INFORMATIONAL REPORT ON OROFACIAL PAIN PROGRAMS ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission's Annual Survey is conducted for orofacial pain programs in alternate years. The next Curriculum Section will be conducted in August/September 2024. The draft Curriculum Section is provided in **Appendix 1** for review by the Orofacial Pain Review Committee.

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

Recommendation:

Prepared by: Ms. Peggy Soeldner

Part II - Orofacial Pain Curriculum Section

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

21. A majority of the total program time must be devoted to providing orofacial pain patient services, including direct patient care and clinical rotation. What percentage of time did residents who completed the program in 2022 spend in each of the following areas during the two-year residency program?

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

	Percentage of Total Time
a. Didactics: conferences/seminars	%
b. Clinical activities: orofacial pain	%
c. Clinical activities: other (please specify)	%
d. Rotations/assignments to other services	%
e. Teaching	%
f. Research	%
g. Other, please specify	%
Total	%

22. Formal instruction must be provided in each of the following biomedical sciences areas. Please indicate the number of clock hours residents spend in formal courses, lectures, and seminars receiving instruction in the following subject areas during the two-year residency program.

If none, enter zero.

	Total Clock Hours
a. Gross and functional anatomy and physiology including the musculoskeletal and articular systems of the orofacial, cranio/orofacial, and cervical structures	
b. Growth, development, and aging of the masticatory system	
c. Head and neck pathology and pathophysiology with an emphasis on pain	
d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures	
e. Sleep physiology and dysfunction	
f. Oromotor disorders including dystonias, dyskinesias, and bruxism	
g. Epidemiology of orofacial pain disorders	
h. Pharmacology and pharmacotherapeutics	
i. Principles of biostatistics, research design and methodology, scientific writing, and critique of literature	

23. The program must provide a foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain. Please indicate the method(s) of instruction and the number of clock hours residents spend receiving instruction in the following subject areas during the two-year residency program. (Standard 2-6)

If none, enter zero.

	Method of Instruction			Total
	Courses	Lectures	Seminars	Clock Hours
a. The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems	☐	☐	☐	☐
b. Mechanisms associated with pain referral to and from the orofacial region	☐	☐	☐	☐
c. Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain	☐	☐	☐	☐
d. Pain classification systems	☐	☐	☐	☐
e. Psychoneuroimmunology and its relation to chronic pain syndromes	☐	☐	☐	☐
f. Primary and secondary headache mechanisms	☐	☐	☐	☐
g. Pain of odontogenic origin and pain that mimics odontogenic pain	☐	☐	☐	☐
h. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction	☐	☐	☐	☐

24. Formal instruction must be provided in each of the following behavioral sciences areas as it relates to orofacial pain disorders and pain behavior. Please indicate the number of clock hours residents spend in formal courses, lectures and seminars receiving instruction in the following subject areas during the two-year residency program. (Standard 2-7)
If none, enter zero.

	Total Clock Hours
a. Cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors	
b. The recognition of pain behavior and secondary gain behavior	
c. Psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain disorders	
d. Conducting and applying the results of psychometric tests	

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

25. The program must provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders. Please indicate the number of clock hours the residents spend in didactic instruction and clinical training addressing the following areas during the two-year residency program. (Standard 2-9)

	Clinical clock hours	Didactic clock hours
a. Conduct a comprehensive pain history interview		
b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient's orofacial pain and/or sleep disorder complaints		
c. Perform clinical examinations and tests and interpret the significance of the data		
d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral		
e. Establish a differential diagnosis and a prioritized problem list		

26. The program must provide instruction and clinical training in multidisciplinary pain management for the orofacial pain patient. Please indicate the number of clock hours the residents spend in didactic instruction and clinical training addressing the following areas during the two-year residency program. (Standard 2-10)

	Clinical clock hours	Didacti clock hours
a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits		
b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care		
c. Obtain informed consent		
d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient's treatment responsibilities		
e. Intraoral appliance therapy		
f. Physical medicine modalities		
g. Sleep-related breathing disorder intraoral appliances		
h. Non-surgical management of orofacial trauma		
i. Behavioral therapies beneficial to orofacial pain		
j. Pharmacotherapeutic treatment of orofacial pain including systemic and topical medications and diagnostic/therapeutic injections		

27. Residents must participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period). Please indicate the clinical rotations/assignment, length in weeks and number of hours per week where the residents gain clinical experiences in other healthcare services during the two-year residency program. (Standard 2-11)

	Number of weeks	Hours per week
a. Oral and maxillofacial surgery (to include procedures for intracapsular TMJ disorders)		
b. Outpatient anesthesia pain		
c. In-patient pain		
d. Rheumatology		
e. Neurology		
f. Oncology		
g. Otolaryngology		
h. Rehabilitation medicine		
i. Headache		
j. Radiology		
k. Oral medicine		
l. Sleep disorder clinic		
m. Other, please specify		
n. Other, please specify		
o. Other, please specify		
p. Other, please specify		

28. If applicable, please indicate the number of hours residents participate in teaching orofacial pain during the two-year residency program.

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

CONSIDERATION OF PROPOSED REVISIONS TO THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN OROFACIAL PAIN

Background: The Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain were adopted by the Commission on Dental Accreditation at its August 5, 2016 meeting for implementation July 1, 2017.

According to the Commission's Policy on Assessing the Validity and Reliability of the Accreditation Standards, "the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years." Thus, the validity and reliability of the standards for a one-year program will be assessed after four (4) years, while standards for programs two years in length will be assessed five (5) years after implementation. Therefore, the validity and reliability study for Advanced Dental Education Programs in Orofacial Pain was initiated in the Spring of 2022 with the results to be considered at the Summer 2022 Commission meeting.

At its Summer 2022 meeting, the Orofacial Pain Education Review Committee (OFP RC) reviewed the survey data and the written comments gathered through the Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain.

Following considerable discussion of the data, including the Executive Summary of responses from orofacial pain program directors, orofacial pain site visitors and professionally active orofacial pain dentists, as well as written comments, the OFP RC determined some areas of the Standards warranted further discussion and possible revision. Due to the amount of information provided, the OFP RC recommended further study of the survey data be conducted with a report for consideration at the Winter 2023 meeting of the Commission. At its August 5, 2022 meeting, the Commission concurred and directed further study of the findings of the Orofacial Pain Validity and Reliability Study to identify Accreditation Standards, if any, which warrant revision with a report for consideration at the Commission Winter 2023 meeting.

At the Winter 2023 meeting, the Orofacial Pain Education Review Committee continued its review of the survey data and the written comments gathered through the Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain. Through its review of the survey data and comments, as well as a lengthy discussion related to the complexity of the discipline of Orofacial Pain and the various procedures used to treat patients with orofacial pain, the OFP RC identified Accreditation Standards that warrant revisions and believed the revisions will ensure the Accreditation Standards are current and relevant resulting in graduates of orofacial pain programs that are appropriately prepared to provide care for individuals with orofacial pain.

Therefore, the OFP RC recommended that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain **(Appendix 1)** be circulated to the communities of interest for review and comment for a period of one (1) year with further consideration of comments received at the Winter 2024 meetings. At its Winter 2023 meeting, the Commission on Dental Accreditation concurred with the recommendation of the OFP RC and directed circulation of the proposed revisions to the communities of interest for review and comment for a period of one (1) year with hearings conducted in conjunction with the March 2023 American Dental Education Association (ADEA) Annual Session and the October 2023 American Dental Association (ADA) Annual Meeting, with comments reviewed at the Commission's Winter 2024 meetings.

In accordance with the Commission's Winter 2023 directive, the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain were circulated for a period of one (1) year for review and comment. The Commission received no (0) comments during the Hearing in conjunction with the March 2023 American Dental Education Association (ADEA) Annual Session and no (0) comments during the Hearing in conjunction with the October 2023 American Dental Association (ADA) Annual Meeting. The Commission received one (1) written comment via its electronic comment portal, prior to the December 1, 2023 deadline (**Appendix 2**).

Summary: At this meeting, the Orofacial Pain Education Review Committee and the Commission are asked to the consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain (**Appendix 1**) and all comments received prior to the December 1, 2023 deadline (**Appendix 2**). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

Recommendation:

Prepared by: Ms. Peggy Soeldner

Commission on Dental Accreditation

At its Winter 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2023, for review at the Winter 2024 Commission meeting.

At its Summer 2023 meeting, the Commission adopted new Standard 2-10, with implementation July 1, 2024. This document reflects the adopted revision to add the new Standard 2-10.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:

https://surveys.ada.org/jfe/form/SV_5nJAioMq6EalSRg

Proposed Revisions to Standards Following Validity and Reliability Study

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain

Accreditation Standards For Advanced Dental Education Programs in Orofacial Pain

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678

(312. 440-4653
https://coda.ada.org/

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain

Document Revision History

Date	Item	Action
~~August 5, 2016~~	~~Accreditation Standards for Advanced General Dentistry Education Programs in Orofacial Pain~~	~~Approved~~
~~August 5, 2016~~	~~Revised Mission Statement~~	~~Adopted~~
~~January 1, 2017~~	~~Revised Mission Statement~~	~~Implemented~~
~~July 1, 2017~~	~~Accreditation Standards for Advanced General Dentistry Education Programs in Orofacial Pain~~	~~Implemented~~
~~August 4, 2017~~	~~Revised Accreditation Status Definitions~~	~~Approved, Implemented~~
~~August 4, 2017~~	~~Revised Standards 1-5, 1-9, 1-10, 2-2, 2-3, 2-4, 2-12, 2-18, 2-20, 3-3, 3-6, 4-6, 4-7, 4-9 and 5-1 and new Standard 3-9~~	~~Adopted~~
~~July 1, 2018~~	~~Revised Standards 1-5, 1-9, 1-10, 2-2, 2-3, 2-4, 2-12, 2-18, 2-20, 3-3, 3-6, 4-6, 4-7, 4-9 and 5-1 and new Standard 3-9~~	~~Implemented~~
~~August 3, 2018~~	~~Revised Terminology Related to Advanced Education Programs~~	~~Adopted~~
~~January 1, 2019~~	~~Revised Terminology Related to Advanced Education Programs~~	~~Implemented~~
~~August 2, 2019~~	~~Revised Definition of "Patients with special needs"~~	~~Adopted, Implemented~~
~~August 2, 2019~~	~~New Standard 4-10~~	~~Adopted, Implemented~~
~~August 2, 2019~~	~~Revised Definition of "Should"~~	~~Adopted~~
~~January 31, 2020~~	~~Revised Definition of "Should"~~	~~Implemented~~

~~August 6, 2021~~	~~Revised Mission Statement~~	~~Adopted~~
~~January 1, 2022~~	~~Revised Mission Statement~~	~~Implemented~~
~~August 11, 2023~~	~~New Standard 2-10~~	~~Adopted~~
~~August 11, 2023~~	~~Revised Accreditation Status Definitions~~	~~Adopted and Implemented~~
~~July 1, 2024~~	~~New Standard 2-10~~	~~Implemented~~

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Mission Statement of the Commission on Dental Accreditation

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

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

Accreditation Status Definitions

Programs That Are Fully Operational

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

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

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

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

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

Programs That Are Not Fully Operational

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

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

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

Introduction

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Orofacial Pain for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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

Although the standards are comprehensive and applicable to all institutions that offer advanced dental education programs, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession, and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in Orofacial Pain provide an identifiable and characteristic core of required training and experience.

Goals

Advanced Dental Education Programs in Orofacial Pain are educational programs designed to provide training beyond the level of predoctoral education in oral health care, using applied basic and behavioral sciences. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates' knowledge and skills to enable them to provide care for individuals with orofacial pain.

The goals of these programs should include preparation of the graduate to:

1. Be knowledgeable in orofacial pain at a level beyond predoctoral education relating to the basic mechanisms and the anatomic, physiologic, neurologic, vascular, behavioral, and psychosocial aspects of orofacial pain.
2. Plan and provide interdisciplinary/multidisciplinary health care for a wide variety of patients with orofacial pain.
3. Interact with other healthcare professionals in order to facilitate the patient's total healthcare.
4. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
5. Function effectively and efficiently in multiple health care environments and within interdisciplinary/multidisciplinary health care teams.
6. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making and technology-based information retrieval systems.
7. Enhance the dissemination of information about diagnosis and treatment/management of orofacial pain to all practitioners of the health profession.
8. Encourage the development of multidisciplinary teams composed of basic scientists and clinicians from appropriate disciplines to study orofacial pain conditions, to evaluate current therapeutic modalities, and to develop new and improve upon existing procedures for diagnosis and treatment/management of such conditions/diseases/syndromes.
9. Enhance the interaction and communication among those investigating pain at their institution and beyond.
10. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.

Definition of Terms

Key terms used in this document (i.e., Must, should, could and may. were selected carefully and indicate the relative weight that the commission attaches to each statement. The definition of these words as used in the standards follows:

Competencies: Written statements describing the levels of knowledge, skills, and values expected of residents completing the program.

Competent: The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

Educationally qualified: Board eligible in orofacial pain or successful completion of an orofacial pain program of at least two years in length.

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

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

Interdisciplinary: Including dentistry and other health care professions.

Manage: Coordinate the delivery of care using a patient-focused approach within the scope of their training. Patient-focused care should include concepts related to the patient's social, cultural, behavioral, economic, medical and physical status.

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

Multidisciplinary: Including all disciplines within the profession of dentistry.

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

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

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

SOAP: Subjective Objective Assessment Plan

Sponsor: The institution that has the overall administrative control and responsibility for the conduct of the program.

Resident: The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.

STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 Each sponsoring or co-sponsoring United States-based educational institution, hospital or health care organization **must** be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:
Written agreement(s)
Contract(s/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

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

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year

1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs **must** be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

Intent*: Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).*

Examples of evidence to demonstrate compliance may include:
Written agreements

1-6 There **must** be opportunities for program faculty to participate in institution-wide committee activities.

Examples of evidence to demonstrate compliance may include:
Bylaws or documents describing committee structure
Copy of institutional committee structure and/or roster of membership by dental faculty

1-7 Orofacial pain residents **must** have the same privileges and responsibilities provided residents in other professional education programs.

Examples of evidence to demonstrate compliance may include:
Bylaws or documents describing resident privileges

1-8 The medical staff bylaws, rules, and regulations of the sponsoring, co-sponsoring, or affiliated hospital **must** ensure that dental staff members are eligible for medical staff membership and privileges.

Intent: *Dental staff members have the same rights and privileges as other medical staff of the sponsoring, co-sponsoring or affiliated hospital, within the scope of practice.*

Examples of evidence to demonstrate compliance may include:
All related hospital bylaws
Copy of institutional committee structure and/or roster of membership by dental faculty

1-9 The program **must** have written overall program goals and objectives that emphasize:

a. orofacial pain,

b. resident education,
c. patient care, and
d. research.

Intent: *The "program" refers to the Advanced Dental Education Program in Orofacial Pain that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standard 2-2. Specific learning objectives for residents are intended to be described as goals and objectives or competencies for resident training and included in the response to Standard 2-2. An example of overall goals can be found in the Goals section on page 8 of this document.*

Examples of evidence to demonstrate compliance may include:
Written overall program goals and objectives

1-10 The program **must** have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program's overall goals and objectives are being met and make program improvements based on an analysis of that data.

Intent: *The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-9 are being met.*

The outcomes process developed should include each of the following steps:

1. *development of clear, measurable goals and objectives consistent with the program's purpose/mission;*
2. *implementation of procedures for evaluating the extent to which the goals and objectives are met;*
3. *collection of data in an ongoing and systematic manner;*
4. *analysis of the data collected and sharing of the results with appropriate audiences;*
5. *identification and implementation of corrective actions to strengthen the program; and*
6. *review of the assessment plan, revision as appropriate, and continuation of the cyclical process.*

Examples of evidence to demonstrate compliance may include:
Written overall program goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results

Meeting minutes where outcomes are discussed
Decisions based on outcomes results
Successful completion of a certifying examination in Orofacial Pain

Ethics and Professionalism

1-11 The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

Intent: *Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*

STANDARD 2 – EDUCATIONAL PROGRAM

2-1 The orofacial pain program **must** be designed to provide advanced knowledge and skills beyond the D.D.S. or D.M.D. training.

Curriculum Content

2-2 The program **must** either describe the goals and objectives for each area of resident training or list the competencies that describe the intended outcomes of resident education.

Intent: *The program is expected to develop specific educational goals that describe what the resident will be able to do upon completion of the program. These educational goals should describe the resident's abilities rather than educational experiences the residents may participate in. These specific educational goals may be formatted as either goals and objectives or competencies for each area of resident training. These educational goals are to be circulated to program faculty and staff and made available to applicants of the program.*

Examples of evidence to demonstrate compliance may include:
Written goals and objectives for resident training or competencies

2-3 Written goals and objectives **must** be developed for all instruction included in this curriculum.

Example of Evidence to demonstrate compliance may include:
Written goals and objectives
Content outlines

2-4 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program's written goals and objectives or competencies for resident training.

Intent: *The program is expected to organize the didactic and clinical educational experiences into a formal curriculum plan. For each specific goal or objective or competency statement described in response to Standard 2-2, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal curriculum plan.*

Examples of evidence to demonstrate compliance may include:

Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies
Didactic and clinical schedules

Biomedical Sciences

2-5 Formal instruction **must** be provided in each of the following:

a. Gross and functional anatomy and physiology including the musculoskeletal and articular system of the orofacial, head, and cervical structures;
b. Growth, development, and aging of the masticatory system;
c. Head and neck pathology and pathophysiology with an emphasis on pain;
d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures;
e. Sleep physiology and dysfunction;
f. Oromotor disorders including dystonias, dyskinesias, and bruxism;
g. Epidemiology of orofacial pain disorders;
h. Pharmacology and pharmacotherapeutics; and
i. Principals of biostatistics, research design and methodology, scientific writing, and critique of literature.

2-6 The program **must** provide a strong foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain including:

a. The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems;
b. Mechanisms associated with pain referral to and from the orofacial region;
c. Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain;
d. Pain classification systems;
e. Psychoneuroimmunology and its relation to chronic pain syndromes;
f. Primary and secondary headache mechanisms;
g. Pain of odontogenic origin and pain that mimics odontogenic pain; and

h. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction.

Behavioral Sciences

2-7 Formal instruction **must** be provided in behavioral science as it relates to orofacial pain disorders and pain behavior including:

a. cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors;

b. the recognition of pain behavior and secondary gain behavior;

c. psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain, sleep disorders, and sleep medicine; and

d. conducting and applying the results of psychometric tests.

Clinical Sciences

2-8 A majority of the total program time **must** be devoted to providing orofacial pain patient services, including direct patient care and clinical rotations.

2-9 The program **must** provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders to ensure that upon completion of the program the resident is able to:

a. Conduct a comprehensive pain history interview;

b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient's orofacial pain and/or sleep disorder complaints;

c. Perform clinical examinations and tests and interpret the significance of the data;

Intent: *Clinical evaluation may include: musculoskeletal examination of the head, jaw, neck and shoulders; range of motion; general evaluation of the cervical spine; TM joint function; jaw imaging; oral, head and neck screening, including facial-skeletal and dental-occlusal structural variations; cranial nerve screening; posture evaluation; physical assessment including vital signs; and diagnostic blocks.*

d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral; and

Intent: *Additional testing may include additional imaging; referral for psychological or psychiatric evaluation; laboratory studies; diagnostic autonomic nervous system blocks, and systemic anesthetic challenges.*

e. Establish a differential diagnosis and a prioritized problem list.

2-10 The program **must** provide training to ensure that upon completion of the program, the resident is able to manage patients with special needs.

Intent*: The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident's ability to manage patients with special needs.*

Examples of evidence to demonstrate compliance may include:
Written goals and objectives or competencies for resident training related to patients with special needs
Didactic schedules

2-11 The program **must** provide instruction and clinical training and direct patient experience in multidisciplinary pain management for the orofacial pain patient to ensure that upon completion of the program the resident is able to:

a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits;

b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care;

c. Obtain informed consent;

d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient's treatment responsibilities;

e. Have primary responsibility for the management of a broad spectrum of orofacial pain patients in a multidisciplinary orofacial pain clinic setting, or interdisciplinary associated services. Responsibilities should include:

1. intraoral appliance therapy;
2. physical medicine modalities;
3. diagnostic/therapeutic injections;
~~3.~~4. sleep-related breathing disorder intraoral appliances;
~~4~~.5. non-surgical management of orofacial trauma;

~~5.~~6. behavioral therapies beneficial to orofacial pain; and

~~6.~~7. pharmacotherapeutic treatment of orofacial pain including systemic and topical medications ~~and diagnostic/therapeutic injections~~.

***Intent**: This should include judicious selection of medications directed at the presumed pain mechanisms involved, as well as adjustment, monitoring, and reevaluation.*

Common medications may include: muscle relaxants; sedative agents for chronic pain and sleep management; opioid use in management of chronic pain; the adjuvant analgesic use of tricyclics and other antidepressants used for chronic pain; anticonvulsants, membrane stabilizers, and sodium channel blockers for neuropathic pain; local and systemic anesthetics in management of neuropathic pain; anxiolytics; analgesics and anti-inflammatories; prophylactic and abortive medications for primary headache disorders; and therapeutic use of botulinum toxin injections.

Common issues may include: management of medication overuse headache; medication side effects that alter sleep architecture; prescription medication dependency withdrawal; referral and co-management of pain in patients addicted to prescription, non prescription and recreational drugs; familiarity with the role of preemptive anesthesia in neuropathic pain.

2-12 Residents **must** participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period).

***Intent:** Experiences may include observation or participation in the following: oral and maxillofacial surgery to include procedures for intracapsular TMJ disorders; outpatient anesthesia pain service; in-patient pain rotation; rheumatology, neurology, oncology, otolaryngology, rehabilitation medicine; headache, radiology, oral medicine, and sleep disorder clinics.*

2-13 Each assigned rotation or experience **must** have:

a. written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b. resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c. evaluations performed by the designated supervisor.

***Intent:** This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.*

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-14 Residents **must** gain experience in teaching orofacial pain.

Intent: *Residents should be provided opportunities to obtain teaching experiences in orofacial pain (i.e. small group and lecture formats, presenting to dental and medical peer groups, predoctoral student teaching experiences, and/or continuing education programs.*

2-15 Residents **must** actively participate in the collection of history and clinical data, diagnostic assessment, treatment planning, treatment, and presentation of treatment outcome.

2-16 The program **must** provide instruction in the principles of practice management.

Intent: *Suggested topics include: quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care*; *medicolegal issues, workers compensation, second opinion reporting; criteria for assessing impairment and disability; legal guidelines governing licensure and dental practice, scope of practice with regards to orofacial pain disorders, and instruction in the regulatory requirements of chronic opioid maintenance.*

Examples of evidence to demonstrate compliance may include:
Course outlines

2-17 Formal patient care conferences **must** be held at least ten (10) times per year.

Intent: *Conferences should include diagnosis, treatment planning, progress, and outcomes. These conferences should be attended by residents and faculty representative of the disciplines involved. These conferences are not to replace the daily faculty/resident interactions regarding patient care.*

Examples of evidence to demonstrate compliance may include:
Conference schedules

2-18 Residents **must** be given assignments that require critical review of relevant scientific literature.

Intent: *Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care. This should include the development of critical evaluation skills and the ability to apply evidence-based principles to clinical decision-making.*

Relevant scientific literature should include current pain science and applied pain literature in dental and medical science journals with special emphasis on pain mechanisms, orofacial pain, head and neck pain, and headache.

Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

Program Length

2-19 The duration of the program **must** be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-20 Where a program for part-time residents exists, it **must** be started and completed within a single institution and designed so that the total curriculum can be completed in no more than twice the duration of the program length.

Intent: *Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.*

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-21 The program's resident evaluation system **must** assure that, through the director and faculty, each program:

a) periodically, but at least two times annually, evaluates and documents the resident's progress toward achieving the program's written goals and objectives of resident training or competencies using appropriate written criteria and procedures;

b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions **must** be taken; and

c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.

Intent: *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-2.*

Examples of evidence to demonstrate compliance may include:
Written evaluation criteria and process
Resident evaluations with identifying information removed
Personal record of evaluation for each resident
Evidence that corrective actions have been taken

STANDARD 3 – FACULTY AND STAFF

3-1 The program **must** be administered by a director who is board certified or educationally qualified in orofacial pain and has a full-time appointment in the sponsoring institution with a primary commitment to the orofacial pain program.

3-2 The program director **must** have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program.

Intent: *The program director's responsibilities include:*

a. *program administration;*
b. *development and implementation of the curriculum plan;*
c. *ongoing evaluation of program content, faculty teaching, and resident performance;*
d. *evaluation of resident training and supervision in affiliated institutions and off-service rotations;*
e. *maintenance of records related to the educational program; and*
f. *resident selection; and*
g. *preparing graduates to seek certification by the American Board of Orofacial Pain.*

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:
Program director's job description
Job description of individuals who have been assigned some of the program director's job responsibilities
Formal plan for assignment of program director's job responsibilities as described above
Program records

3-3 All sites where educational activity occurs **must** be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of orofacial pain included in the program.

Intent: *Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible. The faculty, collectively, should have competence in all areas of orofacial pain covered in the program.*

The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of orofacial pain if that faculty member is not trained in orofacial pain. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program's criteria and qualifications.

Whenever possible, programs should avail themselves of discipline-specific faculty as trained consultants for the development of a mission and curriculum, and for teaching.

Examples of evidence to demonstrate compliance may include:
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of orofacial pain
Records of program documentation that non-discipline specific faculty members as responsible for teaching an area of orofacial pain

3-4 A formally defined evaluation process **must** exist that ensures measurements of the performance of faculty members annually.

Intent: *The written annual performance evaluations should be shared with the faculty members. The program should provide a mechanism for residents to confidentially evaluate instructors, courses, program director, and the sponsoring institution.*

Examples of evidence to demonstrate compliance may include:
Faculty files
Performance appraisals

3-5 A faculty member **must** be present in the clinic for consultation, supervision, and active teaching when residents are treating patients in scheduled clinic sessions.

Intent: *This standard does not preclude occasional situations where a faculty member cannot be available.*

Faculty members should contribute to an ongoing resident and program/curriculum evaluation process. The teaching staff should be actively involved in the development and implementation of the curriculum.

Examples of evidence to demonstrate compliance may include:
Faculty clinic schedules

3-6 At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, **must** be consistently available to allow for efficient administration of the program.

Intent: *The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives.*

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-7 There **must** be evidence of scholarly activity among the orofacial pain faculty

Intent: *Such evidence may include: participation in clinical and/or basic research; mentoring of orofacial pain resident research; publication in peer-reviewed scientific media; development of innovative teaching materials and courses; and presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.*

3-8 The program **must** show evidence of an ongoing faculty development process.

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

Examples of evidence to demonstrate compliance may include:
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment

Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-9 The program **must** provide ongoing faculty calibration at all sites where educational activity occurs.

Intent: *Faculty calibration should be defined by the program.*

Examples of evidence to demonstrate compliance may include:
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared

STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution **must** provide adequate and appropriately maintained facilities and learning resources to support the goals and objectives of the program.

Intent: *The facilities should permit the attainment of program goals and objectives. Clinical facilities suitable for privacy for patients should be specifically identified for the orofacial pain program. Library resources that include dental resources should be available. Resource facilities should include access to computer, photographic, and audiovisual resources for educational, administrative, and research support. Equipment for handling medical emergencies and current medications for treating medical emergencies should be readily accessible. "Readily accessible" does not necessarily mean directly in the dental clinic. Protocols for handling medical emergencies should be developed and communicated to all staff in patient care areas.*

Examples of evidence to demonstrate compliance may include:
Description of facilities

4-2 There **must** be provision for a conference area separated from the clinic for rounds discussion and case presentations, sufficient to accommodate the multidisciplinary team.

4-3 Dental and medical laboratory, dental and medical imaging, and resources for psychometric interpretation **must** be accessible for use by the orofacial pain program.

4-4 Lecture, seminar, study space, and administrative office space **must** be available to conduct the educational program.

Selection of Residents

4-5 Applicants **must** have one of the following qualifications to be eligible to enter the advanced dental education program in orofacial pain:

a. Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b. Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c. Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-6 Specific written criteria, policies and procedures **must** be followed when admitting residents.

Intent: *Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.*

Examples of evidence to demonstrate compliance may include:
Written admission criteria, policies and procedures

4-7 Admission of residents with advanced standing **must** be based on the same standards of achievement required by residents regularly enrolled in the program. Residents with advanced standing **must** receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

Intent*: Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant's past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing residents will not result in an increase of the program's approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for residents in the conventional program and be held to the same academic standards. Advanced standing residents, to be certified for completion, are expected to demonstrate the same standards of competence as those in the conventional program.*

Examples of evidence to demonstrate compliance may include:
Written policies and procedures on advanced standing
Results of appropriate qualifying examinations
Course equivalency or other measures to demonstrate equal scope and level of knowledge

4-8 The program's description of the educational experience to be provided **must** be available to program applicants and include:

a. a description of the educational experience to be provided;
b. a list of program goals and objectives; and
c. a description of the nature of assignments to other departments or institutions.

Intent: *This includes applicants who may not personally visit the program and applicants who are deciding which programs to apply to. Materials available to applicants who*

visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

Examples of evidence to demonstrate compliance may include:
Brochure or application documents
Program's website
Description of system for making information available to applicants who do not visit the program

Due Process

4-9 There **must** be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

Intent: *Adjudication procedures should include institutional policy that provides due process for all individuals who may be potentially involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due process policy, and current accreditation status of the program.*

Examples of evidence to demonstrate compliance may include:
Written policy statements and/or resident contract

Health Services

4-10 Residents, faculty and appropriate support staff **must** be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

Examples of evidence to demonstrate compliance may include:
Immunization policy and procedure documents

STANDARD 5 – PATIENT CARE SERVICES

5-1 The program **must** ensure the availability of patient experiences that afford all residents the opportunity to achieve the program's written goals and objectives or competencies for resident training.

Intent*: Patient experiences should include evaluation and management of head and neck musculoskeletal disorders, neurovascular pain, neuropathic pain, sleep-related disorders, and oromandibular movement disorders.*

Examples of evidence to demonstrate compliance may include:
Written goals and objectives or competencies for resident training
Records of resident clinical activity, including specific details on the variety and type and quantity of cases treated and procedures performed

5-2 Patient records **must** be organized in a manner that facilitates ready access to essential data and be sufficiently legible and organized so that all users can readily interpret the contents.

Intent: *Essential data is defined by the program and based on the information included in the record review process as well as that which meets the multidisciplinary educational needs of the program. The patient record should include a diagnostic problem list, use of pain assessment and treatment contracts, progress sheets, medication log, and outcome data, plus conform to SOAP notes format.*

The program is expected to develop a description of the contents and organization of patient records and a system for reviewing records.

Examples of evidence to demonstrate compliance may include:
Patient records
Record review plan
Documentation of record reviews

5-3 The program **must** conduct and involve residents in a structured system of continuous quality improvement for patient care.

Intent: *Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.*

Examples of evidence to demonstrate compliance may include:

Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

5-4 All residents, faculty, and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

Intent: *ACLS and PALS are not a substitute for BLS certification.*

Examples of evidence to demonstrate compliance may include:
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program
Exemption documentation for anyone who is medically or physically unable to perform such services

5-5 The program **must** document its compliance with the institution's policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Polices **must** be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases **must** be made available to applicants for admission and patients.

Intent: *The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.*

Examples of evidence to demonstrate compliance may include:
Infection and biohazard control policies
Radiation policy

5-6 The program's policies **must** ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

Examples of evidence to demonstrate compliance may include:
Confidentiality policies

STANDARD 6 - RESEARCH

6-1 Residents **must** engage in research or other scholarly activity and present their results in a scientific/educational forum.

Intent: *The research experience and its results should be compiled into a document or publication*

Response Summary:

The Commission on Dental Accreditation directed that the proposed revisions of Accreditation Standards for Orofacial Pain Education programs be distributed to the communities of interest for review and comment. The document is available at the Commission website: https://coda.ada.org/standards#proposed-standards

All communities of interest are invited to submit comment on the proposed revision through the link below. Please note that by submitting a comment you agree to the Commission publishing your name, title, affiliation and comment in a public forum through its policy reports at the meeting during which comments will be considered. The Commission will neither publish your contact information nor follow up with you related to the comment, including its successful or unsuccessful submission. Further, the Commission reserves the right to redact inappropriate and/or unprofessional comments.

Click next to submit a comment.

Q2. Please complete the requested information.

First Name	Annette
Last Name	Puzan
Email	[redacted]
Title	Manager, Dental Education and Licensure

Q3. Please select one of the following options that best describes you or your organization:

- Other (Please specify):
  Council on Dental Education and Licensure (CDEL)

Q4. Is this an official comment from your organization?

- Yes. Please enter the name of your organization below.:
  Council on Dental Education and Licensure (CDEL)

Q5. Enter the Standard number(s), page(s) and line(s) to which you would like to comment.

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain

Q6. Do you agree with the proposed revision?

- Agree

Q7. Enter your comment. Type or copy and paste in the text box below.

The following comment is being submitted on behalf of the ADA Council on Dental Education and Licensure by Dr. James Nickman, chair:
A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, at its January 2023 meeting, the Council considered and supported the proposed addition of Standard 2-10 to the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain.
The Council appreciates the opportunity to submit comment on this important document.

Q8. Do you have additional comment?

- I have NO additional comment and ready to submit.

Scoring

- Score: 0

Embedded Data:

N/A

CONSIDERATION OF PROPOSED REVISIONS TO IMPROVE DIVERSITY IN DENTAL AND DENTAL RELATED EDUCATION PROGRAMS

Background: On December 1, 2023, the Commission on Dental Accreditation (CODA) received a letter from The National Coalition of Dentists for Health Equity (TNCDHE). The request is found in **Appendix 1**. In its letter, TNCDHE provides short-term and long-term suggestions to CODA to improve diversity in all academic dental, allied dental, and advanced dental education programs.

The short-term suggestions from TNCDHE include:

1. Better training of site visit teams on how to assess whether an educational program has implemented a plan to achieve positive results.
2. Ensuring site visit teams are inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Further, when possible, site visit team members should be representative of dental schools with demonstrated success in increasing diversity and assuring a humanistic environment.
3. Redefining the meaning and intent of "diversity" in the Standards, considering the recent Supreme Court decision. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

The long-term suggestions from TNCDHE include:

1. Achieving a humanistic environment, addressing discrimination in policies and practice. Suggested revisions to the Accreditation Standards for Predoctoral Dental Education Programs were provided.
2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.
3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

Summary: The Orofacial Pain Review Committee and Commission are requested to consider the letter from The National Coalition of Dentists for Health Equity (**Appendix 1**). If proposed revisions are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks

The National Coalition of DENTISTS for HEALTH EQUITY

December 1, 2023

Dr. Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
tookss@ada.org

Dear Dr. Tooks,

Recommendations to increase diversity in dental education and practice via the Commission on Dental Accreditation Standards

The National Coalition of Dentists for Health Equity's mission is to support and promote evidence informed policy and practices that address inequities in oral health. One of our priorities is to advocate for greater diversity among dental students and faculty to better reflect the diversity of the US population in the oral health workforce.

In November of 2022, we wrote to the Commission on Dental Education (CODA), expressing concerns about the lack of diversity in predoctoral dental education and the apparent lack of enforcement of the CODA standards on diversity (hot link to our letter on our website). We observed that despite these standards, no dental schools (as of 2022) had received a recommendation related to diversity over the ten years that the standards had been in place. Our letter recommended new standards, policies, and procedures that would enhance diversity in predoctoral dental education. We were pleased to learn that CODA accepted our letter and referred it to a committee reviewing potential changes in the predoctoral standards and that the committee's report will be considered in the early 2024 CODA meetings.

Since 2022, we have spent additional time reviewing CODA standards for the other academic dental educational programs including dental hygiene, dental therapy and advanced education programs and realized our recommendations should also apply to these other programs. In this letter, we review our original recommendations, and propose additional ones for all educational programs.

We believe that the dental school accreditation standards utilized by CODA serve a vital role in achieving a diverse oral health workforce. However, we also believe that the current CODA predoctoral education standards do not appear to be encouraging academic dental institutions to recruit a more diverse student body or faculty. CODA adopted the new diversity predoctoral education standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that "between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis, Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class increased by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, https://www.adea.org/HURE/)" The conclusion we draw is that dental schools are not doing enough to recruit more HURE students to meet the intent of the CODA Standards.

We recognize that the recent Supreme Court decision to abolish the use of race in making admission decisions will prevent academic dental institutions from using race as a determining factor in admissions. The recommendations we make below do not suggest or presume that strategy.

In this letter, we are offering several additional suggestions to CODA to improve the diversity of all academic dental education programs, including predoctoral, dental hygiene, advanced educational programs and dental therapy. Three of these are short term recommendations that are not related to changing accreditation standards, with the understanding that CODA appropriately takes considerable time in changing standards which entails seeking input from many individuals, communities, and entities. In addition, we make another set of suggestions that are long term and include modifications to the “Examples of evidence to demonstrate compliance” for some of the standards. Our recommendations are based on papers found in recent Special Editions of The Journal of Public Health Dentistry and the Journal of Dental Education.

In particular, the longer-term suggestions build on the recommendations of the paper by Smith, PD, Evans CA, Fleming, E, Mays, KAI Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards, as well as two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, 'Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;' and Formicola, AJ and Evans, C, 'Gies re-visited.' Note that some of these recommendations were included in the previous letter to CODA sent on November 4, 2022

SHORT-TERM SUGGESTIONS

Suggestion 1: We recommend that site visit teams be better trained on how to assess whether an educational program has implemented a viable plan that achieves positive results. Under the structural diversity section of the Standards, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is appropriate but showing an improvement in the diversity of the dental schools’ academic communities based on the school's plans and policies should also be demonstrated.

Since site visit teams are different for each school, there can be no consistency in the assessment process unless site visitors are given explicit expectations of what schools should demonstrate to comply with each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards.

Suggestion 2: To be better able to assess whether schools meet diversity and humanistic standards, site visit teams should be inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Wherever possible, site visit team members should also be representative of dental schools that have demonstrated success in increasing diversity and assuring a humanistic environment.

Suggestion 3: Especially in light of the recent Supreme Court decision, CODA should redefine the meaning and intent of the term "diversity" in the Standards documents. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

LONG-TERM SUGGESTIONS

1) Achieving a humanistic environment- Not much is known about how dental schools address discrimination in their humanistic environment policies and practices. Although school policies on anti-discrimination might exist, students, faculty, and staff from underrepresented populations may still experience microaggressions, discrimination, racism, and barriers to socialization and mentorship. It has been suggested that such experiences may be underreported due to numerous factors, including fear of retaliation and/or disbelief that such concerns will be adequately addressed by the dental school. Because there are small numbers of underrepresented students, faculty, and staff in some dental schools, even anonymous humanistic surveys may not reveal these issues.

Suggested new "Examples of evidence to demonstrate compliance with Predoctoral Education Standard 1-3 may include:"

- Policies and procedures (and documentation of their effectiveness) implemented to seek feedback from traditionally underrepresented individuals concerning their experiences with the school's environment.
- Results of feedback that the school has sought from underrepresented students, faculty, and staff about their experiences with the school's environment.
- Documentation of the number and types of problems, complaints, and grievances reported about the school's environment, together with documentation of the school's effectiveness in addressing these issues.

2) Student Admissions

Despite the historical lack of students and faculty from underrepresented segments of the population enrolled in US dental schools, it appears that dental schools are rarely cited for not meeting Standard 1-4. One reason for this may be that the standard allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not appropriately emphasize certain specific underrepresented segments of the population and/or entirely represent the diversity of the local and regional population surrounding the schools, and/or reflect the national demographics in which the schools' graduates will practice their profession. Additionally, CODA provides no specificity for the level of engagement, with respect to recruitment, that dental schools should have with underrepresented populations

Suggested new "Examples of evidence to demonstrate compliance may include".

- Documentation that the school has implemented policies, procedures, and strategies to attract and retain students, faculty and staff from diverse backgrounds in order to achieve parity with the diversity profiles of the school's local, regional or national populations
- Documentation of longitudinal improvement in the diversity of the school's students, faculty, and staff. Where improvement is absent or minimal, documentation of the evaluation of strategies to improve diversity and of modifications made to these strategies to improve outcomes.

The intent of Standard 1-4 states that "admissions criteria and procedures should ensure the selection of a diverse student body with the potential of successfully completing the program". A problem is that the interpretation of this intent can vary dramatically from school to school. Admissions decisions are made by committees of people, and although there are trainings and processes to address implicit biases toward traditionally underrepresented applicants, the admissions process is still largely subjective. There are unique social and structural issues that exist for underrepresented applicants that must also be considered when assessing their potential for success. Those issues may influence undergraduate education academic achievements including GPA's and standardized tests. The question to admissions committees shouldn't necessarily be which applicant has the higher score, but rather does an applicant demonstrate appropriate academic achievements, despite a history of significant barriers, to successfully negotiate the curriculum.

Suggested new "Examples of evidence to demonstrate compliance may include:"

- Documentation of policies and procedures used to consider the unique social and structural constructs that affect traditionally underrepresented applicants in the admissions decision-making process.

- Documentation of procedures used to educate admissions committee members to implicit biases that may exist with respect to the potential of underrepresented applicants to excel in the academic program.
- Documentation of admissions criteria intended to assess not only academic achievements, but also the interest, desire, and commitment of applicants to learn about issues such as cultural competency, community-based practice, and addressing inequities in oral health within the population.

Standards 4-4 for Predoctoral Dental Education programs and Standard 4-2 for Dental Therapy programs state "Admission policies and procedures must be designed to include recruitment and admission of a diverse student population". There are no accreditation standards for Dental Hygiene or Advanced Educational programs that mandate that these programs have policies and practices to achieve a diverse student population. It is recommended that CODA add these standards with appropriate intent statements and examples of evidence to document compliance.

Generally, with respect to Standards 1-3, 1-4, and 4-4, we recommend that CODA strengthen the accountability that should undergird the standards. There must be accountability around these standards. Accountability must be built into the process of reviewing the standards, supporting site visitors in their work, and making sure that dental schools who fail to meet the standards are required to improve their practices and those dental schools who are exceeding the standards should be encouraged to continue to grow.

3) Inclusive Environments in Dental Education

Underrepresented students have a more difficult time achieving both success and a feeling of belonging in dental educational programs for a myriad of reasons.

To improve retention of students in dental education programs facing academic, social or emotional challenge, it is recommended that CODA strengthen the intent statement for student services (Standard 4-7 for predoctoral programs and Standard 4-12 for the dental therapy programs).

The intent statement should state "programs should have policies and procedures which promote early identification and subsequent mentoring/counseling of students having academic and/or personal issues which have the potential of affecting academic success or the personal well-being of students".

Dental Hygiene and Advanced Education programs have no accreditation standards that address academic or personal support for students having difficulties. It is recommended standards be added.

4) Access to Care among Diverse Populations

Access to dental care, and therefore oral and systemic health, is significantly compromised by a number of factors including race, gender, sexual orientation, economic status, education, and neighborhood environment, among other factors.

CODA should strengthen the intent statements with respect to graduates being competent in treating patients in all life stages (predoctoral standard 2-22, dental hygiene standard 2-12 and dental therapy standard 2-20) to assure that foundational knowledge is taught and clinical competence is assessed with respect to changes in oral physiology, the management of the various chronic diseases and associated therapeutics associated with aging, as well as psychological, nutritional and functional challenges manifested in many of these patients.

The intent statement of predoctoral standard 2-17, which addresses student's competence in managing a diverse population, is vague. It is recommended CODA strengthen predoctoral standard 2-17 by stating that "graduates MUST (currently reads should) learn about factors and practices associated with disparities in health status among vulnerable populations, including structural barriers, and must display competency in understanding how these barriers, including prejudices and policies regarding, but not limited to race, gender, sexual preferences, economic status, education and neighborhood environment, affect health and disease and access to care".

There are no standards for dental hygiene or advanced education programs that mandate that graduates be competent in treating a diverse population. CODA should add such standards to these programs.

According to the intent statement of predoctoral Standard 2-26, students working in community health care or service-learning settings are essential to the development of a culturally sensitive workforce. However, the standard merely states that the program makes available such learning environments and that students be urged to avail themselves of such opportunities. CODA should mandate the student’s participation in service-learning and/or community-based health centers clinics.

We are pleased to submit these suggestions to CODA and we hope they will be considered by CODA in our mutual efforts to increase the diversity of the dental workforce.

Sincerely,
Dr. Lawrence Hill DDS MPH
President, National Coalition of Dentists for Health Equity

cc:
American Dental Education Association - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer, American Dental Education Officer

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board
Diverse Dental Society – Dr. Tamana Begay, President
American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director
Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager
Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director;
American Dental Association – Dr. Ray Cohlmia, Executive Director; Dr. Jane Grover, Council on Advocacy for Access, and Prevention; Dr. Linda J. Edgar, President
American Dental Hygienists' Association – Jennifer Hill, Interim CEO; JoAnn Gurenlian, RDH, MS, PhD, AAFAAOM, FADHA Director, Education, Research & Advocacy
Community Catalyst – Tera Bianchi, Director of Partner Engagement; Parrish Ravelli, Associate Director, Dental Access Project
National Indian Health Board – Brett Webber, Environmental Health Programs Director; Dawn Landon, Public Health Policy and Programs Project Coordinator
American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Annaliese Cothron, Executive Director

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