nominations Criteria* for *Public/Consumer Nominees*, the completed nomination forms and discussion of the qualifications of candidates, the committee determined that the nomination of Public Members to the Commission and review committees should be deferred to a future meeting. The committee noted that pool of applications was minimal and believed that additional recruitment efforts could enhance the selection process. The committee reviewed the rosters of review committees and identified vacancies in the following categories: public members, discipline specific members and non-discipline specific members. The committee considered nominations for

vacant positions along with nominee qualifications and information submitted on nomination forms.

The review of nominees for the public member positions and the nominee from the National Association of Dental Laboratories (NADL) for the Review Committee on Dental Laboratory Education were deferred to a future meeting due to lack of sufficient nominees.

After careful consideration of the nominees' qualifications, the Committee proposes the following candidates for the vacant positions:

Dental Anesthesia Educator nominated by The American Society of Dentist Anesthesiologist (ASDA) for the Review Committee on Postdoctoral Education.

- Dr. James Tom

Alternate: Dr. Megann Smiley

Oral Facial Pain Educator nominated by the American Academy of Orofacial Pain (AAOP) for the Review Committee on Postdoctoral Education.

- Dr. Henry Gremillion

Alternate: Dr. Heidi Crow

Oral Medicine Educator nominated by the American Academy of Oral Medicine (AAOM) for the Review Committee on Postdoctoral Education.

- Dr. Michael Brennan

Alternate: Dr. Nathanial Treister

American Board of Prosthodontics (ABP) Representative for the Review Committee on Prosthodontics Education.

- Dr. Lily Garcia

Alternate: Dr. Robert Taft

Commission action: The Commission approves the nominees for appointment to the relevant review committees to fill discipline-specific vacancies.

It is recommended that the following nominees, as identified in order of preference by the committee, be approved by the Commission for appointment by the Commission chair to open positions on review committees based on the nominee's background and the needs of the review committees.

General Dentists (5 vacancies for various RC's):

1. Dr. Mary Ellen Cuccaro
2. Dr. Jane Casada
3. Dr. Diane Talentowski
4. Dr. Marshall Titus
5. Dr. Jeffrey Hochstein

Alternates: Dr. Edward Coryell and Dr. Alan Douglas

Specialty Dentist Practitioner (1 vacancy for Postdoc RC):
1. Dr. Sebastian Ciancio
Alternate: Dr. Mary Pryor

Higher Education or Hospital Administrator (2 vacancies for various RC's)
1. Dr. William Buchanan
2. Dr. Stephen Young
Alternate: Dr. Melanie Peterson

Allied Educator (1 vacancy for Predoc RC)
1. Ms. Sally Muerillo
Alternate: Dr. Ellen Grimes

Dental Assisting Educator (1 vacancy for DA RC):
1. Ms. Deanna Stentiford
Alternate: Ms. Karen Castleberry

Dental Assisting Practitioner (1 vacancy for DA RC)
- Ms. Lori Barnhart

Alternate: Ms. Cathy Roberts

Dental Hygiene Educator (2 vacancies for DH RC)
1. Dr. Lynn Austin
2. Dr. Susan Duley
Alternate: Ms. Heather Flick

Dental Hygiene Practitioner (1 vacancy for DH RC)
- Ms. Barbara Dixon

Alternate: Ms. Carol Johnson

Commission action: The Commission approves the nominees, as identified in order of preference by the Nominating Committee, for appointment by the Commission chair to open positions on review committees based on the nominee's background and the needs of the review committees.

Report of the CODA Task Force on New Dental Team Members: Chair: Dr. Bryan Edgar. Committee Members: Dr. Michael Biermann, Dr. Paul Casamassimo, Ms. Kathleen Leonard, Ms. Mary Kay Richter, Dr. Paul Sims, and Dr. Sharon Turner. Consultant: Dr. Patrick Lloyd. Guest: Dr. Russ Webb (ADA Trustee Liaison). Staff: Dr. Laura Neumann (ADA Senior Vice-President for Education and Professional Affairs) and Dr. Anthony Ziebert.

The CODA Task Force on New Dental Team Members met on May 1, 2010 at the ADA Headquarters Building, Chicago Illinois.

The Commission received requests to accredit the Dental Therapy and Advanced Dental Therapy Educational programs in the state of Minnesota from the Minnesota Board of Dentistry (Sept. 15, 2009); the University of Minnesota (Dental Therapy Program-baccalaureate degree) (Nov. 2, 2009); the Minnesota Dental Association (Nov. 4, 2009); and the Metropolitan State University of the Minnesota and State Colleges and Universities System (Advanced Dental Therapy Program-master's degree) (Dec. 2, 2009). Students are already enrolled in both programs and the statutory language addresses program accreditation by requiring that an applicant for licensure have "…graduated with a baccalaureate degree or a master's degree from a dental therapy education program that has been approved by the board or accredited by the ...Commission on Dental Accreditation or another board-approved national accreditation organization." The requests ask the Commission to develop a document that defines educational standards for dental therapy and advanced dental therapy. In addition, the Commission received a request to accredit Expanded Function Dental Auxilliary (EFDA) educational programs in the State of Washington from the Dental Quality Assurance Commission (DQAC). The DQAC currently approves education programs for graduates to be eligible for the Washington State EFDA license.

At the February 2010 Commission meeting, the Commission noted that its mission is to serve the public by ensuring quality education and patient safety. The accreditation review of programs in areas other than predoctoral dental and dental specialties is feasible and within its purview as evidenced by its review of programs in advanced general dentistry, dental hygiene, dental assisting and dental laboratory technology. The Commission noted that Resolution 31-H, adopted at the 2009 ADA Annual Session in Honolulu by the House of Delegates, may address this issue. In particular, the last resolving clause of Resolution 31-H states: "Resolved**,** that the ADA recommends that any new member of the dental team be supervised by a dentist and be based upon a determination of need, sufficient education and training through a CODA accredited program, and a scope of practice that ensure the protection of the public's oral health."

At the May 10, 2010 meeting, the Task Force reviewed and discussed in detail extensive background documentation, including outlines of models of dental therapy education from throughout the world. The Task Force reviewed the mission of the Commission as it relates to Minnesota request and discussed extensively the rationale for dentistry to be involved with this process. The Task Force noted that CODA is the only body that can set national standards for dentistry and the standards reflect evolving practice of dentistry. While the ADA House of Delegates may not wish to see dentistry evolve in this manner, Minnesota and other states are evolving with similar types of legislation and models. The Task Force reviewed the program at the University of Minnesota and noted that the dental therapy students are being trained alongside the dental students in the school. As defined in the Minnesota law, the scope of practice is very narrow and the law specifies that dental therapists would practice under direct supervision of a dentist. The Task Force learned that the federal government does require accrediting agencies to evaluate employability of graduates of programs they accredit. Gainful employment and the ability to pay off student loans has become an outcomes focus of the USDE.

There is the potential that other accrediting agencies, could accredit dental therapy programs and negatively impact the concept of the dental team. While the Task Force acknowledged the

concerns of private practice dentists around the country regarding dental therapists, the Task Force noted that the legislation in Minnesota and proposed legislation in other states has dental therapists working under direct supervision. The Task Force reviewed American Association of Public Health Dentists (AAPHD) press release on their dental therapy curriculum proposal and noted that the AAPHD model is slightly different than the other models currently being discussed within certain states.

The Task Force also discussed the request from the State of Washington to accredit Expanded Function Dental Auxiliary (EFDA) educational programs. The Task Force came to the conclusion that EFDA standards could be appended to the existing Dental Assisting standards, similar to what is currently done with AEGD and GPR programs that offer an additional second year of residency. The following additional points were expressed by members of the Task Force regarding the feasibility of CODA accrediting Dental Therapy education programs:

- The profession must take ownership of this issue. If the profession does not take ownership, it will appear dentists don't care about the access to care issues.
- There is still a chance for the profession to get in front of this issue and have a major role in shaping the scope of practice.
- State dental boards do not have the expertise to determine the quality of education programs. CODA accreditation frees the dental boards to deal with regulatory issues and allows educators to deal with education issues.
- The ADA and the Commission have an obligation to provide guidance to its members. In addition, there is an obligation to provide resources to all the states. This was the intent of Resolution 31-H, which called for CODA accreditation if dental therapy programs are mandated by state legislatures in certain states.
- Patient welfare and patient care could be adversely affected if there are no standards. The ADA and the Commission have the ability and obligation to make the process safe for the patients.
- There is the potential for fragmentation of the profession if other groups determine the scope of practice and accredit programs.
- The profession and the public can have greater confidence in the utilization of dental therapists who complete their education in a CODA-accredited program.
- Accreditation of dental therapy programs will be financially consistent with accreditation of all other dental and dental-related programs.
- Accreditation of dental therapy programs would not endorse one particular model of care and states would have some flexibility to meet the needs of its citizens by designating the number and/or types of procedures performed.

The Task Force noted that there is currently no Commission policy, nor are there criteria, for determining whether the Commission should establish a process of accreditation for educational programs in new areas of allied dentistry. The Task Force came to the consensus that the generic principles and criteria that were used to determine whether the Commission should establish a process of accreditation for interest areas in general dentistry, could be used to evaluate both the Dental Therapy and EFDA requests. In addition, the Task Force came to the consensus that while most of the generic criteria were met for establishing a process of accreditation for Dental Therapy education programs, there was still a question as to whether there is a demand for this

type of practitioner on a national level. Therefore, the Task Force concluded that the Commission should survey the communities of interest, state dental associations and state dental boards to determine whether there is demand for a Dental Therapy practitioner. The Task Force recommendations are as follows: (1) The criteria and principles used by the Task Force on New Dental Team Members to make the determination of whether educational programs for proposed new member of the dental team are eligible for accreditation by the Commission on Dental Accreditation, should be formalized as official Commission policy and added to the Evaluation and Operational Policies and Procedures Manual; (2) A Commission Task Force should be formed to coordinate a national survey of state dental associations, state dental boards, and other stakeholder groups to determine need and support from the public and professional communities for accreditation of dental therapy educational programs beyond a single state (Minnesota) and to develop standards for dental therapy education programs if such a need and support are indicated by the national survey; and (3) The Dental Assisting Review Committee should begin the process of reviewing and updating the Standards for Dental Assisting Educational Programs to provide for review of programs with an EFDA component.

In regards to the first recommendation from the Task Force, Dr. Elliott stated that the criteria are not well-defined and he questioned some of the interpretation of the criteria by the Task Force. He suggested postponing the decision on accepting the criteria as policy, until data on the actual need for dental therapists is collected. Dr. Elliot made a motion to postpone definitely the discussion of first recommendation until the second recommendation is discussed. Dr. Kantor reminded the Commission that the first recommendation is a process recommendation to codify the procedure that the Task Force used to determine whether programs are even eligible for accreditation. Dr. Kantor stated that the question before the Commission is: does the process as presented need to be modified? Dr. Neumann clarified that the first recommendation is to approve criteria as commission policy, not to consider whether the evidence exists to begin the process of accreditation for dental therapy programs. The motion to postpone definitely failed.

> **Commission action**: The Commission directs that criteria and principles used by the Task Force on New Dental Team Members to make the determination of whether educational programs for proposed new member of the dental team are eligible for accreditation by the Commission on Dental Accreditation should be formalized as official Commission policy and added to the Evaluation and Operational Policies and Procedures Manual.

In regards to the second recommendation from the Task Force, Dr. Joondeph made a motion to amend the recommendation as follows: "A Commission Task Force should be formed to coordinate a national survey of state dental associations, state dental boards, and other stakeholder groups to determine need and support from the public and professional communities for accreditation of dental therapy educational programs beyond a single state (Minnesota) ~~and to develop standards for dental therapy education programs if such a need and support are indicated by the national survey~~." The rationale for this amendment was to ensure that the survey information and evaluation is reported directly to the Commission. This amendment was defeated. Dr. Kantor made a motion to amend the recommendation as follows: "…and to concurrently develop standards for dental therapy education programs~~. if such a need and support~~

~~are indicated by the national survey~~." Dr. Kantor's rationale was that he believed the processes (standards development and surveying) should proceed concurrently. The last two sentences delay the process. Both Drs. Elliot and Hardesty maintained that there is a need to gather evidence first, before developing standards. Dr. Joseph stated that the educational programs are already in place and that it is incumbent upon the Commission to assess quality. The amendment to the recommendation passed. Dr. Elliott then made a motion to amend the recommendation as follows: "A Commission Task Force should be formed to coordinate a national survey of state dental associations, state dental boards, and other stakeholder groups to determine need and support from the public and professional communities for accreditation of dental therapy educational programs beyond a single state (Minnesota) and concurrently develop standards for dental therapy education programs. The task force should assess the employability and the economic viability of the dental therapy model through the survey." Dr. Elliott stated that it was important to also look at economic feasibility of this model and to look at the ability of students to pay back their loans. He further suggested that if there are states already looking at economic viability of the dental therapy model, the survey could trigger a larger study if the survey results suggest that needs to be done. Dr. Hardesty stated that there is further data regarding therapists in Canada, as to the percentage of those trained who are actually employed. There is also data from the British model as far as the viability. Dr. White reminded the Commission there are currently students enrolled in programs graduating within the next year, so the determination of the viability of the program has already been made. He noted that the economics is one factor, but if students are going to be graduating and practicing soon, and one of the missions of the Commission is to protect the public, how does the Commission rationalize not accrediting these programs on an economic basis only? Dr. Neumann clarified that the USDE does not provide information on the employability or viability of graduates of professional programs. The Commission would be responsible for verifying this. Typically, when a group approaches the Commission to accredit programs, the group provides this data, and the data was not provided in this case. She stated that the Commission has the option go back to the groups requesting a process of accreditation be established and ask them to provide the data. In addition, there could be financial implications for conducting such a comprehensive study and there are budgetary considerations for the Commission. Dr. Koppelmann asked if the Commission does an economic examination of all other dental programs vis-a-vis this recommendation? Dr. Neumann responded that the Commission asks all dental education and dental hygiene programs to provide outcomes information on licensure exam pass rates and the Commission has had to present to USDE evidence that graduates from dental programs are employed a certain number of years after graduation. Specialties also have to provide outcomes on whether graduates are practicing and whether they are board-certified. Dr. Koppelmann stated that this is troubling, as the dental therapy programs will have no employment data because they are relatively new. Data that is collected will not be relevant. The amendment passed; however, the amended recommendation failed.

There was no discussion of Task Force recommendation #3: The Dental Assisting Review Committee should begin the process of reviewing and updating the Standards for Dental Assisting Educational Programs to provide for review of programs with an EFDA component.

Commission action: The Commission directs the Dental Assisting Review Committee begin the process of reviewing and updating the Standards for Dental Assisting Educational Programs to provide for review of programs with an EFDA component.

Report on Proposed Standing Committee Restructuring: At the February 2010 Commission meeting, the Commission voted to postpone consideration of the restructure of the standing committees of the Commission to allow Commission members time to evaluate the proposed restructuring. The restructuring recommendation from the CODA Subcommittee on the ADA Task Force on CODA Recommendations partially addresses ADA recommendation #'s 26, 27, and 28 on strategic planning. The Subcommittee recommends the Commission adopt the revised Standing Committee Structure and the charge for each committee: Quality Assurance and Strategic Planning; Documentation and Policy Review; Nomination; Finance; and Communication and Technology.

Commission action: The Commission adopts the revised Standing Committee Structure and the charge for each committee: Quality Assurance and Strategic Planning; Documentation and Policy Review; Nomination; Finance; and Communication and Technology.

ADA Strategic Plan and CODA Progress on Meeting Goals for 2010: Dr. Webb thanked the Commission for its service to the profession and to the patients and briefly discussed the 2011-2014 ADA strategic plan. He reported that the four major 2011-2014 ADA goals and their respective objectives listed in this plan represent the ADA's focused response to this environment and represent the future state to be achieved. The belief statements set the stage for the translation of the strategic plan into an annual operating plan which identifies key initiatives and drives the ADA's day-to-day work. Dr. Ziebert discussed the linkage between the ADA goals and the goals of the Commission. He reported the Commission continues to make progress in achieving its goals in 2010.

Commission action: This report was informational in nature, no action was taken.

Report of the Subcommittee on the ADA Task Force on CODA Report and Recommendations: Chair: Dr. Bryan Edgar. Committee Members: Mr. Gary Gann, Dr. Vincent Iacono, Dr. Karen Kershenstein, Dr. Larry Nissen, and Dr. Alex White. Guests: Dr. Kathy Kell, Chair, ADA Monitoring Committee, Dr. Russ Webb, Trustee, 13th District and BOT Liaison to CODA. Staff: Dr. Laura Neumann, Senior Vice President, Education/Professional Affairs, American Dental Association; Dr. Anthony Ziebert, director, CODA; CODA managers: Dr. Catherine Horan, Dr. Lorraine Lewis, Ms. Patrice Renfrow, Ms. Peggy Soeldner, Ms. Sherin Tooks, and Ms. Gwen Welling.

The Subcommittee on the ADA Task Force on CODA Report and Recommendations met on August 5, 2010, at the ADA Headquarters in Chicago, Illinois.

In response to the ADA Task Force on CODA recommendations on CODA structure and finances, the CODA Subcommittee and the ADA Monitoring Committee formed a Joint Workgroup which met five times to consider extensive background information, feedback from its parent committees and potential recommendations relating to CODA structure and funding. In considering current CODA structure and potential alternatives, the Joint Workgroup had in-depth discussions of the pros and cons and advantages and disadvantages of different models. In its evaluation, the Workgroup focused on issues, such as autonomy; size and role of the decision-making body in relation to any review committees or subcommittees; flow of information; efficiency of operation; the balance in decision-making; and the concept of the dental profession as a team. A critical consideration was the potential for communication and discussion among all of the disciplines in dentistry on issues that impact education and dentistry as a whole. The Joint Workgroup initially considered nine proposed structures, including the current structure of the Commission. The nine different models were narrowed down to three and an in-depth analysis of current structure compared to two other proposed structures was done. The first was a "stove-pipe" model. In this model, there are two or more completely separate accrediting entities with an oversight body. The Joint Workgroup considered the biggest drawbacks to this particular structure were that there were potentially significant communication problems between the stovepipes, and the concept of the "dental team" would not be enhanced. The second was a model which would retain participation of the same organizations currently represented on CODA, but reduce the overall size of the Commission from 30 to 21 members by decreasing the number of ADA, ADEA, AADB and public members representatives from four to three and changing the term of appointment to two three-year terms. While this structure would result in a slight reduction in meeting expenses, the Joint Workgroup noted that three-year terms would be inconsistent with the practices of other ADA agencies and external appointing organizations. The reappointment process for two sequential terms and the 50% rule for filling vacancies would also present challenges. For these reasons, the Joint Workgroup came to the conclusion that changing the terms of commissioners would not be in the best interest of the Commission at this time and both the Commission and the ADA Monitoring Committee agreed with this conclusion. In the end, the Joint Workgroup recommended retaining the current structure of the Commission, as it best meets the needs of the profession and the public. In addition, the implementation of positive changes in Commission functionality has addressed many of the issues that led to a recommendation of possible restructuring in the first place. Both the Subcommittee and the ADA Monitoring Committee agreed with the Joint Workgroup recommendation to retain the current structure of the Commission.

In regards to the ADA Task Force recommendations on CODA finances, the Joint Workgroup evaluated a spreadsheet that was developed to show the impact of increasing program fees over time to make CODA revenue neutral. The model showed that approximately a 20% per year fee increase would be required from 2011 to 2016 to achieve this goal. The Joint Workgroup came to the consensus that the large increases would not be received well by the programs and education community and they noted that although this financial model achieved the goal, it might not be realistic, since the costs to the programs would be enormous. The Joint Workgroup surmised that this level of fee increases would be especially problematic for the allied education programs that are mostly located in community and technical colleges with meager budgets. Instead the Joint Workgroup looked at achieving a balance between ADA support and CODA-generated funding (a 50%-50% split of both direct and indirect costs) which would require an

approximate 7.2% annual fee increase for six years. Both the Subcommittee and the ADA Monitoring Committee agreed that the there should be a balance between ADA support and CODA-generated funding.

Finally, in discussing the effectiveness of CODA in relation to membership and structure, the Joint Workgroup noted that both the CODA Outcomes Assessment Committee and CODA Subcommittee have recommended that CODA require that new Commissioner appointees train for a year prior to their official term of service by attending Commission meetings, review committee meetings and site visits. The Joint Workgroup agreed with the concept of a "redshirt" year and adopted a motion to recommend this to the ADA Monitoring Committee, with a recommendation that the expenses of this orientation period be borne by the appointing organization, except for the student and public members whose expenses should be covered by the ADA. The Joint Workgroup noted that except for the ADA, ADEA and AADB, sponsoring organizations would have to support expenses only every fourth year. The Joint Workgroup and the Subcommittee came to the consensus that other sponsoring organizations, besides the ADA, should also have a financial stake in the accreditation process.

The Subcommittee makes the following recommendations to the Commission:

1. The Subcommittee recommends that the Commission retain its current structure in conjunction with implementation of changes in functionality that have already been initiated.
2. The Subcommittee recommends that new Commissioner appointees be identified one year in advance of their term of service by the sponsoring organizations and participate in orientation activities that include attendance and observation at Commission meetings, appropriate review committee meetings and an accreditation site visit. Sponsoring organizations should be responsible for covering the expenses associated with attending the Commission meetings, the Review Committee meetings and an accreditation site visit, with these expenses covered by the ADA for the new public member and the new student member.
3. The Subcommittee recommends the Commission adopt a funding model in which total expenses, direct and indirect, are shared equally by ADA and the Commission, and that Commission make annual adjustments to its fees over the next six years to achieve this balance.
4. The Subcommittee recommends the Commission consider extending the site visit schedule from seven to eight years, with the ad hoc Committee on Alternate Site Visit Methods developing procedures for interim monitoring of educational programs prior to extending the site visit schedule.
5. The Subcommittee recommends the Commission approve the definitions of accreditation, certification, recognition, credential, and licensure developed by the CDEL/CEBJA/CODA Workgroup on Definitions and that these definitions be included the 2010 Supplemental Report of the Commission to the House of Delegates.
6. The Subcommittee recommends the Commission express its support for the CDEL Resolution to the 2010 HOD on CDEL recognition of interest areas in general dentistry. Further, the Subcommittee recommends that advanced general dentistry education programs in Dental Anesthesiology, Orofacial Pain and Oral Medicine continue to be eligible for accreditation by the Commission.

7. The Subcommittee recommends that the Commission solicit proposals from individuals or agencies to assess current Commission on Dental Accreditation communication efforts and assist in the development of and implementation of a detailed communications and public relations plan as outlined in the "Communication RFP."
8. The Subcommittee recommends the new Commission Chair appoint an appropriate number of new members to the Subcommittee and reappoint an appropriate number of current members to the Subcommittee for an additional year to continue to evaluate and develop implementation plans for any outstanding and ongoing ADA Task Force on CODA Recommendations. Furthermore, the Subcommittee recommends the Commission support the reappointment of an ADA Monitoring Committee to assist the Commission in the evaluation and implementation of the ADA Task Force on CODA Recommendations.

The Commission adopted the following recommendations with no further discussion:

Commission action: The Commission retains its current structure in conjunction with implementation of changes in functionality that have already been initiated.

Commission action: The Commission adopts a funding model in which total expenses, direct and indirect, are shared equally by ADA and the Commission, and that Commission make annual adjustments to its fees over the next six years to achieve this balance.

Commission action: The Commission will consider extending the site visit schedule from seven to eight years, and directs the *ad hoc* Committee on Alternate Site Visit Methods develop procedures for interim monitoring of educational programs prior to extending the site visit schedule.

Commission action: The Commission approves the definitions of accreditation, certification, recognition, credential, and licensure developed by the CDEL/CEBJA/CODA Workgroup on Definitions and directs that these definitions be included the 2010 Supplemental Report of the Commission to the House of Delegates.

Commission action: The Commission will solicit proposals from individuals or agencies to assess current Commission on Dental Accreditation communication efforts and assist in the development of and implementation of a detailed communications and public relations plan as outlined in the "Communication RFP."

Commission action: The Commission directs the new Commission Chair appoint an appropriate number of new members to the Subcommittee and reappoint an appropriate number of current members to the Subcommittee for an additional year to continue to evaluate and develop implementation plans for any outstanding and ongoing ADA Task Force on CODA Recommendations. Furthermore, the Commission supports the reappointment of an ADA Monitoring Committee to assist

the Commission in the evaluation and implementation of the ADA Task Force on CODA Recommendations.

There was further discussion regarding recommendation #2. Dr. Hardesty made a motion to amend the recommendation as follows (additions underlined, deletions indicated by strikethrough): "The Subcommittee recommends that new Commissioner appointees be identified one year in advance of their term of service by the sponsoring organizations and participate in orientation activities that include attendance and observation at Commission meetings, appropriate review committee meetings and an accreditation site visit. ~~Sponsoring organizations~~ The Commission should be responsible for covering the expenses associated with attending the Commission meetings, the Review Committee meetings and an accreditation site visit, with these expenses covered by the ADA for the new public member and the new student member."

Dr. Hardesty's rationale for proposing this amendment was that sponsoring organizations need time to budget for the additional expenses and this is especially difficult in these hard economic times. Dr. Kantor stated that some sponsoring organizations are small and don't have a significant budget. The amendment passed.

Dr. Joondeph made a motion to amend the recommendation so that it was not in conflict with the Commission action taken on a similar OA recommendation (additions underlined, deletions indicated by strikethrough): "The Subcommittee recommends that new Commissioner appointees be identified one year in advance of their term of service by the sponsoring organizations and participate in orientation activities that include six (6) months to a year of training through attendance and observation at Commission meetings, appropriate review committee meetings and an accreditation site visit. The Commission should be responsible for covering the expenses associated with attending the Commission meetings, the Review Committee meetings and an accreditation site visit, with these expenses covered by the ADA for the new public member and the new student member."
The amendment passed.

> **Commission action**: The Commission directs that new Commissioner appointees be identified one year in advance of their term of service by the sponsoring organizations and participate in orientation activities that include six (6) months to a year of training through attendance and observation at Commission meetings, appropriate review committee meetings and an accreditation site visit. The Commission should be responsible for covering the expenses associated with attending the Commission meetings, the Review Committee meetings and an accreditation site visit, with these expenses covered by the ADA for the new public member and the new student member.

Update on the CODA Budget for 2011: Dr. Ziebert reported the Finance Committee conducted a conference call on January 19, 2010 and reviewed the history and past considerations related to funding/fees, along with the actual budget amounts for the 2009 budget, noting that 2010 figures should be similar, with increases in costs due to inflation. The Committee then reviewed the materials developed by staff on the Commission's 2011 Proposed Operating Budget. The

Committee noted that in regard to expenses, the total number of site visits to be conducted in 2011 will be comparable to 2009 and 2010 and projected site visit costs in 2011 should be comparable to 2010 budgeted expenses and final 2009 actual expenses. After considering all budgetary factors, including general inflationary costs and planned Commission activities the Committee believed that revenue for 2011 should be budgeted at a slightly increased level from 2010 figures to correlate with anticipated higher operating expenses in 2011. Further, the Committee concluded that the annual accreditation fees, as well as application fees, should be increased by 4%. At the February 2010 Commission meeting, the Commission directed that the annual accreditation fees and application fees for 2011 be increased by 4% and the Commission approved the 2011 Operating Budget.

Subsequent to the Commission approval of the 2011 budget, the ADA requested that all departments within the Division of Education and Professional Affairs consider further reductions in expenses or further revenue enhancements so that the ADA Board of Trustees can present a balanced budget to the 2010 House of Delegates. After consulting with the Chair of the Commission, CODA staff proposed the following reduction in expenses for 2011:

- Eliminate the following in-house Review Committee meetings:

Review Committee	Expense Savings
Endodontics	$5640
Orthothodontics	$5640
Prosthodontics	$5640
Dental Laboratory Technology	$4550
Dental Public Health	$4550
Oral and Maxillofacial Pathology	$4550
Oral and Maxillofacial Radiology	$4550

- Eliminate the following in-house Standing Committee meetings:

Standing Committee	Expense Savings
Documentation Committee	$1,800
Liaison Committee on Survey	$1,800

- Eliminate the following staff travel:

Meeting	Expense Savings
Fall ASPA meeting (Director attends)	$2950
1 night lodging at ADEA meeting for seven people	$1645

TOTAL EXPENSE REDUCTION: $42,774

- Increase Initial Accreditation Fees from $4,750 to $7,500-revenue enhancement=$96,250

- Increase Annual Fees-revenue enhancement=$35,950
    - Predoctoral from $4,265 to $4,500 (+5.5%)
    - Oral and Maxillofacial Surgery, Dental Assisting, Dental Hygiene, and Dental Laboratory Technology from $865 to $915 (+5.5%)
    - Postdoctoral General Dentistry and Advanced Specialty from $416 to $495 (+19%)

TOTAL REVENUE ENHANCEMENT: $132,200

Commission action: This report was informational in nature, no action was taken.

Report on the Ad Hoc Committee on Alternative Site Visits: Chair: Dr. Judith Messura. Committee Members: Dr. Michael Biermann, Dr. Eric Carlson, Dr. Paul Casamassimo, Dr. Bryan Edgar, and Dr. Sharon Turner. Guest: Dr. Russell Webb, Trustee Liaison. Staff: Ms. Peggy Soeldner.

The Committee reviewed the recommendations made by the Commission at its February 5, 2010 meeting which included developing a proposed pilot project for conducting site visits via videoconferencing, standardization of the self-study to better streamline the site visit process for all disciplines be explored, and exploring the utilization of technology, such as web-based applications for use in the accreditation process, including site visit preparation and continuous monitoring of accredited programs' compliance with the Accreditation Standards.
Numerous options for a pilot project were considered by the Committee, including one that was specific to one institution that had been identified for possible participation in the pilot. This institution had been identified because it utilizes distance sites in two of its advanced education programs and therefore, might be in a better position, technologically, to participate. This option would involve conducting the VTC and in-person visit concurrently. Some of the site visit activities could be conducted at the same time but in different rooms (i.e., record review, tour of facilities). Others would be conducted separately and at different times, so as to not influence either team. This could be handled by having the separate activities conducted one right after the other. This would require careful planning on the part of the program to ensure availability of required interviewees. This would also require careful planning on the part of the Commission to ensure that the VTC visit and in-person visit processes are not influenced by, or do not influence, each other. In the end, this will be very complex with many challenges. The Committee continued the discussion regarding standardizing the self-study as an option to better streamline the accreditation process. One example of a more streamlined and focused self-study was presented and reviewed by the committee. Following further discussion, the Committee determined that further investigation into other electronic self-study documents, including web-based self-study documents should be continued.

The Commission's recommendations from its February 2010 meeting included exploring ways to use technology, such as web-based applications, in the accreditation process and in the continuous monitoring of accredited programs. It was also noted that the ADA Task Force on CODA recommendations included a suggestion that the Commission investigate methods of

continuous monitoring of programs between scheduled accreditation site visits. The Committee discussed the ways that programs are currently monitored through the annual surveys, including completion of a curriculum section every two years. The Committee came to the conclusion that the annual surveys could be revised to more appropriately monitor programs and recommends that each review committee review its annual survey, including the curriculum section, and identify what important elements should be monitored continuously. The Committee recommends the decisions of each review committee be reported back to the Commission, through this Committee, at the Summer 2011 meeting.

Commission action: The Commission approves the pilot project as outlined in Appendix 18 and directs staff proceed with developing the logistical arrangements to implement the project in early 2012.

Commission action: The Commission directs the standardization of the self-study for all disciplines continues to be explored for the purpose of better streamlining the site visit process.

Commission action: The Commission directs the use of technology, such as web-based applications, continues to be explored for use in continuous monitoring of accredited programs' compliance with the Accreditation Standards.

Commission action: The Commission directs each review committee review its annual survey, including the curriculum section to determine which elements should be monitored continuously. The result of this review could be reported back to the Commission, through the Ad Hoc Committee on Alternative Site visits, at the Summer 2011 meeting.

Final Report for the Task Force on Specialty Standards: Chair: Dr. Vince Iacono. Committee members: Dr. Eric Carlson; Dr. Paul Casamassimo; Dr. Don Joondeph; Dr. Mel Kantor; Dr. Kent Knoernschild; Dr. Sharon McPherron; Dr. Christopher Wenkus; Dr. Alex White; and Dr. John Wright. Staff: Dr. Catherine Horan and Ms. Sherin Tooks.

The Commission formed the Task Force on Specialty Standards at the July 2007 meeting to study how proficiency and competency are measured in advanced specialty education programs and to review results of the specialties' validity/reliability studies as they relate to the language common to all advanced specialty education programs (boilerplate language). The Task Force met initially in January 2008 and seven additional times since then. During the period of January 2008 through August 2010, the Task Force also re-evaluated the definitions of Levels of Skill and Knowledge in the broader educational context to ensure consistency of definitions across dental specialty disciplines and to ensure valid and reliable assessment. The Task Force noted that the terms for these levels were not being applied uniformly, and believed that current definitions may be outdated and therefore no longer appropriate. The Task Force further noted that eight of the nine specialty education review committees recommended that the discussion of

a proposal to revise definitions advance to the next level to include feedback from the broad-based communities of interest. The Task Force noted that the Prosthodontic Education Review Committee (PROS RC) favored the maintenance of the current 3-tier system. After reviewing feedback from the communities of interest, the Task Force affirmed that "competency" should be the highest level of measure within the definitions for specialty education.

Additionally, the Task Force noted that there is the need for formalization of evaluation methods that currently may not be well-defined, resulting in great variability in the extent, methods, and quality of student/resident assessment across programs. At the same time, the Task Force maintained that the programs would still have the flexibility in developing, implementing, and maintaining evaluation methods. The Task Force reviewed definitions of "formative" and "summative" evaluation and carefully considered their inclusion in the proposed revised language of the Standard, and proposed a revised standard on evaluation with complementary statement of intent and examples of evidence.

As a result of the work of the Task Force, the second charge was addressed by two (2) sets of revisions, with one set containing non-substantive changes, implemented in July 2009. For the other set of more substantive changes, which incorporated response to the first charge, the Task Force and specialty education review committees reviewed comment from the communities of interest and considered final proposals at their June and July meetings, respectively.

The Task Force acknowledged as a minority position that the Pros RC was the only review committee that recommended retaining the term "proficient" as the highest level of knowledge and skill required in advanced specialty education; nevertheless, the Task Force recommended adoption of the revised definition.

The Task Force also noted that the OMS RC recommended the term "student-resident" be changed to "resident" when referring to trainees in oral and maxillofacial surgery residency programs. The OMS RC strongly believed that the single term "resident" is the appropriate term to be used for trainees in medical-surgical hospital-based settings, providing important clarification for public, private, and government entities. Difficulties may be encountered from other professions and individuals in matters of funding and scope of practice if the term "resident" is not used. The Task Force considered whether it was appropriate for any other specialties to change from "student-resident" to "resident;" however, the Task Force concluded that the recommendation was appropriate for oral and maxillofacial surgery program standards, but did not apply to other specialty standards at this time.

The Task Force confirmed its recommendation of the proposed implementation timeline, noting that all specialty education review committees agreed with the proposal, as follows: (1) final adoption of proposals by Commission on August 6, 2010, and directive by Commission to recognized specialty sponsoring organizations for revision of accreditation standards, based upon adopted proposals; (2) recognized specialty sponsoring organizations to revise accreditation standards, with a deadline of Winter 2012; (3) Commission consideration of proposed revised specialty education accreditation standards and directive to distribute these proposals to communities of interest for comment and Open Hearings, for a period of one year (2012-2013); (4) review of comment from communities of interest for consideration of final adoption of

proposed revised specialty education accreditation standards by the Commission, for a period of one year; and (5) January 1, 2014, implementation date of adopted revised specialty education accreditation standards. In its discussion of the proposed timeline, the Task Force noted that the PROS RC recommended that the inclusion of definition changes be monitored to ensure competencies are maintained as currently written in the Accreditation Standards documents for all disciplines, with concurrent review of all specialty Accreditation Standards documents in Winter 2013. Also, the PROS RC recommended that change in scope of training should not be permitted during this revision. The Task Force believed that the timeline should be considered as the maximum deadlines, allowing the specialties flexibility to complete their standards revisions.

Dr. Knoernschild made a motion to refer the recommendations back to the Task Force for reassessment for the following reasons: 1. While acknowledging that portions of the final report and recommendations of the Task Force have been available for review, the most important portions have just recently been received and there has not been a chance for a thorough review. 2. The impact of the proposed revisions will require broad, sweeping changes for programs. The impact of specific changes directly related to definitions could be negative. 3. There was some uncertainty among the Task Force on the direct of the impact of the revisions on the specialties. Dr. Carlson agreed that more opportunity to discuss the proposal at the Commission level and he would support consideration at the next commission meeting. Dr. Joondeph responded that this has been a long project. He pointed out that the revisions have been sent out for comment to the communities of interest and there is support from all specialties, except prosthodontics. In addition, the previous prosthodontics Commissioner was in support of the revisions. He was concerned that consensus had been reached on the Task Force, but if the amendment passed, the Task Force would be forced to start at the beginning. Dr. Kantor reminded the Commission that the issue of eliminating the terms “proficient” and “proficiencies” has been discussed for two years. The Commission has seen the revision before and it has had the opportunity to talk about it already. The most recent report has to do with items that are not the focus of the prosthodontic community’s objection. Dr. Knoernschild reiterated that some of the implications for the communities of interest were not necessarily realized until recently. He felt it would more collegial and more positive if the Commission made a decision at the February 2011 meeting. Dr. Joondeph stated that if the Commission directs the Task Force to reconsider the definitions, he was not sure the Task Force would come to a different conclusion than it already has. He stated that there is a philosophical difference between specialty education being a continuum from undergraduate education and being distinct and separate from undergraduate education. He appreciated that prosthodontics is more of a continuum of undergraduate education and restorative dentistry; however, he did not see how a six month delay resolves the philosophical difference. In addition, Dr. Joondeph maintained that “proficiency” is a poor choice of a word. There is no difference between definition of competency and proficiency in the dictionary. Also, proficiency implies that it is something that is gained over the years as one practices. Dr. Knoernschild replied that historically, each specialty has defined the terms “competency” and “proficiency” for itself and that dictionary definitions are not the be all and end all. He maintained the core issue that went to Task Force initially was whether outcomes related to student performance across specialties were assessed appropriately. The intent of the Task Force charge was to just have a consistent matrix of assessment. Dr. Kantor responded that while the notion of outcomes assessment was the primary charge, there was a realization that it was not

feasible to address that aspect of the charge when there were multiple levels of performance. There was a consensus early in the Task Force that the multiple levels of performance needed to be addressed in order to go forward with the assessment piece. The motion to refer was defeated.

Commission action: The Commission adopts the revised specialty boilerplate accreditation standards as outlined in Appendix 19.

Commission action: The Commission directs recognized specialty sponsoring organizations to revise their accreditation standards to reflect the changes in definitions of levels of skills and knowledge, with a deadline of Winter 2012.

Commission action: The Commission directs that the revised specialty education standards be distributed to communities of interest for comment and Open Hearings, for a period of one year (2012-2013).

Commission action: The Commission will review comments from communities of interest for consideration of final adoption of proposed revised specialty education accreditation standards by the Commission, for a period of one year, with a January 1, 2014, implementation date of adopted revised specialty education accreditation standards.

Report of the Commission on Dental Accreditation of Canada: Dr. Claude Lemarche, chair of Commission on Dental Accreditation of Canada (CDAC), supplemented the submitted CDAC Annual Report to the Commission with additional information on the recently signed reciprocity agreement between Australia and Canada. Graduates of Australian dental schools will now be able to sit for National Dental Examining Board of Canada without further dental education in Canada, just as graduates of US-accredited dental schools. The provincial and federal governments in Canada asked the CDAC to fast-track licensure of internationally-trained dentists. The CDAC came to the conclusion that if the CDAC does not pursue reciprocity agreements, the government will do it instead, with potentially poor outcomes for the profession and the public.

Commission action: This report was informational in nature; no action was taken.

Report of the Director of CODA on the Observation of a Site Visit to a Canadian Dental School: Dr. Ziebert reported on his observation of a comprehensive site visit to the University of British Columbia, May 2-5, 2010. Dr. Ziebert was provided all relevant documents pertaining to the site visit; participated in two pre-site visit conference calls; and attended all sessions during the site visit. He reported that Commission on Dental Accreditation of Canada (CDAC) accreditation procedures, policies and processes are equivalent to CODA procedures, policies, and processes. CDAC standards for predoctoral dental educations programs are equivalent to CODA accreditation standards.

Commission action: This report was informational in nature; no action was taken.

Report on the Commission Self-Assessment: Dr. Ziebert reported that all ADA Councils and Commissions completed self-assessments in 2003 and these assessments were reported to the 2003 House of Delegates. Based on the outcome of the 2003 self-assessment process, the ADA Board of Trustees determined that this process should serve as a template for future reviews. The Board established a five-year cycle for agencies to conduct a review of their relevancy, productivity, efficiency, mission and duties. While reports were not requested for 2008, the scheduled reporting year, nor were they requested for 2009, the Board of Trustees has requested reports for the 2010 House of Delegates. The Commission on Dental Accreditation self-assessment was reviewed by the Standing Committee on Outcomes Assessment at its June 17, 2010 conference call.

Commission action: This report was informational in nature; no action was taken.

Election of Chair and Vice Chair of the Commission: Dr. Don Joondeph was elected chair of the Commission for 2010-2011. Dr. Steven Tonelli was elected vice-chair of the Commission for 2010-2011.

Presentation of Plaques: The following Commissioners received a plaque acknowledging their service on the Commission:

Mr. Ken Thomalla
Dr. Michael Reed
Dr. Andy Elliott
Dr. Bryan Edgar

New Business: There was no new business.

Adjourn: The meeting adjourned at 1:45 PM