MEETING MINUTES
AMERICAN DENTAL ASSOCIATION
COUNCIL ON DENTAL EDUCATION AND LICENSURE
ADA HEADQUARTERS, CHICAGO | Zoom Meetings
JANUARY 18-19, 2024

Call to Order: The regular meeting of the Council on Dental Education and Licensure was called to order by Dr. Najia Usman, CDEL chair, at 9:02 am on Thursday, January 18, 2024. Council members attended in-person and virtually via Zoom Meetings.

Roll Call: Dr. Cheska Avery-Stafford (ADA, 2024); Dr. Donald P. Bennett (via Zoom), (AADB, 2025); Dr. Shandra L. Coble (via Zoom), (ADEA, 2025); Dr. Kimon Divaris (ADEA, 2024); Dr. Brian J. Howe (via Zoom), (ADEA, 2027); Dr. Arthur Chen-Shu Jee (AADB, 2027); Dr. Rachel Maher (ADA, 2027); Dr. Maureen McAndrew (ADEA, 2026); Dr. Craig P. McKenzie (NDC, 2024); Dr. Barbara L. Mousel (AADB, 2024); Dr. Kelley Ryals (ADA, 2027); Dr. Paul A. Shadid (ADA, 2026); Dr. Todd Smith (ADA, 2026); Dr. Jason A. Tanguay (ADA, 2025); Dr. Bruce R. Terry (ADA, 2024); Dr. Najia Usman (ADA, 2025); and Dr. Catherine A. Watkins (AADB, 2026) were present.

Dr. Randall C. Markarian, ADA Board Liaison to the Council, and Mr. Judd Burns, student representative from the American Student Dental Association, also attended.

Council Staff in attendance: Ms. Tierra Braxton, coordinator, Ms. Mary Ellen Murphy, licensure affairs coordinator, Dr. Sarah Ostrander, senior manager, Ms. Annette Puzan, manager and Dr. Meaghan D. Strotman, director.

Other ADA Staff in attendance for all or portions of the meeting: Dr. Raymond Cohlmia, executive director; Dr. Matthew W. Grady, director, test development, Department of Testing Services; Ms. Jennifer Hall, assistant general counsel; Dr. Kathleen J. Hinshaw, director, DTS Operations, Department of Testing Services; Ms. Catherine Mills, vice-president, Product Development, CE, and Meeting Engagement, Conferences and Continuing Education; Ms. Heidi M. Nickisch Duggan, director, ADA Library & Archives; Mr. Chad Olson, director, Department of State Government Affairs; Dr. Jo Peterson, senior director, Continuing Education; Mr. Matthew Rossetto, legislative liaison, Department of State Government Affairs; Ms. Christy Picker Rothchild, senior associate general counsel; Ms. Samara K. Schwartz, senior associate general counsel; Dr. Sherin Tooks, senior director, CODA and USDE Recognition Compliance, Commission on Dental Accreditation; Dr. David Waldschmidt, senior director, Department of Testing Services and director, Joint Commission on National Dental Examinations; and Dr. Anthony J. Ziebert, senior vice-president, Education and Professional Affairs.

The following guests attended portions of the meeting (in order of appearance): Ms. Kimber Cobb, executive director, American Association of Dental Boards; Ms. Rebecca Stolberg, vice-president, Allied Dental Education and Faculty Development, American Dental Education Association; and Ms. Isabelle Gingras, program advisor, Canadian Dental Association.

Adoption of Agenda, Disclosure Policy and Confidentiality Policy: The Council approved the meeting agenda and authorized the chair to alter the order of the agenda items as necessary to expedite business. Dr. Usman directed the Council's attention to the ADA Disclosure Policy and ADA Confidentiality Policy. Dr. Arthur C. Jee disclosed that he is the vice president of the American Association of Dental Boards and recused himself for the duration of the discussion on the Dentist and Dental Hygienist Compact.

Ms. Schwartz reminded Council members and staff to adhere to the ADA's Professional Conduct Policy in all facets of Council activities, including in person meetings and social events, as well as when attending calls/webinars. Ms. Schwartz explained the ADA's goal is to maintain an appropriate and compliant workplace environment free of discrimination or harassment. The ADA Division of Legal Affairs is always available to assist in promoting compliance.

Affirmation of E-mail Ballots: The Council acknowledged e-mail ballots since the June 2023 meeting:

a. Minutes: September 27, 2023 Meeting (Ballot 2023-3)

Consent Calendar: A consent calendar was prepared to expedite the business of the Council. Dr. Usman reminded Council members that any report, recommendation or resolution could be removed from the consent calendar for discussion. The following reports in their entirety, including recommendations, were placed on the consent calendar and adopted as received:

Reports to the Council:

Dental Education Committee:

Update on Activities of the Commission on Dental Accreditation (CODA)

Annual Report of the National Board for Certification in Dental Laboratory Technology (NBC)

Recommends, that the Council accept the 2023 Abbreviated Annual Report submitted by the National Board for Certification in Dental Laboratory Technology (NBC).

Annual Report of the Dental Assisting National Board, Inc. (DANB)

Recommends, that the Council accept the 2023 Abbreviated Annual Report submitted by the Dental Assisting National Board (DANB).

Consideration of Proposed Revision to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency) (All Standards)

Recommends, that the Council send written comment to CODA supporting the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency) (Appendix 1).

Consideration of Proposed Revision to the Accreditation Standards for Advanced Dental Education Programs (related to program sponsor and authority to operate)

Recommends, that the Council send written comment to CODA supporting the proposed revisions to each of the advanced dental education standards (Appendices 2-17).

Consideration of AAL/ITL Scholarship Nominee Rubric

Recommends, that the Council approve the AAL/ITL Scholarship Nominee Rubric (Appendix 18), to be used in selecting the 2023 ITL scholarship recipients.

Success and/or Program Feedback of Transitioning from Practice to Dental Education CE Course

Consideration of AAL/ITL Scholarship Nominee Rubric

Success and/or Program Feedback of 2023 Institute for Teaching and Learning (ITL) Scholarship Program

Unofficial Report of Actions of the 2023 House of Delegates

Update on ADEA Dentists of Tomorrow 2023

Update on Predoctoral Dental Education

Licensure Committee:

Update on the Dentist and Dental Hygienist Licensure Compact

Update on the Coalition for Modernizing Dental Licensure

Update on Bills and Changes in State Regulations

Unofficial Report of Action of the 2023 ADA House of Delegates

Anesthesiology Committee:

Update on Review of Managing Sedation Complications Online Course

Continuing Education Committee:

Report on ADA Continuing Education Programming

Update on Council and Committee Current and Planned Continuing Education

Update on the Commission on Continuing Education Provider Recognition (CCEPR)

REPORTS OF RELATED GROUPS TO THE COUNCIL

American Dental Association Board of Trustees Liaison: On behalf of the Board of Trustees, Dr. Markarian provided the Council with an update on Board activities. Dr. Markarian shared that the Board of Trustees approved its first Financial Operating Plan and noted that during quarterly financial planning programs will be reviewed and evaluated to ensure they align with advance the goals, mission and vision of the ADA. He underscored the importance of communicating the value of the ADA to members and highlighted the work on insurance reform, specifically the Employee Retirement Income Security Act of 1974 (ERISA), as an example of the membership values that should be shared. Finally, Dr. Markarian talked about the desire to grow the ADA and potential international opportunities to expand and lead the profession.

Senior Vice President, Education/Professional Affairs: Dr. Ziebert reminded the Council of the new rolling budget with quarterly reforecasting process that began in 2024. He also shared that there have been increased test administrations across almost all testing programs and noted that currently there are a total of 73 CODA accredited dental education programs.

New Dentist Committee (NDC): Dr. McKenzie provided an update on the activities of the New Dentist Committee. The NDC is working on growing membership and supporting leadership development within the ADA, as well as building community through the Town Hall Series and the New Dentist Networks CE series. To engage with dental students the NDC hosted various ASDA events at the national and district levels and continues to oversee and support the ADA Success program. Finally, Dr. McKenzie highlighted the 10 Under 10 Award and noted that 2024 winners will be announced in March.

Commission on Dental Accreditation: The Council was reminded that the Unofficial Report of Major Actions of CODA's August 2023 meeting and CODA's 2023 Annual Report were provided in the agenda book and both documents are available on CODA's website. Dr. Tooks noted that all the final reviews of onsite visitations to dental education programs that were required following the virtual visits that the Commission had to perform during the COVID-19 pandemic have been completed. Dr. Tooks shared that in 2023, the Commission accredited a total of 19 new dental education programs. The Commission has appointed an ad hoc committee to study the closures of dental assisting education programs, and the findings will be reported to the Commission for consideration at a future meeting. Dr. Tooks noted that the Commission's Review Committee on Dental Laboratory Technology (DLT) Education is reviewing the Council's correspondence urging the Commission to pursue a comprehensive review and possible revision of the Accreditation Standards for Dental Laboratory Technology Education Programs to address the impact digital workflow has had on the materials and technology used by dental laboratory technicians. The DLT Review Committee's recommendation related to this matter will be considered by the Commission during its February meeting. Dr. Tooks highlighted that the Commission has hosted numerous training programs in the past year for both site visitors and program directors at dental education programs. She concluded her update by welcoming Council members to attend the open session of the Commission's meeting on February 2nd.

American Dental Education Association (ADEA): Ms. Stolberg reminded the Council that the American Dental Education Association's written report summarizing the association's activities was provided and can be found in the New Reports folder in ADA Connect. Ms. Stolberg began her update by sharing that 2023 ended ADEA's 100th anniversary and that the 2024 ADEA Annual Session and Exhibition will be held in March in New Orleans, Louisiana in conjunction with the Seventh International Women's Leadership Conference. Ms. Stolberg noted that this will be the first time the International Women's Leadership Conference will be held in the United States and that the conference will focus on women's global health issues. The dental student graduate survey titled, "Dentists of Tomorrow 2023" was published in October 2023, the 2022-2023 ADEA Dental School Faculty Salary and Demographic Census was published in August 2023 after a redesign, and the 2024 ADEA Survey of U.S. Dental School Seniors is expected to launch in January 2024. ADEA is also launching a new survey in 2024 titled, "ADEA Allied Dental Education Senior Student Survey," to collect data on students' motivations to pursue a degree in allied dental education, preparedness to practice, inter- and intra-professional education experiences, funding sources for their degree, education debt, professional plans upon graduation and certifications.

Ms. Stolberg provided a brief update on the ADEA Council of Deans Fellowship and the ADEA Compendium EPA Workgroup and highlighted the collaboration with the ADA to oversee the development of the ADEA Modular Faculty curriculum focused on enhancing the skills of those faculty that have transitioned from private practice to academia. Ms. Stolberg concluded her report by sharing that ADEA completed its three-year Climate Study which focuses on measuring the perceptions of students, faculty, staff and administrators regarding inclusion, equity and diversity and noted that the results of the study are available on ADEA's website.

Joint Commission on National Dental Examinations (JCNDE): Dr. Waldschmidt shared a presentation highlighting the activities of the Joint Commission on National Dental Examinations (JCNDE). The presentation focused on the role of the JCNDE as a commission of the ADA as well as the role of the Department of Testing Services (DTS). He highlighted JCNDE strategic initiatives discussed during its May 2023 strategic planning meeting, five-year roadmaps for dental and dental hygiene examinations, and provided updates on the Dental Licensure Objective Structured Clinical Examination (DLOSCE) and the Dental Hygiene Licensure Objective Structured Clinical Examination (DHLOSCE).

American Association of Dental Boards (AADB): Ms. Cobbs provided an update from the American Association of Dental Boards (AADB). She shared that the 34th edition of the Composite is being finalized and that AADB recently updated its website. AADB hosted its 140th Annual Meeting in October 2023 in Hollywood, California, and its next meeting is scheduled in Chicago, Illinois on April 12-13, 2024. Finally, she noted that a workgroup was formed in Summer 2023 to develop the AADB Dental and Dental Hygiene Compact, and that legislation was publicly available in September 2023.

Canadian Dental Association (CDA): Ms. Gingras shared that the Canadian Dental Association (CDA) continues to collaborate with the ADA on the Dental Aptitude Test program. Ms. Gingras also noted that for the first time since the COVID-19 pandemic, the Committee on the Admission to the Profession will reconvene to discuss the future of the manual dexterity test, CDA-funded research projects on the admission to dental schools have resumed, and the survey of Canadian dental schools will be launched. Finally, Ms. Gingras concluded her report by noting that the CDA has been closely involved with and will continue to monitor the Federal Government's rollout of the new Canadian Dental Care Plan, to ensure that dental schools can treat and be fairly compensated for services provided to patients covered by the plan.

American Student Dental Association (ASDA): Mr. Burns noted that ASDA's membership numbers have exceed the goal of 23,000 and may reach 24,000 in 2024. He shared that ASDA welcomed a new chapter from the Kansas City University College of Dental Medicine in Joplin, and currently has 70 chapters, with 50 of the chapters on auto-enroll status and the remaining chapters recruiting annually. ASDA's Council on Membership is reviewing applications for the Gold Crown Award Program, which recognizes chapter efforts to support ASDA's mission through innovative programming. Finally, Mr. Burns noted that ASDA's annual session, "Ignite Your Passion, Illuminate the Possibilities", is scheduled February 23-25, 2024, in Denver, Colorado.

REPORTS OF COUNCIL MEMBERS SERVING ON OTHER ASSOCIATION AGENCIES/COMMITTEES

Library and Archives Advisory Board Update: Ms. Nickisch-Duggan briefed the Council on the Library and Archives on highlights from 2023 and planned activities for 2024. She emphasized the member value of accessing PubMed through the ADA Library link which provides access to full text articles when available. ADA Commons, the institutional repository of state and component publications, went live in Q3 2023 and to date has over 10,000 downloads from 89 countries. She noted that the Library's informationists and reference staff actively engage in searching for clinical guideline development and systematic reviews and provide support for other initiatives and publications. Finally, she shared that with the advent of the ADA Forsyth Institute, scientific information services formerly housed in the ADA Science and Research Institute (ADASRI) will join the library team, enhancing the available science, evidence and information services.

COMMITTEE REPORTS

Dental Education Committee: Dr. Maureen McAndrew presented the Committee's comments and recommendations to the Council. The following summarizes the agenda items discussed.

2024 CDEL Review of ADA Dental Education Policies: Following the Association's protocol for periodic

review of policies every five years, the ADA policies related to dental education must be reviewed in 2024. Accordingly, the Council considered seven policies. Full text of the policies and proposed changes to these policies are presented in Appendix 19.

After review of the Statement on Credentialing Dental Assistants (*Trans*.1995:634), the Committee recommended, and the Council agreed, that the policy is current and relevant.

> **Action:** The Council directed that the policy titled "Statement on Credentialing Dental Assistants" be retained as written and that the Council report this conclusion to the 2024 House of Delegates.

After review of the Criteria for Recognition of a Certification Board for Dental Assistants (*Trans*.1989:520; 2014:460; 2019:278), the Committee recommended, and the Council agreed, that the policy is current and relevant. In further discussion of this policy, the Council considered a proposed revision related to DANB's board composition. Specifically, the proposed revision would enable DANB to expand the organizations represented on its Board to ensure broader representation across stakeholder groups. The Council reviewed and supported the proposed revision.

> **Action:** The Council directed that the policy titled "Criteria for Recognition of a Certification Board for Dental Assistants" be amended as noted in Appendix 19 and that the Council report this conclusion to the 2024 House of Delegates.

After review of the Development of Alternate Pathways for Dental Hygiene Training (*Trans*.1998:714; 2014:459), the Committee recommended, and the Council agreed, that the policy is current and relevant; however, the Committee concluded, and the Council agreed, that the term "acknowledges" imparts a more neutral tone while being cognizant of workforce shortages.

> **Action:** The Council directed that the policy titled "Development of Alternate Pathways for Dental Hygiene Training" be amended as noted in Appendix 19 and that the Council report this conclusion to the 2024 House of Delegates.

After review of the Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans*.1992:616; 2010:542), the Committee recommended, and the Council agreed, that the policy is redundant and concluded that the CODA Accreditation Standards address both resolving clauses of this policy. The first resolving clause is addressed by Standards 3-5 and 3-7 of the Accreditation Standards for Dental Assisting Education Programs (Appendix 20) and Standard 3-6 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 21). The second resolving clause is addressed by Standards 3-3 and 3-4 of the Accreditation Standards for Dental Assisting Education Programs (Appendix 20) and Standard 3-3 of the Accreditation Standards for Dental Hygiene Education Programs (Appendix 21). Regarding the second resolving clause, the flexibility built into the CODA Accreditation Standards acknowledges that faculty shortages in dental education are a consideration and that the most qualified individual, whether a dentist or non-dentist, should administer the dental assisting and dental hygiene educational program.

> **Action:** The Council directed that the policy titled "Dentist Administered Dental Assisting and Dental Hygiene Education Programs" be rescinded and that the Council report this conclusion to the 2024 House of Delegates.

After review of the Certifying Board in Dental Assisting (*Trans*.1990:551; 2014:460), the Committee recommended, and the Council agreed, that the policy is current and relevant.

> **Action:** The Council directed that the policy titled "Certifying Board in Dental Assisting" be retained as written and that the Council report this conclusion to the 2024 House of Delegates.

After review of the Criteria for Recognition of a Certification Board for Dental Laboratory Technicians (*Trans*.1998:92, 713; 2014:462; 2019:280), the Committee recommended, and the Council agreed, that the policy is current and relevant.

> **Action:** The Council directed that the policy titled "Criteria for Recognition of a Certification Board for Dental Laboratory Technicians" be retained as written and that the Council report this conclusion to the 2024 House of Delegates

After review of the Certifying Board in Dental Laboratory Technology (*Trans*.2002:400; 2014:460), the Committee recommended, and the Council agreed, that the policy is current and relevant.

> **Action:** The Council directed that the policy titled "Certifying Board in Dental Laboratory Technology" be retained as written and that the Council report this conclusion to the 2024 House of Delegates.

Consideration of Resolution 408H-2023 and Resolution 409H-2023: The Council noted that the 2023 ADA House of Delegates adopted Resolution 408H-2023 Increasing Allied Personnel in the Workforce and Resolution 409H-2023 Methodology of CODA Accreditation Standards.

Resolution 408H-2023 Increasing Allied Personnel in the Workforce directs that the findings of the Commission on Dental Accreditation's (CODA) ad hoc committee be used to suggest programs to attract students into allied educational programs and careers. Further, this resolution directs programs and policies be recommended to urge CODA to improve the ability of allied education programs to expand enrollment.

The Council reviewed and supported the Dental Education Committee's suggested actions to address Resolution 408H-2023, including: a review of findings of the CODA Ad Hoc Committee on Faculty to Student Ratios in Accreditation Standards along with the responses to the Survey of Allied Dental Education Programs Related to Faculty to Student Ratios; a review of current career resources available on the ADA website as well as those available at state and local levels; and collaboration with the appropriate ADA agencies to discuss how to enhance the current materials promoting allied dental careers. Gathered information and recommendations will be reported and prepared for consideration by the Dental Education Committee and Council in the spring.

> **Action:** The Council conduct a scan of currently available allied dental career guidance resources and collaborate with other ADA Councils and Departments to review the resources and recommend steps, if any, that should be pursued to enhance the current offerings.

Resolution 409H-2023 Methodology of CODA Accreditation Standards directs that CODA be urged to demonstrate transparent methodology for the establishment of faculty to student ratios and educational requirements for part-time and adjunct instructors in allied dental education programs. Further, this resolution directs that CODA be urged to allow allied personnel with ten or more years of experience to be part time or adjunct faculty in allied dental education programs where other faculty meet current educational degree requirements. Finally, this resolution directs that CODA be urged to revise its faculty to student ratio for Dental Hygiene education programs to be consistent with other allied dental education programs.

The Council reviewed and supported the Dental Education Committee's suggested action to address Resolution 409H-2023, including communication to CODA urging consideration of the directives set forth by the 2023 House of Delegates as stated in the resolution.

> **Action:** The Council directed that written correspondence be sent to the Commission on Dental Accreditation (CODA) urging the Commission to 1) demonstrate transparent methodology for the establishment of faculty-to-student ratios and educational requirements for part-time and adjunct faculty in allied dental education programs, 2) permit Registered Allied personnel with ten or more years of experience to work as part-time or adjunct clinical and laboratory faculty in Allied Dental Education Programs that have other faculty who meet educational degree requirements, and 3) revise the clinical and laboratory faculty-to-student ratios in Dental Hygiene Education Programs to 1:6.

Licensure Committee: Dr. Avery-Stafford presented the Committee's comments and recommendations to the Council. The following summarizes the agenda items discussed and the Council's actions.

House of Delegates Action Regarding the Comprehensive Policy on Dental Licensure

The Council reviewed the Comprehensive Policy on Dental Licensure in 2023 and determined amendment was warranted. The Council submitted Resolution 401, and in September 2023, the Ninth District submitted Resolution 401S-1 calling for further amendment of the terminology for current and retired members of the United States military services. During the Reference Committee on Dental Education, Science and Related Matters hearing at the 2023 House of Delegates meeting, testimony was provided on Resolutions 401 and 401S-1 both supporting and opposing the proposed amendments, as well as several comments suggesting referral of the policy. The Reference Committee recommended, and the House of Delegates supported, the

referral of Resolutions 401 and 401S-1 for further study and update to the 2024 House of Delegates. Comments and testimony provided at the Reference Committee hearing, focused on five specific sections of the policy summarized below. Full text of the policy and proposed changes are presented in Appendix 22.

The Committee recommended, and the Council agreed, that the statement in Appendix 22, page 4001, lines 14-18 should be further amended to clarify that the real or perceived conflict of interest is related to the selection of which examinations will be accepted for licensure, not the administration of examinations. Additionally, the Committee recommended, and the Council agreed, with striking the statement that dental board members should not serve simultaneously as examiners with a clinical testing agency because some states require this of their board members.

Action: The Council directed that page 4001, lines 14-18 be amended as noted in Appendix 22.

The Committee recommended, and the Council agreed, with further amendment of the statement in Appendix 22, page 4002, lines 6-13 to clarify that advanced dental education programs in general dentistry are defined as Advanced Education General Dentistry (AEGD) and General Practice Residency (GPR) programs. The Committee concluded that CODA Standards requiring programs assess the international graduate's knowledge, training and skills to determine equivalency to the DDS/DMD program address concerns about specifying program length, however the Council felt a two-year program should be specified. Finally, the Council further amended the policy, adding a statement encouraging advanced dental education programs to use the Advanced Dental Admission Test (ADAT) to inform admission decisions.

Action: The Council directed that page 4002, lines 6-13, be amended as noted in Appendix 22.

The Committee recommended, and the Council agreed with and supported, without further amendment, the proposed language in Appendix 22, page 4002, lines 43-46 and page 4003, lines 1-7, that emphasizes current ADA policy regarding provisions for freedom of movement across state lines and participation in licensure compacts.

Action: The Council supports without further amendment the proposed language on page 4002, lines 43-46 and page 4003, lines 1-7 as noted in Appendix 22.

After consideration of amendments proposed in Resolution 401S-1 and testimony provided at the House of Delegates, the Committee recommended, and the Council agreed, with further amendment to the statement in Appendix 22, page 4004, lines 6-8 to clarify the terminology for current and retired members of the United States military services.

Action: The Council directed that page 4004, lines 6-8 be amended as noted in Appendix 22.

The Committee recommended, and the Council agreed, with further amendment of the statement in Appendix 22, page 4004, lines 3-5 to reflect support of faculty licensure for both US educated and internationally educated faculty, echoing the support of military licensure mobility.

Action: The Council directed that page 4004, lines 3-5, be amended as noted in Appendix 22.

Anesthesiology Committee: Dr. Divaris presented the Committee's comments and recommendations to the Council. The following summarizes the agenda items discussed.

Update on Council on Scientific Affairs Scoping Review: Moderate Sedation on Adults

The Council was reminded that CDEL was responsible for the periodic review of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists, the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, and the ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists in 2021. Review of the guidelines and policy was postponed pending the development of new evidence-based clinical guidelines on sedation and general anesthesia by the Council on Scientific Affairs (CSA) with the support of the ADA Science and Research Institute (ADASRI), as agreed upon by CDEL and CSA. Initiation of the CSA project was delayed until summer 2022. During preliminary discussions concerns were raised that evidence-based clinical practice guidelines may not be the appropriate or most effective tool to meet CDEL's request, and in December 2022, CSA informed CDEL that the scope of the project would be modified. The new recommendation was to complete a scoping review on moderate sedation in adults in the practice setting with anticipated completion of the project no later than Q4 2023. However, in August 2023 CSA informed CDEL that it was unable to complete the work based on limited

resources and the broad nature of the desired topic. It was determined that the scoping review still needs to occur prior to updating the Guidelines, and there are now some options for this to occur with assistance from the ADA Library, outside agencies, and the ADA Forsyth Institute. It was determined that the scoping review would be completed on only moderate sedation on adults and needs to occur before scheduling a Dental Anesthesia Provider Summit.

AAOMS Request Regarding Dental Anesthesia Provider Summit

In August 2023, the American Association of Oral and Maxillofacial Surgeons (AAOMS) sent a letter recommending the ADA to convene a "Dental Anesthesia Provider Summit" with the primary objective of updating the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists. AAOMS suggested that communities of interest be invited to the Summit and that Summit attendees assume their travel expenses through their respective organizations. It was also suggested that consideration be given to including all age groups in the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists. For children, the ADA supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry (AAP/AAPD) pediatric anesthesia guidelines that were first published in 1985. ADA President at the time, Dr. George Shepley, referred this matter to the Council and its Anesthesiology Committee. It was determined that a Summit could be beneficial to all organizations and that the ADA could serve in a facilitator role.

ASDA Request Regarding Draft Model State Sedation/General Anesthesia Rules

In August 2023 the American Society of Dentist Anesthesiologists (ASDA) requested that the ADA support the ASDA's draft Model State Sedation/General Anesthesia Rules document. The document intends to assist state legislatures and dental boards in constructing, writing, and revising sedation and general anesthesia regulations in dental settings. The Committee agreed that the document is lengthy and very specific, requiring further study. Potential conflicts with current ADA policies, e.g., ADA Adult Use Guidelines, ADA Adult Teaching Guidelines, ADA Pediatric Teaching Guidelines, and the ASDA Model State Sedation/General Anesthesia must be carefully considered before ADA endorsement or support of the Model Rules can be pursued. Accordingly, the Committee determined that an in-depth review of the Model Rules needs to occur before providing recommendations to the Council for consideration at its June 2024.

Withdrawn Resolutions 406 and 407 to the 2023 ADA House of Delegates

When the Council was informed that CSA could no longer perform the scoping review, Resolutions 406 and 407 were withdrawn from consideration by the October 2023 House of Delegates.

Moving Forward in 2024: Recommendation for the Council

After discussion and consideration of the updates and proposed tentative timeline, the Council agreed with the Committee's recommendation that a scoping review be conducted in preparation for review of the ADA Guidelines for Use of Sedation and General Anesthesia by Dentists and confirmed that the Council should convene a Dental Anesthesia Provider Summit as urged by AAOMS. The Council directed that the summit be scheduled six months after receipt of the results of the scoping review on moderate sedation in adults.

> **Action:** The Council directed the conduct of a scoping review on moderate sedation in adults with the report available to the Anesthesiology Committee and Council with a tentative due date of May 1, 2024.
> Financial Implication (estimated): $25,000 - $50,000

> **Action:** The Council agreed with the request by the American Association of Oral and Maxillofacial Surgeons to facilitate a Dental Anesthesia Provider Summit with the primary objective of updating the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists within six months of receiving the results of the scoping review. (Date to be determined).
> Financial Implication (estimated): $35,000

Continuing Education Committee: The following summarizes the agenda items discussed.

Consideration of Continuing Education Pilot

Dr. Terry indicated all items were on consent for the CE Committee, except the proposal for a CE Pilot Program to occur from February 1, 2024 – May 1, 2024. During this time, the CE Committee would receive

monthly progress reports utilizing a dashboard provided by the Department of CE. Ms. Mills and Dr. Peterson provided an overview of the CE Pilot Program, showed an example of the dashboard and included metrics, and answered questions. The CE Pilot Program will utilize volunteer advisors to assist with development of new continuing education courses, attend periodic advisory meetings, and strategize to determine new continuing education topics. The CE team indicated its goal is to have 500 continuing education courses by 2025. The Committee recommended, and the Council agreed, to proceed with the CE Pilot.

> **Action:** The Council directed the ADA Department of Continuing Education to conduct a CE Pilot Program, February 1 – May 1, 2024, with monthly progress reports to the Council and CE Committee and a final report to the Council's June meeting.

EMERGING ISSUES, TRENDS AND MISCELLANEOUS AFFAIRS:

ADA Executive Director's Update: Dr. Cohlmia provided an update on membership, highlighted current data on both dentists and patients, and reviewed trends that will impact future delivery of oral health care, including consumerism, payment reform, shifting practice models and technology. He also discussed the ADA Forsyth Institute and the transition to the new Fonteva/Salesforce association management system.

Opening Remarks from the ADA President: Dr. Edgar greeted the Council and shared her goals as president. She highlighted the membership recruitment contest and emphasized the importance of promoting the numerous ways the Association supports the profession. She also discussed the lunchbox initiative aimed at providing nutrition and brushing information to elementary students. Finally, she noted the efforts being made across the Association to increase efficiency.

Coalition for Modernizing Dental Licensure (CMDL): Dr. Ostrander provided an update on the activities of the Coalition for Modernizing Dental Licensure. The Coalition currently has 129 partner organizations. To increase communication with the partner organizations, a quarterly newsletter was launched in July 2023, with the second edition sent in October 2023 and the third edition scheduled for distribution at the end of January 2024. The Coalition held its annual webinar on September 14, 2023. The webinar focused on advocacy efforts and resources for partner organizations and included an update on the Dentist and Dental Hygienist (DDH) Compact and a panel discussion. In support of increased licensure mobility, the Coalition sent a second letter of support for the DDH Compact to the Council of State Governments. The Executive Committee issued a call for nominations for one of the at-large positions on the Executive Committee for the term beginning July 1, 2024. The next Executive Committee meeting is scheduled for February 29, 2024.

Dentist and Dental Hygienist Compact Update: Mr. Olson and Mr. Rossetto provided an update on the progress and advocacy efforts in support of the Dentist and Dental Hygienist (DDH) Compact. There are currently three states that have enacted the compact, including Iowa, Washington, and Tennessee, and 12 states that have pending legislation. Mr. Rossetto informed the Council that multiple hearings are scheduled in states with pending legislation, including Indiana, Missouri, and Virginia. In Wisconsin, legislation was passed by the State Senate and State Assembly and is anticipated to soon be signed into law by the governor.

2024 Self-Assessment of the Council on Dental Education and Licensure: All ADA councils, commissions, and committees are required to undertake a thorough self-assessment every five years. CDEL last completed a self-assessment in 2019. In preparation for CDEL's 2024 assessment, a self-assessment survey was proposed for consideration by the Council. With oversight from the Council Chair and Vice-Chair, the survey results will be prepared and presented to the Council in the spring of 2024.

> **Action:** The Council directed that the 2024 self-assessment be conducted via the proposed survey in accord with the proposed timeline and oversight by Dr. Usman and Dr. Tanguay, and that the results of the survey and recommendations be presented to the Council for consideration in the spring.

Council Priorities for 2024: The Council discusses and confirmed its priorities and projects for 2024 in light of the Strategic Forecasting Committee's priorities, ADA's Vision and Mission, and the Council's defined responsibilities:

- On behalf of the ADA, monitor and comment on matters of the Commission on Dental Accreditation, Commission for Continuing Education Provider Recognition, the National Commission on Recognition of Dental Specialties and Certifying Boards and the Joint Commission on National Dental Examinations.

- Continue to promote and support the Dentist and Dental Hygienist Compact model legislation and advocate for changes to state dental practice acts, rules and regulations regarding licensure.
- Continue to support the implementation and promotion of non-patient clinical licensure examinations, including the Dental Licensure Objective Structured Clinical Examination (DLOSCE).
- Continue to support the ADA and its involvement with the Coalition for Modernizing Dental Licensure. Provide oversight to the Department of Testing Services regarding the administration of the Dental Admission Test (DAT), the Advanced Dental Admission Test (ADAT) and the Admission Test for Dental Hygiene (ATDH).
- Per the 5-year association policy review cycle, consider and possibly recommend revision to the dental education policies assigned to the Council for review.
- Continue to support and promote careers in dental education by awarding three 2024 CDEL Tuition Scholarships to the Academy for Advancing Leadership's Institute for Teaching and Learning.
- Support the collaboration with ADEA on development of a modular curriculum to assist new dental and allied dental teaching faculty transitioning from private practice to academia.
- Consider the annual reports of the Dental Assisting National Board (DANB) and the National Board for Certification in Dental Laboratory Technology (NBC).
- Consider and monitor the progress of the proposed CE Pilot Program.
- Conduct a scoping review on moderate sedation in adults and consider facilitating a Dental Anesthesia Provider Summit in support of possible revisions to the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists.
- Address Resolution 401-2023: Amendment of Policy, Comprehensive Policy on Dental Licensure, Resolution 401S-1-2023: Amendment of Policy, Comprehensive Policy on Dental Licensure, Resolution 408H-2023: Increasing Allied Personnel in the Workforce, and 409H-2023: Methodology of CODA Accreditation Standards and report back to the 2024 House of Delegates.
- Pursuant to Resolution 1H-2013, conduct a self-assessment of the Council on Dental Education and Licensure and report findings to the 2024 House of Delegates.

Action: The Council approved its priorities and projects for 2024 as noted above.

Council Chair and Vice-chair Election Process for 2024-2025: Dr. Najia Usman (ADA appointee) will complete her term as chair of the Council on Dental Education and Licensure at the close of the 2024 ADA House of Delegates meeting on October 22, 2024. Dr. Jason A. Tanguay (ADA appointee) will also complete his one-year term as vice-chair of the Council at that time. The Council was reminded that at its June 2024 meeting, members will elect a chair and vice-chair for the 2024-2025 year.

Adjournment: 12:13 PM Friday, January 19, 2024.

Appendices

Appendix 1:	Proposed Revision to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency) (All Standards)
Appendix 2-17:	Proposed Revision to the Accreditation Standards for Advanced Dental Education Programs (related to program sponsor and authority to operate)
Appendix 18:	AAL/ITL Scholarship Nominee Rubric
Appendix 19:	2024 CDEL Review of ADA Dental Education Policies
Appendix 20:	Accreditation Standards for Dental Assisting Education Programs
Appendix 21:	Accreditation Standards for Dental Hygiene Education Programs
Appendix 22:	Proposed Revisions to Comprehensive Policy on Dental Licensure

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency) be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_8iBzregPEo1y1Ei

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency)

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-4653
https://coda.ada.org/

Document Revision History

Date	Item	Action
February 12, 2021	Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery	Adopted and Implemented
February 12, 2021	Revised Standards 4-4 and 4-6 through 4-8; Deletion of Standard 4-6.1; and Addition of 4-8.2 and 4-18 through 4-20	Adopted
August 6, 2021	Revised Mission Statement	Adopted
January 1, 2022	Revised Standards 4-4 and 4-6 through 4-8; Deletion of Standard 4-6.1; and Addition of 4-8.2 and 4-18 through 4-20	Implemented
January 1, 2022	Revised Mission Statement	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 *(<u>without</u> reporting requirements*): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

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

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

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

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

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

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

specific occupational area. The classification "initial accreditation" is granted based upon one or more site evaluation visit(s).

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9

Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

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

Preface

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

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

Accreditation is extended to institutions offering acceptable programs in the disciplines of advanced dental education: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, advanced education in general dentistry, general practice residency, dental anesthesiology, oral medicine, and orofacial pain. Program accreditation will be withdrawn when the training program no longer conforms to the standards as specified in this document, when all first-year positions remain vacant for a period of two years or when a program fails to respond to requests for program information. Exceptions for non-enrollment may be made by the Commission for programs with "approval without reporting requirements" status upon receipt of a formal request from an institution stating reasons why the status of the program should not be withdrawn.

Advanced dental education may be offered on either a certificate-only or certificate and degree-granting basis.

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all disciplines of advanced dental education, institutions and programs. Each discipline develops discipline-specific standards for educational programs in its discipline. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the

standards for the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.

As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status.

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).

Definitions of Terms Used in Oral and Maxillofacial Surgery Accreditation Standards

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

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

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

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

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

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

Graduates of discipline-specific advanced dental education programs provide unique services to the public. While there is some commonality with services provided by specialists and general dentists, as well as commonalities among the specialties, the educational standards developed to prepare graduates of discipline-specific advanced dental programs for independent practice should not be viewed as a continuum from general dentistry. Each discipline defines the educational experience best suited to prepare its graduates to provide that unique service.

Competencies: Statements in the advanced dental education standards describing the knowledge, skills and values expected of graduates of discipline-specific advanced dental education programs.

Competent: Having the knowledge, skills and values required of the graduates to begin independent, unsupervised discipline-specific practice.

In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.

Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

A degree-granting program a planned sequence of advanced courses leading to a master's or doctoral degree granted by a recognized and accredited educational institution.

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program recognized by the American Dental Association.

Resident: The individual enrolled in an accredited advanced dental education program.

International Dental School: A dental school located outside the United States and Canada.

Evidence-based dentistry: Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Formative Assessment*: guiding future learning, providing reassurance, promoting reflection, and shaping values; providing benchmarks to orient the learner who is approaching a relatively unstructured body of knowledge; and reinforcing students' intrinsic motivation to learn and inspire them to set higher standards for themselves.

Summative Assessment*: making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility; and providing professional self-regulation and accountability.

*Epstein, R.M. (2007) *Assessment in Medical Education*. The New England Journal of Medicine, 387-96.

Oral and Maxillofacial Surgery Terms:

Oral and maxillofacial surgery teaching service: that service in which the resident plays the primary role in the admission, management and/or discharge of patients.

General anesthesia: is a controlled state of unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or combination thereof.

Deep sedation: is a controlled state of depressed consciousness, accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to verbal command, and is produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

Board Certified: as defined by the American Board of Oral and Maxillofacial Surgery.

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

The program **must** document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced dental education resident achievement.

1-1 The program must document success of graduates in obtaining American Board of Oral and Maxillofacial Surgery certification.

1-2 The program must document participation in a national, standardized and psychometrically validated in-service examination.

~~Example of Evidence to demonstrate compliance may include:~~

- ~~OMSITE~~

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

Example of Evidence to demonstrate compliance may include:

- OMSITE

1-3 The program must document ongoing structured use of a standardized educational curriculum.

Examples of evidence to demonstrate compliance may include:

- Consistent use of a structured curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.
- Conference schedule including This Week In SCORE(TWIS)

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

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

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

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

Advanced dental education programs **must** be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced dental education programs **must** ensure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters **must** rest within the sponsoring institution.
The institution/program **must** have a formal system of quality assurance for programs that provide patient care.

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

~~1-3~~1-4 There must be adequate bed availability to provide for the required number of patient admissions and appropriate independent care by the oral and maxillofacial surgery service.

~~1-4~~1-5 Oral and maxillofacial surgeons who are members of the teaching staff participating in an accredited educational program must be eligible to practice the full scope of the advanced dental education discipline in accordance with their training, experience and demonstrated competence.

Examples of evidence to demonstrate compliance may include:

- Details of bylaws and credentialing process that document that oral and maxillofacial surgeons are allowed to practice those aspects of the advanced dental education discipline for which they have documented evidence of training and experience

- List of procedures performed that show scope, and/or hospital privileges list

~~1-5~~1-6 The educational mission must not be compromised by a reliance on residents to fulfill institutional service, teaching or research obligations. Resources and time must be provided for the proper achievement of educational obligations.

Intent*: All resident activities have redeeming educational value. Some teaching experience is part of a residents training, but the degree to which it is done should not abuse its educational value to the resident.*

Examples of evidence to demonstrate compliance may include:

- Clinic assignment schedule

USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

~~1-6~~1-7 All arrangements with major and minor activity sites, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

Intent: *Ownership may entail clinical operations, and not necessarily the physical facility.*

~~1-7~~1-8 Documentary evidence of agreements, for major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

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

Intent*: An "institution (or organizational unit of an institution)" is defined as a dental, medical or public health school, patient care facility, or other entity (e.g., OMS practice facility) that engages in advanced dental education. The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).*

~~1-8~~1-9 Rotations to an affiliated institution which sponsors its own accredited oral and maxillofacial surgery residency program must not exceed 26 weeks in duration.

~~1-9~~1-10 All standards in this document must apply to training provided in affiliated institutions.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission's Policy on Accreditation of Off-Campus Sites found in the Evaluation and Operational Policies and Procedures manual (EOPP).

1-11 The program and sponsoring institution's collaborative responsibilities must include an ongoing effort for recruitment and retention of a diverse and inclusive workforce of faculty, residents and staff.

Examples of evidence to demonstrate compliance may include:

- Nondiscriminatory policies and practices at all organizational levels.
- Mission and policy statements which promote diversity and inclusion.
- Evidence of training in diversity, inclusion, equity, and belonging.

STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program **must** be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, **must** be board certified.)

> ***Intent***: *The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.*
>
> Examples of evidence to demonstrate compliance may include:
>
> For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification
>
> (For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.

Documentation of all program activities **must** be ensured by the program director and available for review.

2-1 Program Director: The program must be directed by a single responsible individual who is a full time faculty member as defined by the institution.

Intent: *Other activities do not dilute a program director's ability to discharge his/her primary obligations to the educational program.*

The responsibilities of the program director must include:

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

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

2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff. This must include documentation of evaluation of the members of the teaching staff by the residents at least annually.

Intent: *In some situations, the evaluation of the teaching staff may be performed by the chairman of the department of oral and maxillofacial surgery in conjunction with the program director.*

2-1.4 Responsibility for adequate educational resource materials for education of the residents, including access to an adequate health science library and electronic reference sources.

Examples of evidence to demonstrate compliance may include:

- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

2-1.5 Responsibility for selection of residents and ensuring that all appointed residents meet the minimum eligibility requirements, unless the program is sponsored by a federal service utilizing a centralized resident selection process.

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

Examples of evidence to demonstrate compliance may include:

- Copies of faculty meeting minutes
- Sign-in sheets
- Monthly records of outpatient visits by category
- Resident surgical logs/other electronic record databases
- Evaluations of teaching staff

2-1.7 The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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

Examples of evidence to demonstrate compliance may include:

- Established policies regarding ethical behavior by faculty, staff and residents that are regularly reviewed and readily available
- Resident, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities
- Focus groups and/or surveys directed towards gathering information on resident, faculty, patient, and alumni perceptions of the cultural environment

2-1.8 The program director and teaching staff must lead by example in all aspects of professionalism.

Intent: *The purpose of the program's culture and environment is to promote excellence in safe, high-quality care, preparing residents for lifetime learning and a successful future professional life. Practices and policies that exemplify faculty well-being and promote resident well-being in a humanistic environment, while not compromising on quality and safety, create the optimal culture and environment. Professionalism, integrity, and an open culture; where problems can be raised and solved as a team, allow for progress and flexibility while promoting a shared responsibility of all involved to create and maintain an optimal educational environment. Program directors' and teaching staff model, at all times, excellence in patient care, demonstrated by safe and compassionate clinical practice, integrity in their approach to service and scholarly activity, respect for others, especially residents, in their efforts to assure an optimal educational environment.*

Examples of evidence to demonstrate compliance may include:

- Written evaluations from faculty and the chair of the program director and teaching staff.
- Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.
- External evaluations of culture, climate, and learning environment.
- Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation.

- Policies and requirements that promote an optimal educational experience, working culture and environment.

2-1.9 Lines of communication must be established and ongoing within the program to address culture concerns without the fear of retaliation.

Examples of evidence to demonstrate compliance may include:

- Written evaluations from faculty that occur at least twice a year.
- Anonymous surveys of the program director and teaching staff by residents evaluating the core aspects of the standard.
- Anonymous evaluations of culture, climate, and learning environment.
- Policies and practices that promote the ability for residents to raise concerns in an anonymous fashion and demonstrate the prohibition of retaliation.
- Policies and requirements that promote an optimal educational experience, working culture and environment.

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

2-2.1 Provide direct supervision in all patient care settings appropriate to a resident's competence and level of training.

***Intent**: Faculty is present and available in clinics, emergency rooms and operating rooms for appropriate level supervision during critical parts of procedures.*

Examples of evidence to demonstrate compliance may include:

- Faculty coverage for clinic, operating room and call schedules
- Patient records

2-2.2 In addition to the full time program director, the teaching staff must have at least one full time equivalent oral and maxillofacial surgeon as defined by the institution per each authorized senior resident position. One of the teaching staff who is not the program director must be at least half-time faculty as defined by the institution.

CODA authorized enrollment per year (n)	Required Program Director F.T.E.	Required minimum F.T.E. of second faculty member	Required cumulative additional F.T.E. of faculty who are not program director	Required Total faculty F.T.E. for program

1	1	0.5	0.5	2
2	1	0.5	1.5	3
3	1	0.5	2.5	4
n	1	0.5	n – 0.5	n + 1

2-2.3 Eligible oral and maxillofacial surgery members of the teaching staff, with greater than a .5 FTE commitment appointed after January 1, 2000, who have not previously served as teaching staff, must be diplomates of the American Board of Oral and Maxillofacial Surgery or in the process of becoming board certified. Foreign trained faculty must be comparably qualified.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the oral and maxillofacial surgery faculty.
Examples of Evidence to demonstrate compliance may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;
b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media; and
c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.

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

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

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

Student/Resident assessment
Cultural Competency
Ability to work with students/residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities
Consistent faculty use of a national curriculum (e.g., SCORE).
Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

STANDARD 3 – FACILITIES AND RESOURCES

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

***Intent**: The facilities and resources (e.g.; support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.*

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

***Intent**: The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the residents, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.*

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

***Intent**: The program should have written policy that encourages (e.g., delineates the advantages of) immunization for residents, faculty and appropriate support staff.*

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**: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.*

The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.

3-1 Clinical facilities must be properly equipped for performance of all ambulatory oral and maxillofacial surgery procedures, including administration of general anesthesia and sedation for ambulatory patients.

3-2 There must be a space properly equipped for monitoring patients' recovery from ambulatory surgery, general anesthesia and sedation.

3-3 An adequate and accessible dental laboratory facility must be available to the residents to utilize for patient care.

3-4 Adequate onsite computer resources with internet access must be available to the residents.

3-5 Adequate on call facilities must be provided to residents when fulfilling in-house call responsibilities.

3-6 Adequate and accessible diagnostic imaging facilities must be available to residents to utilize for patient care.

STANDARD 4 - CURRICULUM AND PROGRAM DURATION

The advanced dental education program **must** be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards of the discipline's practice as set forth in specific standards contained in this document.

***Intent**: The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies standards for the discipline.*

Advanced dental education programs **must** include instruction or learning experiences in evidence-based practice. Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or "searching publication databases and appraisal of the evidence")
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of national in-service examinations or board certification examinations.

The level of discipline-specific instruction in certificate and degree-granting programs **must** be comparable.

***Intent**: The intent is to ensure that the residents of these programs receive the same educational requirements as set forth in these Standards.*

If an institution and/or program enrolls part-time residents, the institution **must** have guidelines regarding enrollment of part-time residents. Part-time residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls residents on a part-time basis **must** ensure that: (1) the educational experiences,

including the clinical experiences and responsibilities, are the same as required by full-time residents; and (2) there are an equivalent number of weeks spent in the program.

4-1 An advanced dental education program in oral and maxillofacial surgery must encompass a minimum duration of four (4) years of full-time study.

4-2 Each resident must devote a minimum of 120 weeks to clinical oral and maxillofacial surgery.

***Intent**: While enrolled in an oral and maxillofacial surgery program, full-time rotations on the oral and maxillofacial surgery service while doing a non-oral and maxillofacial surgery residency year or full-time service on oral and maxillofacial surgery during vacation times during medical school may be counted toward this requirement.*

Examples of evidence to demonstrate compliance may include:

- Complete schedule of resident activity

4-2.1 Fifty-two weeks of the time spent on the oral and maxillofacial surgery service must be at a senior level of responsibility, 26 weeks of which must be in the final year.

***Intent**: Senior level responsibility means residents serving as first assistant to attending surgeon on major cases. Resident serves as first assistant for the majority of surgical procedures performed during this rotation. They are to be present for most pre- and post-operative patient visits.*

4-2.2 Rotations to affiliated institutions outside the United States and Canada must not be used to fulfill the core 120 weeks clinical oral and maxillofacial surgery training experience. Surgical procedures performed during foreign rotations must not count toward fulfillment of the 175 major surgical procedures.

4-2.3 Rotations to a private practice ~~must not be used to~~ that fulfill the core 120 weeks of clinical oral and maxillofacial surgery training experience must not exceed 4 weeks.

***Intent:** It is recognized that educational value exists in resident exposure to the private practice environment. Rotations to private practice are intended to broaden the educational experience of residents and not for service needs of the private practice.*

4-3 The residency program in oral and maxillofacial surgery must include education and training in the basic and clinical sciences, which is integrated into the training program. A distinct and specific curriculum must be provided in anesthesia, clinical medicine and surgery.

The integrated clinical science curriculum must include off-service rotations, lectures, ~~and~~ seminars, and high-quality educational materials in a structured program for learning given during the oral and maxillofacial surgery training program by oral and maxillofacial surgery residents and attending staff.

Intent: *Course work and training taken as requirements for the medical degree and the general surgery residency year provided within integrated MD or DO/oral and maxillofacial surgery training programs may also qualify to satisfy some of the clinical science curriculum requirements.*

When assigned to a required rotation on another service (surgery, medicine, anesthesiology, and eight weeks of additional off-service elective), the oral and maxillofacial surgery resident must devote full-time to the service and participate fully in all the teaching activities of the service, including regular on-call responsibilities.

Intent: *Beyond the required 56 week rotations, residents may take call on the oral and maxillofacial surgery service when on additional rotations (oral pathology, etc.).*

Examples of evidence to demonstrate compliance may include:

- Lecture schedules
- Curriculum; behavioral objectives
- Attendance sign-in sheets
- Policy of anesthesia department related to on-call participation by residents if residents are not permitted to be on-call
- Rotation schedules
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-3.1 Anesthesia and Medical Service:

The combined assignment must be for a minimum of 32 weeks. A minimum of 20 weeks must be on the anesthesia service and should be consecutive. Four of these 20 weeks should be dedicated to pediatric anesthesia. The resident must function as an anesthesia resident with commensurate level of responsibility. A minimum of 8 weeks must be on the medicine or medical subspecialty services.

***Intent**: It is desirable that four weeks of the required 32 weeks, not fulfilled by the 20 weeks on anesthesia and 8 weeks on medicine or medical subspecialty services be an experience in pre-anesthetic risk stratification and perioperative medical assessment of the surgical patient. The experience beyond the 20 weeks rotation on the anesthesia service may be at the medical student or resident level, and may include the rotations on medical/anesthesia specialty services (e.g., Medicine, Cardiology, Critical Care, Pediatrics, anesthesia perioperative medicine clinic). The 20 week Anesthesia Service time can be during medical school as long as the oral and maxillofacial surgery trainee functions at the anesthesia resident level.*

Examples of evidence to demonstrate compliance may include:

- Resident on-call anesthesia and medicine schedules
- Resident anesthesia and medical service rotation schedules
- Anesthesia records

4-3.2 Surgical Service:

A minimum of 16 weeks of clinical surgical experience must be provided. This experience should be achieved by rotation to a surgical service (not to include oral and maxillofacial surgery) and the resident must function as a surgery resident with commensurate level of responsibility.

***Intent**: The intent is to provide residents with adequate training in pre- and post-operative care, as well as experience in intra-operative techniques. This should include management of critically ill patients. Oral and maxillofacial surgery residents operate at a PGY-1 level of responsibilities or higher, and are on the regular night call schedule.*

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

4-3.3 Other Rotations:

Eight additional weeks of clinical surgical or medical education must be assigned. These must be exclusive of all oral and maxillofacial surgery service assignments.

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

4-4 Departmental seminars and conferences, directed by participating members of the teaching staff, must be conducted to augment the biomedical science and clinical program. They must be scheduled and structured to provide instruction in the broad scope of oral and maxillofacial surgery and related sciences and must include retrospective audits, clinicopathological conferences, tumor conferences and guest lectures. The majority of teaching sessions must be presented by the institutional teaching staff and may include remote access educational opportunities. The residents must also prepare and present departmental conferences under the guidance of the faculty.

Intent: *The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain.*

Examples of evidence to demonstrate compliance may include:

- Seminar schedules for at least one year
- Resident log of lectures attended
- Course outlines
- Sign-in sheets
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

BASIC SCIENCES

4-5 Instruction must be provided in the basic biomedical sciences at an advanced level beyond that of the predoctoral dental curriculum. These sciences must include anatomy (including growth and development), physiology, pharmacology, microbiology and pathology. This instruction may be provided through formal courses, seminars, conferences or rotations to other services of the hospital.

Intent: *This instruction may be met through the completion of the requirements for the M.D./D.O. or any other advanced degrees.*

4-5.1 Instruction in anatomy must include surgical approaches used in various oral and maxillofacial surgery procedures.

Examples of evidence to demonstrate compliance may include:

- Resident log of lectures attended
- Course outlines
- Goals and objectives of biomedical sciences curriculum
- Sign-in sheets
- Schedule showing curriculum in the mandated areas for a typical year
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

PHYSICAL DIAGNOSIS

4-6 A didactic and practical course in physical diagnosis must be provided. This instruction must be initiated in the first year of the program. Resident competency in physical diagnosis must be documented prior to the completion of the program.

Intent*: A medical student/resident level course in physical diagnosis, or a faculty led, formally structured and comprehensive physical diagnosis course that includes didactic and practical instruction should be completed prior to commencement of rotations on the anesthesia, medicine and surgical services. This is to ensure that residents have the opportunity to apply this training throughout the program on adult and pediatric patients.*

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Course syllabi
- Course schedules

CLINICAL ORAL AND MAXILLOFACIAL SURGERY

4-7 The program must provide a complete, progressively graduated sequence of outpatient, inpatient and emergency room experiences. The residents' exposure to non-surgical management and surgical procedures must be integrated throughout the duration of the program.

In addition to providing the teaching and supervision of the resident activities described above, there must be patients of sufficient number and variety to give residents exposure to and competence in the scope of oral and maxillofacial surgery. The program director must ensure that all residents receive comparable clinical experience.

Intent: *The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain.*

Examples of evidence to demonstrate compliance may include:

- Records kept by program director that show comparability of surgical experiences in the various aspects of oral and maxillofacial surgery across years and among residents.
- Oral and Maxillofacial Surgery Benchmarks

MINIMUM CLINICAL REQUIREMENTS

OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE

4-8 The program must ensure a progressive and continuous outpatient surgical experience in non-surgical and surgical management, including preoperative and postoperative evaluation, in a broad range of oral and maxillofacial surgery involving adult and pediatric patients. This experience must include dentoalveolar surgery, the placement of implant devices, management of traumatic injuries and pathologic conditions including temporomandibular disorders and facial pain, augmentations and other hard and soft tissue surgery, including surgery of the mucogingival tissues. Faculty cases may contribute to this experience, but they must have resident involvement.

***Intent**: Residents are to participate in outpatient care activities.*

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules
- Outpatient clinic schedules
- Outpatient surgery case log
- Dentoalveolar-related didactic course materials

4-8.1 Dental implant training must include didactic and clinical experience in comprehensive preoperative, intraoperative and post-operative management of the implant patient.

The preoperative aspects of the comprehensive management of the implant patient must include interdisciplinary consultation, diagnosis, treatment planning, biomechanics, biomaterials and biological basis.

The intraoperative aspects of training must include surgical preparation and surgical placement including hard and soft tissue grafts.

The post-operative aspects of training must include the evaluation and management of implant tissues and complications associated with the placement of implants.

Examples of evidence to demonstrate compliance may include

- Implant-related didactic course materials
- Patient records, indicating interaction with restorative dentists
- Consistent use of a national curriculum (e.g., SCORE)
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-8.2 The training program must include didactic and clinical experience in the comprehensive management of temporomandibular disorders and facial pain.

Examples of evidence to demonstrate compliance may include:

- Education in the diagnosis, imaging, surgical and non-surgical management, including instruction in biomaterials.
- Didactic Schedules
- Resident case logs
- Clinic Schedules

GENERAL ANESTHESIA AND DEEP SEDATION

4-9 The off-service rotation in anesthesia must be supplemented by longitudinal and progressive experience throughout the training program in all aspects of pain and anxiety control. The ambulatory oral and maxillofacial anesthetic experience must include the administration of general anesthesia/deep sedation for oral and maxillofacial surgery procedures to pediatric, adult, and geriatric populations, including the demonstration of competency in airway management.

Examples of evidence to demonstrate compliance may include:

- Resident's anesthetic log
- Clinical tracking system
- Anesthesia records
- Oral and Maxillofacial Surgery Benchmarks

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

***Intent**: The cumulative experience includes time on the anesthesia rotation as well as anesthetics administered while on the oral and maxillofacial surgery service. Locations for ambulatory anesthesia may include dental school clinics, hospital clinics, emergency rooms, and oral and maxillofacial surgery offices.*

Examples of evidence to demonstrate compliance may include:

- Resident's anesthetic log.
- Clinical tracking system.
- Anesthesia records.

- Oral and Maxillofacial Surgery Benchmarks

4-9.2 The graduating resident must be trained to competence in the delivery of general anesthesia/deep sedation to patients of at least 8 years of age and older.

4-9.3 The graduating resident must be trained in the management of children younger than 8 years of age using techniques such as behavior management, inhalation analgesia, sedation, and general anesthesia.

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-9.4 The graduating resident must be trained in the anesthetic management of geriatric patients.

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-9.5 The clinical program must be supported in part by a core comprehensive didactic program on general anesthesia, deep sedation, moderate sedation, behavior management and other methods of pain and anxiety control. The didactic program must include lectures and seminars emphasizing:

a. Perioperative evaluation and optimization of patients of all ages,
b. Risk assessment,
c. Anesthesia and sedation techniques,
d. Monitoring, and
e. The diagnosis and management of complications.

4-9.6 Advanced Cardiac Life Support (ACLS) must be obtained in the first year of residency and must be maintained throughout residency training.

Examples of evidence to demonstrate compliance may include:

- ACLS certification records and cards

4-9.7 Each resident must be certified in Pediatric Advanced Life Support (PALS) prior to completion of training.

Examples of evidence to demonstrate compliance may include:

- PALS certification records and cards

ADMISSIONS

4-10 Inpatient surgical experience must ensure adequate training in a broad range of inpatient oral and maxillofacial surgery care, including admission and management of patients.

MAJOR SURGERY

4-11 For each authorized final year resident position, residents must perform 175 major oral and maxillofacial surgery procedures on adults and children, documented by at least a formal operative note. For the above 175 procedures there must be at least 20 procedures in each category of surgery. The categories of major surgery are defined as: 1) trauma 2) pathology 3) orthognathic surgery 4) reconstructive and cosmetic surgery. Sufficient variety in each category, as specified below, must be provided. Surgery performed by oral and maxillofacial surgery residents while rotating on or assisting with other services must not be counted toward this requirement.

***Intent**: The intent is to ensure a balanced exposure to comprehensive patient care for all major surgical categories. In order for a major surgical case to be counted toward meeting this requirement, the resident serves as an operating surgeon or first assistant to an oral and maxillofacial surgery teaching staff member. The program documents that the residents have played a significant role (diagnosis, perioperative care and subsequent follow-up) in the management of the patient.*

Examples of evidence to demonstrate compliance may include:

- Department and institution general operating room statistics and logs
- Patient Medical Records
- Schedules showing that resident was present in pre- and post-operative visits
- Progress notes or resident logs showing resident was present during pre- and post-operative visits
- Resident logbook of all procedures with which resident had active participation

4-11.1 In the trauma category, in addition to mandibular fractures, the surgical management and treatment of maxillary, nasal and orbito-zygomatico-maxillary complex injuries must be included.

***Intent:** Trauma management includes, but is not limited to, tracheotomies, open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region and repair of facial, oral, soft tissue injuries and injuries to specialized structures.*

4-11.2 In the pathology category, experience must include management of temporomandibular joint pathology and at least three other types of procedures.

***Intent**: Pathology of the temporomandibular joint includes, but is not limited to, internal derangement arthritis, post-traumatic dysfunction, and neoplasms. Management of termporomandibular joint pathology may include medical or outpatient procedures. Other Pathology management includes, but is not limited to, major maxillary sinus procedures, salivary gland/duct surgery, management of head and neck infections, (incision and drainage procedures), and surgical management of benign and malignant neoplasms and cysts.*

4-11.3 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.

***Intent**: Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial*

bones as well as the treatment of obstructive sleep apnea. Surgical procedures in this category include, but are not limited to, ramus and body procedures, subapical segmental osteotomies, Le Fort I, II and III procedures and craniofacial operations. Comprehensive care should include consultation and treatment by an orthodontic specialist when indicated; and a sleep medicine team should be included when indicated. Residents participate in the pre- and post-operative care and intra-operative participation in the treatment of the orthognathic patient and the sleep apnea patient.

Examples of evidence to demonstrate compliance may include:

- Evidence of collaborative care (with orthodontist and/or sleep medicine team)
- Oral and maxillofacial surgery record with orthodontic and/or sleep medicine involvement

4-11.4 In the reconstructive and cosmetic category, both bone grafting and soft tissue grafting procedures must be included. Residents must learn the harvesting of bone and soft tissue grafts during the course of training.

***Intent**: Distant bone graft sites may include but are not limited to calvarium, rib, ilium, fibula and tibia. Harvesting of soft tissue grafts may be from intraoral or distant sites. Distant soft tissue grafts include but are not limited to cartilage, skin, fat, nerve & fascia.*

Examples of evidence to demonstrate compliance may include:

- Patient records revealing evidence of hard - and soft-tissue harvesting and grafting to maxillofacial region, including donor sites distant from oral cavity

4-11.5 Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of hard and soft tissue maxillofacial defects, insertion of craniofacial implants, facial cleft repair, peripheral nerve reconstruction and other reconstructive surgery.

***Intent**: It is expected that in this category there will be both reconstructive and cosmetic procedures performed by residents.*

Cosmetic surgery should include but is not limited to three of the following types of procedures: **rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty, and scar revision.**

Examples of evidence to demonstrate compliance may include:

- Patient records revealing resident experience in reconstructive and cosmetic surgery

4-12 Accurate and complete records of the amount and variety of clinical activity of the oral and maxillofacial surgery teaching service must be maintained. These records must include a detailed account of the number and variety of procedures performed by each resident. Records of patients managed by residents must evidence thoroughness of diagnosis, treatment planning and treatment.

4-12.1 Residents must keep a current log of their operative cases.

4-13 Emergency Care Experience: Residents must be provided with emergency care experience, including diagnosing, rendering emergency treatment and assuming major responsibility for the care of oral and maxillofacial injuries. The management of acute illnesses and injuries, including management of oral and maxillofacial lacerations and fractures, must be included in this experience. A resident must be available to the emergency service at all times.

4-13.1 Each resident must be certified in Advanced Trauma Life Support (ATLS) prior to completion of training.

4-14 The program must provide instruction in the compilation of accurate and complete patient records.

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedule on patient record keeping

4-15 The program must provide training in interpretation of diagnostic imaging.

Ethics and Professionalism

4-16 ~~Graduates~~ Residents must receive instruction in the application of the principle of ethical reasoning~~,~~ and ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

***Intent**: ~~Graduates~~ 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.*

4-17 The program must include participation in practice and risk management seminars and instruction in coding and nomenclature.

***Intent**: Parameters of Care should be taught either in a seminar setting, individually or shown to be utilized throughout the program, i.e. Morbidity &Mortality Conferences.*

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedules on practice and risk management
- Familiarity with AAOMS Parameters of Care

Patient Safety

4-18 Residents must receive formal training in programs, policies, and procedures enhancing patient safety.

***Intent:** An ongoing, comprehensive focus on promoting safety and quality improvement is an essential part of quality patient care. Residents are exposed throughout training to theoretical and practical means to ensure that consideration of patient safety is routine and consistent.*

Examples of evidence to demonstrate compliance may include:

- Documentation of an active, ongoing clinical safety training program. This may include participation in institution-wide programs, or documentation of training in Crew Resource Management, Root Cause Analysis, or other safety-focused protocols
- Formative and summative evaluation of residents' knowledge of and engagement and compliance with safety initiatives (e.g., use of Benchmarks)
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

4-18.1 The program must provide resident supervision to promote safe and optimal patient care.

Intent: *Comprehensive guidelines and consistent communication assist residents in decision making regarding the balance between a relatively autonomous learning environment and direct supervision of patient care. Patient care is a shared responsibility among faculty and residents with the faculty ultimately responsible. Supervision ensures safety and excellence. Supervision is accomplished through a variety of methods including direct supervision with physical presence and where applicable indirect supervision including the use of fellows or residents or through means of telecommunication and general oversight.*

Examples of evidence to demonstrate compliance may include:

- Resident supervision policy
- Documented resident responsibility based on OMS benchmarks or similar metrics.
- Faculty and resident call schedules
- Documentation of didactic and clinical competency or Core Entrustable Professional Activities (EPAs)
- Didactic sessions focused on the process of progressive entrustment

4-19 The program must have a formal program for medical emergency preparedness in its ambulatory surgery clinics.

Intent: *Safety training is enhanced by immersing residents at all stages of training in policies procedures, and practices which minimize the risk of harm to patients. Active participation by residents, faculty, and appropriate clinical staff in regular routines, including mock emergency drills, reinforces theoretical concepts and models the attention to patient safety expected of the contemporary surgical team. Programs meet or exceed applicable minimal institutional or regulatory requirements, and may develop and implement protocols custom to their clinical facilities.*

Examples of evidence to demonstrate compliance may include:

- Logs of mock emergency drills demonstrating participation by faculty, residents and clinical staff
- Ongoing training using high fidelity simulation adapted to simulate the community-based, ambulatory surgery environment
- Adherence to established emergency preparation recommendations, e.g. the AAOMS Office Anesthesia Evaluation Manual

4-20 The program must routinely employ patient safety tools and techniques in its clinical facilities.

Examples of evidence to demonstrate compliance may include:

- Documentation of routine procedural time-outs
- Checklists for preanesthetic preparation, patient and procedure readiness verification, or similar
- Readily available cognitive aids (e.g. charts, placards, checklists, guides) for management of anesthetic and or/medical emergencies

Wellness

4-21 Residents must be educated in wellness, impairment, burnout, depression, suicide, and substance abuse as well as on the importance of adequate rest to avoid fatigue in order to balance their professional lives and deliver high quality care.

Intent: *It is understood that many competing interests exist both within and outside of their commitment to residency obligations. Residents need to understand the value of wellness and fatigue and have the ability to openly address individual and programmatic concerns. Programs need to be responsive to concerns raised regarding out of balance or inappropriate burdens placed on residents that undermine the primary purposes of their training. Programs also need to look for resident duties that could be reasonably offloaded to non-residents in order to optimize resident education, promote wellness, and avoid fatigue.*

Examples of evidence to demonstrate compliance may include:

- ROAAOMS Wellness Webinar Series
- Resident Evaluations of the program
- SCORE and/or institutional modules on wellness

4.21.1 The program must have policies in place that promote faculty and residents looking out for the wellness of one another and fitness for patient care with mechanisms for reporting at-risk behaviors without the fear of retaliation.

4-21.2 Programs must blend supervised patient care, teaching responsibilities of residents, didactic commitments, and scholarly activity of residents such that it is accomplished without the excessive reliance on residents to fulfill other service needs and without compromising wellness and fatigue.

4-21.3 Resident work hours must be monitored and reviewed.

Intent: It is required that programs have a system in place for ongoing monitoring of weekly work hours including total number of hours worked, time off between shifts, and days off per week. This data can then be reviewed in appropriate settings such as faculty and resident meetings, annual reviews, and morbidity and mortality conferences. The tracking of hours creates data for shared decision making and assists programs in addressing outlying individuals or situations that could be avoided with more effective training and programmatic structure.

4-21.4 The program must have policies and procedures which allow residents leaves of absence from work in order to address issues not limited to fatigue, illness, family emergencies, and parental leave.

STANDARD 5 - ADVANCED DENTAL EDUCATION RESIDENTS ELIGIBILITY AND SELECTION

Eligible applicants to advanced dental education programs accredited by the Commission on Dental Accreditation **must** be graduates from:

a. Predoctoral dental programs in the U.S. accredited by the Commission on Dental Accreditation; or
b. Predoctoral dental programs in Canada accredited by the Commission on Dental Accreditation of Canada; or
c. International dental schools that provide equivalent educational background and standing as determined by the program.

Specific written criteria, policies and procedures **must** be followed when admitting 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.*

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:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge

5-1 If the program has determined that graduates of U. S. or Canadian accredited medical schools are eligible for admission, the candidate must obtain a dental degree from a

predoctoral dental education program accredited by the Commission on Dental Accreditation prior to starting the final 52 weeks of the required 120 weeks of core OMS training.

Intent: *The obtainment of a Medical Degree provides a degree of patient care knowledge and technical skill translatable to many aspects of oral and maxillofacial surgery. This prior experience is amenable to the possibility of simultaneous credit for certain training experiences but not for any aspect of the final 52 weeks of training in OMFS.*

EVALUATION

A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program:

a. Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods;
b. Provides to residents an assessment of their performance, at least semiannually;
c. Advances residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and
d. Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Intent*: (a) The evaluation of competence is an ongoing process that requires a variety of assessments that can measure the acquisition of knowledge, skills and values necessary for discipline-specific level practice. It is expected that programs develop and periodically review evaluation methods that include both formative and summative assessments. (b) Resident evaluations should be recorded and available in written form. (c) Deficiencies should be identified in order to institute corrective measures. (d) Resident evaluation is documented in writing and is shared with the resident.*

5-2 The program director must provide written evaluations of the residents based upon written comments obtained from the teaching staff. The evaluation must include:

a. Cognitive skills;
b. Clinical skills;
c. Interpersonal skills;
d. Patient management skills; and
e. Ethical standards.

Examples of evidence to demonstrate compliance may include:

- Rotational evaluations

- Semi-annual summative/formative evaluations
- Oral and Maxillofacial Surgery Benchmarks
- AAOMS DVD on Professionalism, AAOMS Code of Professional Conduct, ADA Principles of Ethics and Code of Professional Conduct, ADEA Statement on Professionalism in Dental Education, Institutional ethics guidelines, lecture on ethics

5-3 The program director must provide counseling, remediation, censuring, or after due process, dismissal of residents who fail to demonstrate an appropriate level of competence, reliability, or ethical standards.

5-4 The program director must provide a final written evaluation of each resident upon completion of the program. The evaluation must include a review of the resident's performance during the training program, and must state that the resident has demonstrated competency to practice independently. The final evaluation must be a summative assessment demonstrating a progression of formative assessments throughout the residency program. This evaluation must be included as part of the resident's permanent record and must be maintained by the institution. A copy of the final written evaluation must be provided to each resident upon completion of the residency.

***Intent**: The summative assessment may include utilization of formative assessments such as Simulation training, Objective Structured Clinical Exam, Resident Surgical Log, Resident semi-annual evaluations, Oral and Maxillofacial Surgery Benchmarks, and In-Service ~~Training~~ Examinations.*

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the advanced dental education residents **must** be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all advanced dental education residents **must** be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.

***Intent**: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a resident (for academic or disciplinary*

reasons). In addition to information on the program, residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.

STANDARD 6 – RESEARCH

Advanced dental education residents **must** engage in scholarly activity.

***Intent**: The resident is encouraged to be involved in the creation of new knowledge, evaluation of research, development of critical thinking skills and furthering the profession of oral and maxillofacial surgery.*

6-1 Each graduating resident must demonstrate evidence of scholarly activity.

Examples of evidence to demonstrate compliance may include:

- Oral or poster presentations at scientific meetings aside from program curriculum
- Submission for publication of abstracts, journal articles (particularly peer reviewed) or book chapters
- Active participation in or completion of a research project (basic science or clinical) with mentoring

6-2 The program must provide instruction in research design and analysis.

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in research design and analysis
- Participation in a clinical trials course
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

6-3 The program must provide instruction in the critical evaluation of scientific literature.

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in the critical evaluation of scientific literature through journal club or other educational seminars
- Consistent use of a national curriculum (e.g., SCORE).
- Curricula developed aligned with the blueprint of a national in-service examinations or board certification examinations.

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_8CuJce7nLbEhgod

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are ~~stricken~~

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1-1 FOR ADVANCED EDUCATION IN GENERAL DENTISTRY, ORAL MEDICINE, AND OROFACIAL PAIN:

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 from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in General Practice Residency be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:
https://surveys.ada.org/jfe/form/SV_0d2IXnuLZoCiPaJ

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Accreditation Standards for Advanced Dental Education Programs in General Practice Residency

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

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PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1-1 FOR GENERAL PRACTICE RESIDENCY AND DENTAL ANESTHESIOLOGY:

The program **must** be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution **must** be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_3HPDw4NdvHk7apE

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Accreditation Standards for Advanced Dental Education Programs in Dental Public Health

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

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PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

~~Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.~~ Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of advanced dental education programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

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- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
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Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:
https://surveys.ada.org/jfe/form/SV_eYb699Ulbs9Hifj

Additions are Underlined
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Accreditation Standards for Advanced Dental Education Programs in Endodontics

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

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PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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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.

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Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs

conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_57KS6LaWebI0cRf

Additions are Underlined;
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Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

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PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

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Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:
https://surveys.ada.org/jfe/form/SV_6lBISpSsAiRyJy5

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Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

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PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

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PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

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(CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

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Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential

Institutional accreditation indicating app

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency) be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_2aR7n1r330I3rM1

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Residency)

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are ~~stricken~~

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

~~Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.~~ Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of advanced dental education programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_9ZGlrQxr8mlwyKV

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Clinical Fellowship Training Programs in Oral and

Maxillofacial Surgery

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR CLINICAL FELLOWSHIP TRAINING PROGRAMS IN ORAL AND MAXILLOFACIAL SURGERY:

Standard 1-Institutional Commitment/Program Effectiveness

Hospitals that sponsor fellowships **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor fellowships **must** be accredited by an agency recognized by the United States Department of Education or its equivalent. Health care organizations that sponsor advanced dental education programs **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) The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of fellowship programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and

confer a credential

- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (Residency) be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_07KERlrD7jTgibP

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics

(Residency)

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS ~~RE~~LATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

~~Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.~~ Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of advanced dental education programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

At its Summer 2023 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2024, for review at the Summer 2024 Commission meeting.

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

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and

Special Care Orthodontics

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 CLINICAL FELLOWSHIP TRAINING PROGRAMS IN CRANIOFACIAL AND SPECIAL CARE ORTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

Hospitals that sponsor fellowships **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor fellowships **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of fellowship programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
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Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:
https://surveys.ada.org/jfe/form/SV_0lm22grEOzgxgaN

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are ~~stricken~~

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

~~Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.~~ Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of advanced dental education programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_b45NxzExHvE6FQ9

Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education

Programs in Periodontics

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

~~Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.~~ Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of advanced dental education programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_9prDaivvNxOLFJz

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education

Programs in Prosthodontics

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1 FOR DENTAL PUBLIC HEALTH, ENDODONTICS, ORAL AND MAXILLOFACIAL PATHOLOGY, ORAL AND MAXILLOFACIAL RADIOLOGY, ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS (RESIDENCY), ORAL AND MAXILLOFACIAL SURGERY (RESIDENCY), PEDIATRIC DENTISTRY, PERIODONTICS, AND PROSTHODONTICS:

Standard 1-Institutional Commitment/Program Effectiveness

~~Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity.~~ Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. Health care organizations that sponsor advanced dental education programs **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). The bylaws, rules and regulations of hospitals or health care organizations that sponsor or provide a substantial portion of advanced dental education programs **must** assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link: https://surveys.ada.org/jfe/form/SV_6wZigrrcFOpF0I5

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental

Education Programs in Dental Anesthesiology

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are stricken

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1-1 FOR GENERAL PRACTICE RESIDENCY AND DENTAL ANESTHESIOLOGY:

The program **must** be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution **must** be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:

- Accreditation certificate or current official listing of accredited institutions from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

Commission on Dental Accreditation

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

Written comments will only be accepted through the Commission's Electronic Comment Submission Portal at this link:
https://surveys.ada.org/jfe/form/SV_cRWHUnX6yWGWTkN

Additions are Underlined;
~~Strikethroughs~~ indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral Medicine

PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS RELATED TO SPONSORING INSTITUTION AND AUTHORITY TO OPERATE

Additions are underlined; Deletions are ~~stricken~~

PROPOSED REVISIONS FOR ALL ADVANCED DENTAL EDUCATION STANDARDS:

Definition of Terms:

Health Care Organization: A Federally Qualified Health Center (FQHC), Indian Health Service (IHS), Veterans Health Administration system (VA), or academic health center/medical center/ambulatory care center (both public and private) that is 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).

PROPOSED REVISIONS FOR STANDARD 1-1 FOR ADVANCED EDUCATION IN GENERAL DENTISTRY, ORAL MEDICINE, AND OROFACIAL PAIN:

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 from a United States Department of Education recognized accreditation organization
- Evidence of successful achievement of Service-specific organizational inspection criteria
- Accreditation certificate or current official listing of accredited institution from an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). For example: Accreditation Association for Ambulatory Health Care (AAAHC); Accreditation Commission for Health Care, Inc. (ACHC); American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP); Center for Improvement in Healthcare Quality (CIHQ); Community Health Accreditation Program (CHAP); DNV GL-Healthcare (DNV GL); National Dialysis Accreditation Commission (NDAC); The Compliance Team (TCT); The Joint Commission (JC).

Advanced dental education programs conferring a certificate **must** have state or federal approval to operate and, as applicable, to confer a certificate. Advanced dental education programs conferring a degree **must** have institutional accreditation and authority to confer a degree.

Examples of evidence to demonstrate compliance may include:

- State license or federal authority documenting the institution's approval to operate and confer a credential
- Institutional accreditation indicating approval to confer a degree

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
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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*

Appendix 18

Applicant Name	General Dentist	ADA Member	Graduate from Dental Education Program (DDS/DMD) accredited by CODA or CDAC	Licensed to practice/teach dentistry in the U.S.	Currently engaged in the active practice or teaching of dentistry	CAREER STAGE: Early Career (0-10 years) Mid-Career (11-25 years) Later Career (26+ years)	FACULTY APPOINTMENT: Part-time (faculty/practitioner) Full-time Faculty Full-time Practitioner	Awards/Other Distinctions	Dental Education Program Location (State)	Curriculum Vitae/Resume (strong/acceptable/ weak)	Personal Statement (strong/acceptable/ weak)	Recommendation Letters (strong/acceptable/ weak)

Consideration of Dental Education Policies Assigned to the Council on Dental Education and Licensure for Review in 2024

1. Statement on Credentialing Dental Assistants (*Trans.*1995:634)

Resolved, that the American Dental Association recognizes and encourages the advancement of education and job qualifications for dental assistants and thus believes that voluntary credentialing is appropriate for dental assistants who perform duties as defined by the state dental practice acts.

Action: The Council directed that the policy titled "Statement on Credentialing Dental Assistants" be retained as written and that the Council report this conclusion to the 2024 House of Delegates.

2. Criteria for Recognition of a Certification Board for Dental Assistants (*Trans.*1989:520; 2014:460; 2019:278)

An area of subject matter responsibility of the Council on Dental Education and Licensure as indicated in the Governance and Operational Manual of the American Dental Association is certifying boards and credentialing of allied dental personnel. The Council studies and makes recommendations on policy related to the approval or disapproval of national certifying boards for allied dental personnel (each of which is referred to herein after as "the Board").

A mechanism should be made available for providing evidence that a dental assistant has acquired the knowledge and ability that is expected of an individual employed as a dental assistant through a program of certification. Such a certification program should be based on the educational requirements for dental assistants approved by the Commission on Dental Accreditation.

The dental profession is committed to assuring appropriate education and training of all personnel who participate in the provision of oral health care to the public. The following basic requirements are applied by the Council on Dental Education and Licensure for the evaluation of an agency which seeks recognition of the American Dental Association for a program to certify dental assistants that reflects educational standards approved by the dental profession.

I. Organization

1. The Board shall have no ~~less than five nor~~ more than ~~nine~~ fifteen voting members designated on a rotating basis in accordance with a method approved by the Council on Dental Education and Licensure. The following organizations/interests shall be represented on the Board:

a. American Dental Assistants Association
b. American Dental Association
c. American Dental Education Association
d. American Association of Dental Boards
e. Public
f. The at-large population of Board Certificants

All dental assistant members shall be currently certified by the Board.

2. The Board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.
3. The Board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Dental assistant consultants should be certified by the Board.

4. The Board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board for dental assistants. This statement should include evidence that the Board has the support of the American Dental Assistants Association, the organization representative of dental assistants, as well as other groups within the communities of interest represented by the Board.

II. Operation of Board

1. The Board shall grant certification to individuals who have provided evidence of knowledge-based competence in dental assisting.

2. The Board shall submit in writing to the Council on Dental Education and Licensure a plan for renewal of certificate currently held by certified persons.

3. The Board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant eligibility criteria, examination procedures and pass/fail results of its certifying examination. The Certification Board must establish and maintain documented policies concerning current, prospective and lapsed certificants including, but not limited to: eligibility, application, assessments, certification renewals and appeals. Additionally, the Certification Board must establish, analyze, publish and review examination content outlines which lay the foundation for the knowledge and skills tested on the assessment instruments and provide evidence of validity and reliability.

4. The Board shall administer the certification examinations at least twice each calendar year with administrations publicized at least six months prior to the examination.

5. The Board shall maintain and make available a current list of all persons certified.

6. The Board shall have authority to conduct the certification program; i.e., the Board shall be responsible for evaluating qualifications and competencies of persons certified and for maintaining adequate standards for the annual renewal of certificates. However, proposals for important changes in the examination eligibility criteria or the Board procedures and policies must be circulated reasonably well in advance of consideration to affected communities of interest for review and comment. Proposed changes must have the approval of the Council on Dental Education and Licensure.

7. The Board shall maintain close liaison with the organizations represented on the Board. The Board shall report on its program annually to the organizations represented on the Board.

III. Granting Certificates

1. In the evaluation of its candidates for certification, the Board shall use standards of education and clinical experience approved by the Commission on Dental Accreditation. The Board shall

require for eligibility for certification the successful completion of a dental assisting education program accredited by the Commission on Dental Accreditation, and satisfactory performance on an examination prescribed by the Board.
2. The Board shall grant certification or recertification annually to those who qualify for certification.

The Board may require an annual certificate renewal fee to enable it to carry on its program.

IV. Waivers

It is a basic view of the Council that all persons seeking certification shall qualify for certification by completing satisfactorily a minimum period of approved training and experience and by passing an examination. However, the Council realizes that there may be need for a provision to recognize candidates who do not meet the established eligibility criteria on educational training. Therefore, the Board may make formal requests to the Council on Dental Education and Licensure regarding specific types of waivers which it believes essential for certification and/or certificate renewal. Such requests shall be substantiated and justified to and supported by the organizations represented on the Board; only waivers approved by the Council on Dental Education and Licensure may be used.

Action: The Council directed that the policy titled "Criteria for Recognition of a Certification Board for Dental Assistants" be amended as noted and that the Council report this conclusion to the 2024 House of Delegates.

3. Development of Alternate Pathways for Dental Hygiene Training (*Trans.*1998:714; 2014:459)
Supporting Agency: CDP

Resolved, the American Dental Association ~~supports~~ acknowledges the alternate pathway model of Dental Hygiene Education as used in Alabama.

Action: The Council directed that the policy titled "Development of Alternate Pathways for Dental Hygiene Training" be amended as noted and that the Council report this conclusion to the 2024 House of Delegates.

4. Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans.*1992:616; 2010:542)

Resolved, that licensed or legally permitted dentists must be actively involved in the clinical supervision of dental assisting and dental hygiene educational programs, and be it further

Resolved, that dental assisting and dental hygiene educational programs should be administered or directed by a dentist whenever possible.

Action: The Council directed that the policy titled "Dentist Administered Dental Assisting and Dental Hygiene Education Programs" be rescinded and that the Council report this conclusion to the 2024 House of Delegates.

5. Certifying Board in Dental Assisting (*Trans.*1990:551; 2014:460)

Resolved, that the American Dental Association approves the Dental Assisting National Board, Inc. as the national certifying board for dental assisting.

Action: The Council directed that the policy titled "Certifying Board in Dental Assisting" be retained as written and that the Council report this conclusion to the 2024 House of Delegates.

6. Criteria for Recognition of a Certification Board for Dental Laboratory Technicians (*Trans.*1998:92, 713; 2014:462; 2019:280)

An area of subject matter responsibility of the Council on Dental Education and Licensure as indicated in the *Governance and Operational Manual* of the American Dental Association is certifying boards and credentialing of allied dental personnel. The Council studies and makes recommendations on policy related to the approval or disapproval of national certifying boards for allied dental personnel (each of which is referred to hereinafter as "the Board").

A mechanism for the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are applied by the Council on Dental Education and Licensure for the evaluation of an agency which seeks recognition of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

I. **Organization:** An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

II. **Authority and Purpose:** The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure on the basis of these requirements. Changes that are planned in the rules and regulations of the Certification Board should be reported to the Council before they are put into effect. The Board shall submit data annually to the Council on Dental Education and Licensure relative to its financial operations, applicant admission and examination procedures, and results thereof.

The principal functions of the Certification Board shall be:

a. to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation;

b. to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and
c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of certificants.

III. Qualifications of Candidates: It will be expected that the minimum requirements established by the Certification Board for the issuance of a certificate will include the following:

a. satisfactory legal and ethical standing in the dental laboratory industry;
b. graduation from high school or an equivalent acceptable to the Certification Board;
c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of working experience as a dental laboratory technician; or, five years of education and/or experience in dental technology; and
d. satisfactory performance on examination(s) prescribed by the Certification Board.

IV. Standards: The Certification Board must establish and maintain documented policies concerning current, prospective and lapsed certificants including, but not limited to: eligibility, application, assessments, certification renewals and appeals. Additionally, the Certification Board must establish, analyze, publish and review examination content outlines which lay the foundation for the knowledge and skills tested on the assessment instruments and provide evidence of validity and reliability.

Action: The Council directed that the policy titled "Criteria for Recognition of a Certification Board for Dental Laboratory Technicians" be retained as written and that the Council report this conclusion to the 2024 House of Delegates

7. Certifying Board in Dental Laboratory Technology (*Trans.*2002:400; 2014:460)

Resolved, that the American Dental Association approves the National Board for Certification in Dental Laboratory Technology as the national certifying board for dental laboratory technology.

Action: The Council directed that the policy titled "Certifying Board in Dental Laboratory Technology" be retained as written and that the Council report this conclusion to the 2024 House of Delegates.

Commission on Dental Accreditation

Accreditation Standards for Dental Assisting Education Programs

Accreditation Standards for Dental Assisting Education Programs

Commission on Dental Accreditation
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Effective February 12, 2021

Accreditation Standards for Dental Assisting Education Programs

Document Revision History

Date	Item	Action
August 2, 2019	Accreditation Standards for Dental Assisting Education Programs	Adopted
January 30, 2020	Definition of Terms (Should and Dental Emergencies) and Standards 2-11 and 3-7	Adopted
July 1, 2020	Accreditation Standards for Dental Assisting Education Programs	Implemented
February 12, 2021	Revised Intent Statements: Standards 3-3 and 3-7	Adopted and Implemented
August 6, 2021	Revised Mission Statement	Adopted
January 1, 2022	Revised Mission Statement	Implemented
August 5, 2022	Revision to Standard 1-5 (Institutional Accreditation) Examples of Evidence	Adopted and Implemented
November 7, 2022	Revision to Standard 1-5 (Institutional Accreditation) Examples of Evidence	Adopted and Implemented
August 11, 2023	Revision to Standard 2-7 (Instruction) and Examples of Evidence	Adopted and Implemented
August 11, 2023	Revision to Standard 3-6 (Faculty)	Adopted and Implemented
August 11, 2023	Revised Accreditation Status Definitions	Adopted and 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

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

Other Accreditation Actions

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

of a Commission accredited program. Such graduates may be ineligible for certification/licensure examinations.

Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9

Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

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

Preface

The Accreditation Standards for Dental Assisting Education Programs have been developed for the following reasons: (1) to protect the public, (2) to serve as a guide for dental assisting program development, (3) to serve as a stimulus for the improvement of established programs, (4) to provide criteria for the evaluation of new and established programs, and (5) to protect enrolled students. To be accredited by the Commission on Dental Accreditation a dental assisting program must meet the standards set forth in this document. These standards are national in scope and represent the minimum requirements for accreditation. It is expected that institutions that voluntarily seek accreditation will recognize the ethical obligation of complying with the spirit as well as the letter of these standards.

The importance of academic freedom is recognized by the Commission; therefore, the standards are stated in terms which allow an institution flexibility in the development of an educational program. The Commission encourages curricular experimentation, development of institutional individuality, and achievement of excellence without establishment of uniformity. No curriculum has enduring value, and a program will not be judged by conformity to a given type.

Programs and their sponsoring institutions are encouraged to provide for the educational mobility of students through articulation arrangements and career laddering (e.g., between dental assisting education programs and dental hygiene education programs). Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying and proficiency examinations.

The Commission on Dental Accreditation

From the early 1940's until 1975, the Council on Dental Education was the agency recognized as the national accrediting organization for dentistry and dental-related educational programs. On January 1, 1975, the Council on Dental Education's accreditation authority was transferred to the Commission on Dental Accreditation and Dental Auxiliary Education Programs, an expanded agency established to provide representation of all groups affected by its accrediting activities.
In 1979, the name of the Commission was changed to the Commission on Dental Accreditation.

The Commission is comprised of 30 members. It includes a representative of the American Dental Assistants Association (ADAA) and other disciplines accredited by the Commission as well as public representatives.

Specialized Accreditation

Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards. Accreditation standards are developed in consultation with those affected by the standards who represent the board communities of interest. The Commission on Dental Accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs which provide basic preparation for licensure or certification in dentistry and the related disciplines.

Dental Assisting Accreditation

In 1957, the Council on Dental Education sponsored the first national workshop on dental assisting. Practicing dentists, dental educators and dental assistants participated in the workshop during which recommendations pertaining to education and certification of dental assistants were formulated. These recommendations were considered in developing the first "Requirements for an Accredited Program in Dental Assisting Education" which were approved by the House of Delegates of the American Dental Association in 1960. The accreditation standards have been revised seven times--in 1969, 1973, 1979, 1991, 1998, 2014, and 2020 to reflect the dental profession's changing needs and educational trends.

In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation utilized the following procedures: appointing an ad hoc committee, holding open hearings and distributing widely a draft of the proposed revision of the standards for review and comment. Prior to approving the revised standards in August 2019, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in January 2020.

Prior to 1960, the ADAA approved courses of training for dental assistants, varying in length from 104 clock hours to two academic years. Subsequent to the adoption in 1960 of the first accreditation standards, the Council on Dental Education granted "provisional approval" to those programs approved by the ADAA which were at least one academic year in length until site visits could be conducted. Thus 26 programs appeared on the first list of accredited dental assisting programs published in 1961.

Statement of General Policy

Maintaining and improving the quality of dental assisting education is a primary aim of the Commission on Dental Accreditation. In meeting its responsibilities as a specialized accrediting agency recognized by the dental profession and the United States Department of Education, the Commission on Dental Accreditation:

1. Evaluates dental assisting education programs on the basis of the extent to which program goals, institutional objectives and approved accreditation standards are met.

2. Supports continuing evaluation of and improvements in dental assisting education programs through institutional self-evaluation.

3. Encourages innovations in program design based on sound educational principles.

4. Provides consultation in initial and ongoing program development.

As a specialized accrediting agency, the Commission relies on an authorized institutional accrediting agency's evaluation of the institution's objectives, policies, administration, financial and educational resources and its total educational effort. The Commission's evaluation will be confined to those factors which are directly related to the quality of the dental assisting program. In evaluating the curriculum in institutions that are accredited by a recognized regional accrediting agency, the Commission will concentrate on those courses which have been developed specifically for the dental assisting program and core courses developed for related disciplines. When an institution has been granted an accreditation status or candidate for accreditation status by a regional agency, the Commission will accept that status as evidence that the general studies courses included in the dental assisting curriculum meet accepted standards, provided the level and content of such courses are appropriate for the discipline.

This entire document constitutes the Accreditation Standards for Dental Assisting Education Programs. Each standard is numbered (e.g., 1-1,1-2) and in bold print. Where appropriate, standards are accompanied by statements of intent that explain the rationale, meaning and significance of the standard. Expanded guidance in the form of examples to assist programs in better understanding and interpreting the must statements within the standards follow. This format is intended to clarify the meaning and application of standards for both those responsible for educational programs and those who evaluate these programs for the Commission.

Definitions of Terms Used in Dental Assisting Accreditation Standards

The terms used in this document indicate the relative weight that the Commission attaches to each statement. Definitions of these terms are provided.

Standard: Offers a rule or basis of comparison established in measuring or judging capacity, quantity, quality, content and value; criterion used as a model or pattern.

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

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

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

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

Clinical Competence: The achievement of a predetermined level of special skill derived from education and experience in the clinical setting.

Clinical Instruction: Indicates any instruction in which students receive supervised experience in performing functions on patients. Clinical performance of the functions is evaluated by faculty according to predetermined criteria.

Clinical Experience: Clinical experiences that exceed the basic clinical education requirements of the program and that are provided to enhance the basic clinical education. Experiences may be provided in an on-campus comprehensive dental clinic and/or in extramural dental offices or clinics. Students are supervised and evaluated by both faculty and non-program personnel according to predetermined learning objectives and evaluation criteria.

Competence: The level of knowledge and skill determined by the program and required of students/new graduates in performing dental assisting functions.

Competency evaluation: Assessment of skill level related to specific performance objective

Didactic Instruction: Refers to lectures, demonstrations or other instruction without active participation by students.

Distance Education: As defined by the United States Department of Education, distance education is "an educational process that is characterized by the separation, in time or place, between instructor and student. The term includes courses offered principally through the use of (1) television, audio or computer transmission; (2) audio or computer conferencing; (3) video cassettes or disks; or (4) correspondence."

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

HIPAA: Health Insurance Portability and Accountability Act

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

Institution: The post-secondary entity that directly sponsors the dental assisting program and provides immediate administration and local leadership.

Instruction: Describes any teaching, lesson, rule or precept; details of procedure; directives.

Laboratory/Preclinical Competence: The achievement of a predetermined level of special skill derived from laboratory/preclinical instruction.

Laboratory or Preclinical Instruction: Indicates instruction in which students receive experience under faculty supervision, performing functions using materials, study models, manikins or other simulation methods; student performance is evaluated by faculty according to predetermined criteria.

Special Needs: Those patients whose medical, physical, psychological, cognitive or social conditions make it necessary to consider a wide range of assessment and care options in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with cognitive and/or developmental disabilities, complex medical conditions, significant physical limitations, and vulnerable older adults.

Dental Emergencies: Those emergencies treated by a dental professional.

The Commission's accreditation standards have been stated, purposefully, in terms which allow flexibility, innovation and experimentation. Regardless of the method(s) used to provide instruction, the Commission expects that each accredited program will comply with the spirit as well as the letter of the accreditation standards.

STANDARD 1 – INSTITUTIONAL EFFECTIVENESS

Planning and Assessment

1-1 The program must demonstrate its effectiveness through a formal and ongoing planning and outcomes assessment process that is systematically documented and annually evaluated. This process must include the following:

a. Dental assisting program goals that include, but are not limited to student outcomes that are consistent with the goals of the sponsoring institution and appropriate to dental assisting education;
b. Time-table for implementation that indicates roles and responsibilities of all participants;
c. Methods to assess goals and provide outcomes that include, but are not limited to, measures of student achievement;
d. Review and analysis of compiled data obtained from assessment methods, and related conclusions;
e. Findings and conclusions are used for program improvement, and for revisions to the overall planning and outcomes assessment process.

Intent:
Outcomes assessment planning is broad-based, systematic, and designed to promote achievement of the program's stated goals and objectives. Through this process, evaluation and improvement of the educational quality of the program is monitored.

Examples of evidence to demonstrate compliance may include the bulleted points below:

a. Dental assisting program goals that include, but are not limited to, student outcomes, that are consistent with the goals of the sponsoring institution and appropriate to dental assisting education:

- The program's purpose and goals are consistent with the sponsoring institution's mission and strategic plan and appropriate to dental assisting education.
- The Commission on Dental Accreditation expects each program to regularly examine and re-define its goals and objectives as necessary, based on the current needs of the program and that one program goal is to comprehensively prepare competent individuals in the discipline.
- Long and short-term goals that address program growth, promotion, and outreach; admissions; faculty recruitment, qualifications and development; financial resources; on-site patient care and treatment; needs of local community and liaison mechanism.
- Established benchmarks with rationale provided

b. A time-table for implementation that indicates roles and responsibilities of all participants:
- Schedule for planning that coincides with strategic planning timetable of larger institution
- Names, titles, and responsibilities of those individuals involved in the planning and outcomes assessment process
- Meeting minutes

c. Methods to assess goals and provide outcomes that include, but are not limited to, measures of student achievement:
- Periodic analyses to measure the validity of established admission criteria and procedures
- Audit of faculty qualifications and participation in professional development opportunities
- Community needs surveys
- Assessment of attrition rates in relation to admissions criteria
- Clinical externship, graduate, employer surveys
- Employment data
- State and national certification examinations and/or licensure rates
- Consideration of individual course examinations and completion

d. Review and analysis of data obtained from assessment methods, and related conclusions:
- The expertise of institutional research personnel is utilized
- Interpretations of data and correlations with program objectives are provided
- Data comparisons with established benchmarks and national averages
- Spread sheets, scores, percentage pass-rates

e. Findings and conclusions are used for program improvement, and for changes to the planning and outcomes assessment process:
- Meeting minutes that describe suggested changes and implementation
- Curriculum revisions
- Budget changes or re-allocations
- Goals revisions or eliminations and/or appropriate additions
- Descriptions of future strategies with time-table

Financial Support

1-2 The institution must demonstrate stable financial resources to ensure support of the dental assisting program's stated mission, goals and objectives on a continuing basis. Resources must be sufficient to ensure adequate and qualified faculty and staff, clinical and laboratory facilities, equipment, supplies, reference materials and teaching aids that reflect technological advances and current professional standards.

Examples of evidence to demonstrate compliance may include:

- Program's mission, goals and objectives
- Institutional strategic plan
- Previous and current-year revenue and expense statements for the past three years
- Revenue and expense projections for the program for the next three to five years

1-3 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.

1-4 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

Examples of evidence to demonstrate compliance for DA 1-3 and DA 1-4 may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, faculty financial support

Institutional Accreditation

1-5 Programs must be sponsored by institutions of post-secondary education which are accredited by an agency recognized by the United States Department of Education.

Intent:
Dental schools, four-year colleges and universities, community colleges, technical institutes, vocational schools, private schools and recognized federal service training centers which offer appropriate fiscal, facility, faculty and curriculum resources are considered appropriate settings for the program.

Examples of evidence to demonstrate compliance may include:

- Accreditation (or candidate status) from a recognized institutional (regional, national or state) accrediting agency such as: Middle States Commission on Higher Education; New England Commission of Higher Education;

Commission on Technical and Career Institutions, New England Association of Schools and Colleges; Higher Learning Commission; Northwest Commission on Colleges and Universities; Southern Association of Colleges and Schools, Commission on Colleges; WASC Accrediting Commission for Community and Junior Colleges; WASC Senior Colleges and University Commission; Accrediting Bureau of Health Education Schools; Accrediting Commission for Career Schools and Colleges; Distance Education Accrediting Commission; The Council on Occupational Education

1-6 All arrangements with co-sponsoring or affiliated institutions must be formalized by means of written agreements which clearly define the roles and responsibilities of each institution involved.

Intent:
This standard is not applicable to designated extended campus facilities. Co-sponsoring or affiliated institution allow dental assisting program students to utilize all resources available to their regularly enrolled students, e.g., bookstore, library, health center fitness facility, etc. as defined in an affiliation agreement.*

***See DA Standard 4-10**

Examples of evidence to demonstrate compliance may include:
- Formal affiliation agreement(s) with termination clause

Community Resources

1-7 There must be an active advisory committee to serve as a liaison between the program, local dental and allied dental professionals and the community. Dentists and dental assistants must be equally represented.

Intent:
The purpose of the advisory committee is to provide a mutual exchange of information for program enhancement, meeting program and community needs, standards of patient care, and scope of practice. Membership should include representation from a variety of practice settings. The program administrator, faculty, students, and appropriate institutional personnel are non-voting participants.

Examples of evidence to demonstrate compliance may include:
- Membership responsibilities are defined and terms staggered to provide both new input and continuity
- Diverse membership with consideration given to student representation, recent graduate(s), public representation, and a profile of the local dental community.
- Responsibilities of program representatives on the committee are defined in writing.
- Meeting minutes are maintained and distributed to committee members.

STANDARD 2 – EDUCATIONAL PROGRAM

Admissions

2-1 Admission of students must be based on specific published criteria, procedures and policies that include a high-school diploma or its equivalent, or post- secondary degree. Previous academic performance or other predictors of scholastic aptitude and ability must be utilized as criteria in selecting students with the potential to successfully complete the program. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability, scope of practice and employment opportunities for dental assistants.

Intent:
The dental assisting program is based on a science-oriented program of study and skill development offered at the post-secondary level that requires critical thinking, psychomotor skills, and ethical reasoning.

The program administrator and faculty, in cooperation with appropriate institutional personnel establish admissions criteria and procedures which are non-discriminatory, contribute to the quality of the program, and allow selection of post-secondary students with the potential to be successful. Because enrollment is limited by facility, capacity, and special program admissions criteria and procedures are necessary to ensure that students are selected based on a demonstrated potential for completing the program. Published promotional materials and website information related to student recruitment and admissions comply with the Commission's "Policy on Principles of Ethics in Programmatic Advertising and Student Recruitment."

Examples of evidence to demonstrate compliance may include:

Criteria and Selection Process:

- There is an established admissions committee which includes the program administrator, representatives of the program faculty, general education faculty who teach dental assisting students and counseling staff.
- Previous college academic performance and/or performance on standardized national scholastic tests are utilized for criteria in selecting students.
- High school class rank
- Cumulative grade point averages in previous education with particular attention given to grades in science subjects
- Copies of catalogs, program brochures, admissions packets, or other published materials.

Academic Strengthening:

- If academic strengthening is needed to meet basic admission criteria or to proceed satisfactorily through the curriculum, the institution and program should have the

resources necessary to assist students.
- Academic strengthening occurs prior to entry into the program courses.

2-2 Admission of students with advanced standing must be based on the same criteria required of all applicants admitted to the program. The program must ensure that advanced standing credit awarded is based on equivalent didactic, laboratory and preclinical content and student achievement.

Intent:
Policies ensure that advanced standing credit is awarded based on equivalent coursework, knowledge, and/ or experience that meets or exceeds content required in the curriculum and results in equivalent student competence. The curriculum may be structured to allow individual students to meet performance standards specified for graduation in less than the required length as well as to provide the opportunity for students who require more time to extend the length of their instructional program. The curriculum design may provide maximum opportunity for students to continue their formal education with minimum duplication of learning experiences.

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

Examples of evidence to demonstrate compliance may include:
- Policies and procedures for advanced standing
- Results of appropriate qualifying or challenge examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge
- Copies of transcripts
- Articulation agreement
- Equivalency determination by a nationally recognized transcript evaluator

2-3 The program must demonstrate that student enrollment numbers are proportionate to the number of faculty, availability of appropriate classroom, laboratory, and clinical facilities, equipment, instruments, and supplies.

Intent:
In determining the maximum number of dental assisting students enrolled in a program, including off-campus sites, hybrid, or on-line courses, careful consideration

is given to ensure that the number of students does not exceed the program resources including, as appropriate, financial support, scheduling options, facilities, equipment, and faculty.

Examples of evidence to demonstrate compliance may include:

- Blueprints or floor plan
- Number of clinical stations
- Schedule for use of facility
- Budget
- Radiographic units
- Equipment and instrument inventory list
- Comprehensive faculty assignment schedule

Curriculum Management

2-4 The curriculum must be structured on the basis of, a minimum of, 900 instructional hours at the postsecondary level that includes 300 clinical practice hours.

Intent:
Instructional hours should include didactic, laboratory, preclinical, and clinical content required in the standards. Curriculum content not required by the standards accordingly increases the length of the program. Clinical practice hours assisting a dentist are obtained in a facility that provides comprehensive dental treatment.

Examples of evidence to demonstrate compliance may include:

- Institutional catalogue with program requirements
- Schedule of classes
- Tracking mechanism for clinical externship hours
- Official student roster with positive attendance hours

2-5 The curriculum must be designed to reflect the interrelationship of its biomedical sciences, dental sciences, clinical and behavioral sciences, preclinical and clinical practice. Curriculum must be sequenced to allow assimilation of foundational content in oral anatomy; basic chairside skills, medical emergencies, confidentiality and privacy regulations, infection control, sterilization, and occupational safety precautions, procedures and protocols prior to any patient contact or clinical experiences. Content must be integrated with continued elevation throughout the program. Curriculum must demonstrate sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies and program's goals and objectives.

Intent:
Curriculum content should be sequenced to allow assimilation of foundational knowledge and critical thinking skills necessary to ensure patient safety, and opportunity for students to develop the knowledge and skills necessary to ensure

patient, student, faculty, and staff safety when performing or assisting in clinical procedures involving patients, including student partners.

Programs that admit students in phases, including modular or open-entry shall provide content in tooth anatomy, tooth numbering, general program guidelines, basic chairside skills, emergency and safety precautions, infection control and sterilization protocols associated with, and required for patient treatment, prior to any other program content and/ or performances of activities involving preclinical/clinical activities.

Examples of evidence to demonstrate compliance may include:

- Curriculum map demonstrating progression of content elevation

2-6 The dental assisting program must have a formal, written curriculum management plan, which includes:

a. at minimum, an annual curriculum review and evaluation process with input from faculty, students, administration and other appropriate sources;
b. evaluation of the effectiveness of all courses as they support the program's goals and competencies;
c. a defined mechanism for coordinating instruction among dental assisting program faculty.

Intent:
Curriculum management should assure the incorporation of emerging information and sequencing, the elimination of unwarranted repetition, and the attainment of student competence. Periodic workshops and in-service sessions should be held for the dissemination of curriculum information and modifications.

Examples of evidence to demonstrate compliance may include:

- Competencies documentation demonstrating relationship of course content to defined competencies of the program
- Documentation of ongoing curriculum review and evaluation
- Minutes of meetings documenting curriculum review and evaluation
- Student evaluation of instruction
- Curriculum management plan
- Documentation of calibration exercises

Instruction

2-7 Written documentation of each course in the curriculum must be provided to students at the start of each course and include:

a. The course title, number, description, faculty presenting course and contact information
b. Course objectives
c. Course competencies
d. Content outline including topics to be presented
e. Course schedule including learning and evaluation mechanisms for didactic, laboratory, and clinical learning experiences
f. Specific criteria for final course grade calculation

Examples of evidence to demonstrate compliance may include:
- Course syllabus
- Rubrics for grade calculation
- Institutional grading policies
- Course schedules to include activities, assignments, and evaluations for each date the course meets.

Student Evaluation

2-8 Objective student evaluation methods must be utilized to measure all defined course objectives to include:

a. Didactic, laboratory, preclinical and clinical content
b. Specific criteria for measuring levels of competence for each component of a given procedure

Examples of evidence to demonstrate compliance may include:
- Rubric for grading
- Evaluation criteria to measure progress for didactic, laboratory, preclinical and course objectives
- Skills assessments
- Grading policies for multiple assessment attempts

Preclinical Instruction

Essential Dental Assisting Skills

2-9 Curriculum content must include didactic and laboratory/preclinical objectives in the following dental assisting skills and functions. Prior to performing these skills/functions in a clinical setting, students must demonstrate knowledge of, and laboratory/preclinical competence in the program facility.

a. Take/review and record medical and dental histories
b. Take and record vital signs
c. Assist with and/or perform soft tissue extra/intra oral examinations
d. Assist with and/or perform dental charting
e. Manage infection and hazard control protocol consistent with published professional guidelines
f. Prepare tray set-ups for a variety of procedures and specialty areas
g. Seat and dismiss patients
h. Operate oral evacuation devices and air/water syringe
i. Maintain clear field of vision including isolation techniques
j. Perform a variety of instrument transfers
k. Utilize appropriate chairside assistant ergonomics
l. Provide patient preventive education and oral hygiene instruction
m. Provide pre-and post-operative instructions prescribed by a dentist
n. Maintain accurate patient treatment records
o. Identify and respond to medical and dental emergencies

Chairside Dental Assisting Functions

2-10 Curriculum content must include didactic and laboratory/preclinical objectives in the following dental assisting skills and functions. Prior to performing these skills/functions in a clinical setting, students must demonstrate knowledge of, and laboratory/preclinical competence in the program facility.

a. Assist with and/or apply topical anesthetic and desensitizing agents
b. Assist with and/or place and remove rubber dam
c. Assist with and/or apply fluoride agents
d. Assist with and/or apply bases, liners, and bonding agents
e. Assist with and/or place, fabricate, and remove provisional restorations
f. Assist with and/or place and remove matrix retainers, matrix bands, and wedges
g. Assist with and/or remove excess cement or bonding agents
h. Assist with a direct permanent restoration
i. Fabricate trays, e.g., bleaching, mouthguard, custom
j. Preliminary impressions
k. Clean removable dental appliances

Advanced/Expanded Dental Assisting Functions

2-11 Where graduates of a CODA-accredited program are authorized to perform additional functions defined by the program's state-specific dental board or regulatory agency, and the program has chosen to include those functions in the program curriculum, the program must include content at the level, depth, and scope required by the state. Further, curriculum content must include didactic and laboratory/preclinical objectives for the additional dental assisting skills and functions. Students must demonstrate laboratory/preclinical competence in performing these skills in the program facility prior to clinical practice. Students must be informed of the duties for which they are trained in the educational program.

Intent:
Functions allowed by the state dental board or regulatory agency for dental assistants are taught and evaluated at the depth and scope required by the state. The inclusion of additional functions does not compromise the length and scope of the educational program or content required in the Accreditation Standards.

Examples of evidence may include but are not limited to:

a. Place and/or remove retraction cord
b. Take final impressions
c. Place, pack, finish restorations
d. Perform polishing of coronal surfaces of teeth
e. Perform pit and fissure sealant application
f. Perform cement removal
g. Perform restoration polishing
h. Perform monitoring and/or administration of Nitrous Oxide-Oxygen analgesia
i. Remove sutures
j. Perform pulp vitality tests
k. Place and remove periodontal dressing
l. Perform orthodontic functions

2-12 Students must demonstrate competence in the knowledge at the familiarity level in dental practice management:

a. Computer and dental software
b. Business ethics and jurisprudence
c. Business oral and written communications
d. Inventory systems and supply ordering
e. Maintenance and retention of business records
f. Management of patient information
g. Recall systems

Biomedical Sciences

2-13 The biomedical science aspect of the curriculum must include content at the in- depth level in bloodborne pathogens and hazard communications standards and content must be integrated throughout the didactic, preclinical, laboratory and clinical components of the curriculum.

Intent:
The biomedical sciences provide a basic understanding of body structure and function; disease concepts; and dietary considerations of the dental patient.

Dental Sciences

Intent:
Dental science content provides the student with an understanding of materials used in intra-oral and laboratory procedures, including experience in their manipulation; an *understanding of the development, form and function of the structures of the oral cavity and of oral disease; pharmacology as they relate to dental assisting procedures; and scientific principles of dental radiography.*

2-14 The dental science aspect of the curriculum must include content at the familiarity level in:

- **a. Oral pathology**
- **b. General anatomy and physiology**
- **c. Microbiology**
- **d. Nutrition**
- **e. Pharmacology to include:**
  - **i. Drug requirements, agencies, and regulations**
  - **ii. Drug prescriptions**
  - **iii. Drug actions, side effects, indications and contraindications**
  - **iv. Common drugs used in dentistry**
  - **v. Properties of anesthetics**
  - **vi. Drugs and agents used to treat dental-related infection**
  - **vii. Drug addiction including opioids and other substances**
- **f. Patients with special needs including patients whose medical, physical, psychological, or social conditions make it necessary to modify normal dental routines.**

2-15 The dental science aspect of the curriculum must include content at the in-depth level in oral anatomy.

Intent:
Content in oral anatomy should include oral histology and oral embryology.

2-16 The curriculum must include content at the in-depth level in dental materials. Students must demonstrate knowledge of the properties, and competence in the uses and manipulation of, dental materials to include:

- **a. Gypsum**
- **b. Restorative materials**
- **c. Dental cements**
- **d. Impression materials**
- **e. Acrylics and or thermoplastics**
- **f. Waxes**
- **g. Fabrication of casts, temporary crown and/or bridge**
- **h. Abrasive agents used to polish coronal surfaces and appliance**
- **i. Study casts/occlusal registrations**

2-17 The curriculum must include content at the in-depth level in dental radiology. Students must demonstrate knowledge and skills to produce diagnostic dental image surveys on manikins. Prior to exposing dental images on patients, students must demonstrate competence in:

- **a. Radiation health protection techniques,**
- **b. Processing procedures,**
- **c. Anatomical landmarks and pathologies,**
- **d. Mounting survey of dental images, and**
- **e. Placing and exposing dental images on manikins**

2-18 Prior to exposing dental images during extramural clinical assignments, students must demonstrate competence, under faculty supervision, in exposing diagnostically acceptable full-mouth dental image surveys on a minimum of two patients in the program, or contracted facility.

Intent:
Full-mouth dental image surveys are comprised of periapical and bitewing images.

Clinical and Behavioral Sciences

2-19 The curriculum must include didactic content at the in-depth level to include:

- **a. General dentistry**
- **b. Dental specialties**
- **c. Chairside assisting**
- **d. Dental-related environmental hazards**
- **e. Preventive dentistry**
- **f. Management of dental and medical emergencies**

Intent:
Content provides background for preclinical and clinical experiences.

2-20 The program must demonstrate effectiveness in creating an academic environment that supports ethical and professional responsibility to include:

a. Psychology of patient management and interpersonal communication
b. Legal and ethical aspects of dentistry

Intent:
Faculty, staff and students 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.

Examples of evidence may include:
- Faculty, student, staff membership and participation in dental professional organizations, e.g., American Dental Assistants Association, American Dental Education Association, American Dental Association
- Professional Code of Conduct
- State Dental Practice Act
- Student Handbook
- Professional and ethical expectations

2-21 The dental assisting program must provide opportunities and encourage students to engage in service and/or community-based learning experiences.

Intent:
Community-based experiences are essential to develop dental assistants who are responsive to the needs of a culturally diverse population.

Examples of evidence may include:
- Service hours
- Volunteer activities

Clinical Externship Experience

2-22 Clinical experience assisting a dentist must be an integral part of the educational program designed to perfect students' competence in performing chairside assisting functions, rather than to provide basic instruction. Students must have a minimum of 300 hours of clinical experience.

Intent:
More than fifty percent (50%) of the clinical assignments should be

accomplished through assignment to general dentistry offices, and may include a pediatric dental office. Clinical experiences should be at different locations with different dentists.

Examples of evidence to demonstrate compliance may include:

- Attendance logs
- Time-sheets
- Clinical rotation schedule
- Student journals

2-23 Each student must be assigned to two or more offices or clinics for clinical experience and assisting in general dentistry situations is emphasized.

Intent:
More than fifty percent (50%) of the clinical assignments should be accomplished through assignment to general dentistry offices, and may include a pediatric dental office. Clinical experiences should be at different locations with different dentists.

2-24 The major portion of the students' time in clinical assignments must be spent assisting with, or participating in, patient care.

2-25 The dental assisting faculty must plan, approve, supervise, and evaluate the student's clinical experience, and the following conditions must be met:

a. A formal agreement exists between the educational institution and the facility providing the experience
b. The program administrator retains authority and responsibility for the student
c. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the dental assisting program.
d. The facility accommodates the scheduling needs of the program
e. Notification for termination of the agreement ensures that instruction will not be interrupted for currently assigned students
f. Expectations and orientation are provided to all parties prior to student assignment

2-26 Students must maintain a record of their activities in each clinical assignment.

2-27 During the clinical phase of the program, program faculty must conduct seminars periodically with students for discussion of clinical experiences.

Intent:
Seminar discussions provide students with opportunities to share clinical experiences

with other students and faculty.

2-28 When clinical experience is provided in extramural facilities, dental assisting faculty must visit each facility to assess student progress. Budgetary provisions must be made to support faculty travel.

2-29 Objective evaluation criteria must be utilized by faculty and office or clinical personnel to evaluate students' competence in performing specified procedures during clinical experience.

STANDARD 3 – ADMINISTRATION, FACULTY AND STAFF

3-1 The program must be a recognized entity within the institution's administrative structure which supports the attainment of program goals.

Intent:
The position of the program in the institutions administrative structure should permit direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program The administration of the program should include formal provisions for program planning, staffing, management, coordination and evaluation.

Examples of evidence to demonstrate compliance may include:
- Institutional organizational flow chart
- Short and long-range strategic planning documents
- Examples of program and institution interaction to meet program goals
- Dental assisting representation on key college or university committees
- Institutions program review

Program Administrator

3-2 The program administrator must have a full-time commitment to the institution and an appointment which provides time for program operation, evaluation and revision. The program administrator must have the authority and responsibilities for:

a. Budget preparation
b. Fiscal administration
c. Curriculum development and coordination
d. Selection and recommendation of individuals for faculty appointment and promotion
e. Supervision and evaluation of faculty
f. Determining faculty teaching assignments and schedules
g. Determining admissions criteria and procedures
h. Scheduling use of program facilities
i. Development and responsibilities to maintain CODA accreditation compliance and documentation

Intent:
The program administrator's teaching contact hours and course responsibilities are less than a full-time instructor who does not have administrative responsibilities or as defined by the collective bargaining agreement of the institution or state teachers association. The program administrator's teaching contact hours and course responsibilities allow sufficient time to fulfill assigned administrative responsibilities.

3-3 The program administrator must be a Dental Assisting National Board "Certified Dental Assistant" or dentist licensed to practice in the state of the program location*, with occupational experience in the application of fourhanded dentistry principles, either as a dental assistant or working with a chairside assistant.

Intent:
*A dental hygienist appointed after January 1, 2000, would be eligible for such an appointment after acquiring the "Certified Dental Assistant" credential offered by the Dental Assisting National Board and obtaining occupational experience in the application of clinical chairside dental assisting involving fourhanded dentistry. *A dentist currently licensed in the United States who has obtained a teaching dispensation from the state that grants him/her the ability to practice dentistry as defined by the state's dental practice act within a teaching institution, is exempt from this requirement. Honorary emeritus status issued by the Dental Assisting National Board is not recognized by the Commission on Dental Accreditation.*

3-4 The program administrator must have a baccalaureate degree or higher. The program administrator must have had instruction in educational theory and methodology, e.g., curriculum development, educational psychology, test construction, measurement and evaluation.

Examples of evidence to demonstrate compliance may include:
- Biosketch
- Documented evidence of instruction in educational methodology from a recognized provider or accredited institution. Instruction may occur through recognized continuing education providers, online courses, seminars, conferences or meetings
- Transcripts to document degree completion

Faculty

3-5 Dental assisting faculty must have background in and current knowledge of dental assisting, the specific subjects they are teaching and educational theory and methodology consistent with teaching assignment, e.g., curriculum development, educational psychology, test construction, measurement and evaluation.

Intent:
Dental assisting faculty have current knowledge at an appropriate level for the subject they teach, educational theory and methodology, and if applicable, in distance education techniques and delivery. Licensed dentists who provide supervision in the facility as required by the state dental practice act, who are not evaluating students, should have qualifications that comply with the state's dental practice act, and are calibrated with program policies and protocols, goals and objectives.

Examples of evidence may include:

- Documented evidence of instruction in educational methodology from a recognized provider or accredited institution. Instruction may occur through recognized continuing education providers, online courses, seminars, conferences or meetings
- Transcripts
- Certificate of completion

3-6 Faculty providing didactic instruction must have earned at least a baccalaureate degree within three years of the date of initial hire as a didactic faculty.

Intent:
**Military program faculty with a rank of staff sergeant, E5, or non-commissioned officer are exempt.*

Examples of evidence to demonstrate compliance may include:

- Transcript(s)

3-7 Laboratory, preclinical and clinical faculty must hold any current dental assisting credential required by the state in addition to a Dental Assisting National Board "Certified Dental Assistant" credential*.

Intent:
Faculty members teaching additional or expanded dental assisting functions should be credentialed appropriately in those functions as required by the state. Faculty who are state-licensed dentists are not required to obtain additional certification. Licensed dental hygiene faculty who teach dental radiography, coronal polishing, and the placement of pit and fissure sealants would be eligible to teach these functions to dental assisting students without obtaining additional certification. Honorary emeritus status issued by the Dental Assisting National Board is not recognized by the Commission on Dental Accreditation.

Examples of evidence to demonstrate compliance may include:

- Copy of certification certificate or card
- Copy of license or dental credential
- Clinical faculty have recent experience in the application of four-handed dentistry principles
- Curriculum vitae

3-8 The number of faculty positions must be sufficient to implement the program's goals and objectives. The faculty/student ratio during clinical and radiography (clinical and laboratory) sessions must not exceed one instructor to six students. During laboratory and preclinical instruction in dental materials and chairside assisting procedures, the faculty/student ratio must not exceed one instructor for each twelve students.

Intent:
Student contact hour loads allow sufficient time for class preparation, student evaluation and counseling, development of subject content and appropriate evaluation criteria and methods, and professional development. Student partner-patients are not counted as students when calculating the ratio.

Examples of evidence to demonstrate compliance may include:
- Class schedules reflecting faculty/student ratio
- Listing of ratios for laboratory, preclinical and clinical courses

3-9 Opportunities must be provided for program faculty to continue their professional development.

Intent:
Time is provided for professional association activities, research, publishing and/or practical experience.

Examples of evidence to demonstrate compliance may include:
- Each faculty member is provided release time and financial support to attend at least one national or regional conference or workshop related to dental assisting education each year.
- Formal in-service for full and part-time faculty are held regularly.
- The program/institution provides periodic in-service workshops for faculty designed to provide an orientation to program policies, goals, objectives and student evaluation procedures.

3-10 Faculty must be ensured a form of governance that allows participation in the program and institution's decision-making process.

Intent:
There are opportunities for program faculty representation on institution-wide committees and the program administrator is consulted when matters directly related to the program are considered by committees that do not include program faculty.

3-11 A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member.

Intent:
An objective evaluation system including student, administration and peer evaluation can identify strengths and weaknesses for each faculty member (to include those at distance sites) including the program administrator. The results of evaluations should be communicated to faculty members on a regular basis to ensure continued improvement.

Examples of evidence to demonstrate compliance may include:
- The faculty evaluation system includes student, administration and peer evaluation to help identify areas of strengths and weaknesses for each faculty

member.
- Measurement mechanism(s) address teaching, scholarship and service.
- The evaluations are communicated to each faculty member.

Support Staff

3-12 Institutional support personnel must be assigned to facilitate program operation.

Examples of evidence to demonstrate compliance may include:
- Secretarial and clerical staff are assigned to assist the administrator and faculty in preparing course materials, typing correspondence, maintaining student records, and providing supportive services for student recruitment activities and admissions.
- The secretarial personnel are located in an area which is readily accessible to the faculty.
- There are support services to assist the faculty in ordering supplies and equipment, maintaining and distributing equipment, and providing other instructional aid assistance.
- Services of maintenance and custodial staff ensure that the unique requirements of the program facilities are met.
- The program faculty and students have access to available institutional specialists such as those in the areas of curriculum, testing, computer usage, counseling and instructional resources equal to that of other programs.

STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The program must provide adequate and appropriately maintained facilities to support the purpose/mission of the program and which are in conformance with applicable regulations.

Intent:
The physical facilities and equipment effectively accommodate the schedule, the number of students, faculty and staff, and include appropriate provisions to ensure health and safety for patients, students, faculty and staff. The facilities permit attainment of program goals. This Standard applies to all sites where students receive instruction.

Clinical Facilities

4-2 A clinical facility must be available for students to obtain required experience with faculty supervision.

4-3 Each treatment area must contain functional equipment including:

a. Power-operated chair(s) for treating patients in a supine position
b. Dental units and mobile stools for the operator and the assistant which are designed for the application of current principles of dental assistant utilization.
c. Air and water syringe
d. Adjustable dental light
e. High and low speed handpieces
f. Oral evacuating equipment
g. Work surface for the chairside assistant

Examples of evidence to demonstrate compliance may include:
- One treatment area per five students enrolled in the program is considered minimal
- Floor plan

4-4 Each treatment area must accommodate an operator and a patient as well as the student and faculty.

4-5 The sterilizing area must include sufficient space for preparing, sterilizing and storing instruments.

4-6 Instruments and appropriate models and armamentaria must be provided to accommodate students' needs in learning to identify, exchange, prepare procedural trays and assist in procedures including:

a. Diagnostic
b. Operative
c. Surgical
d. Periodontal
e. Orthodontic
f. Removable and fixed prosthodontics
g. Endodontic

Examples of evidence to demonstrate compliance for DA 4-2 through 4-6 may include:

- List of equipment
- List of instruments

Radiography Facilities

4-7 A radiography facility must accommodate initial instruction and practice required for students to develop competence in exposing and processing dental images with faculty supervision.

4-8 Each radiography area must provide equipment for faculty supervision and effective instruction to accommodate several students simultaneously that include:

a. Dental radiography units which meet applicable regulations
b. Radiographic teaching manikins
c. Radiographic view boxes and/or monitors
d. Processing units with darkroom capacity or digital equipment
e. Multiple sets of image receptor holding devices
f. Radiation-monitoring devices are provided for students and faculty (according to state regulations)
g. Lead aprons and cervical collars for each unit
h. Counter with sink
i. Dental chair or unit

Intent:
The radiography facilities should allow the attainment of program goals and objectives. Radiography facilities and equipment should effectively accommodate the clinic and/or laboratory schedules, the number of students, faculty and staff, and comply with applicable regulations to ensure effective instruction in a safe environment.

Laboratory Facilities

4-9 A sufficient multipurpose laboratory facility must be provided for effective instruction which allows for required laboratory activities and can accommodate all scheduled students simultaneously. There must be an appropriate number of student stations, equipment, supplies, instruments and space for individual student performance of laboratory procedures with faculty supervision.

Intent:
The location and number of general use equipment such as lathes, model trimmers, dremmels, handpieces, vibrators, and other devices as well as dental materials, instruments, trays, mixing bowls, spatulas, etc. allows each student the access needed to develop proficiency in performing procedures.

Examples of evidence to demonstrate compliance may include:
- Outlets for electrical equipment are available in the laboratory.
- Sinks and plaster control devices are adequate in number to promote cleanliness and efficiency.
- Adequate ventilation (exhaust)
- Placement and storage location of equipment, supplies, instruments and materials that is conducive to efficient and safe utilization
- Student stations that are designed and equipped for students work while seated including sufficient ventilation and lighting, necessary utilities, storage space and an adjustable chair
- Documentation of compliance with applicable local, state and federal regulations.

Extended Campus Laboratory/Clinical Facilities

4-10 It is preferable and, therefore recommended, that the educational institution provide physical facilities and equipment which are adequate to permit achievement of the program's objectives. If the institution finds it necessary to contract for use of an existing facility for laboratory, preclinical and/or clinical education, then the following conditions must be met in addition to all existing standards.

a. There is a formal agreement between the educational institution and agency or institution providing the facility.
b. The program administrator retains authority and responsibility for instruction.
c. All students receive instruction and practice experience in the facility.
d. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the educational program.
e. Availability of the facility accommodates the scheduling needs of the program.
f. Notification for termination of the contract ensures that instruction will not be interrupted for currently enrolled students.

g. Instruction is provided and evaluated by calibrated dental assisting program faculty.

Intent:
This standard applies to sites off-campus used for laboratory, preclinical and/or clinical education. All students assigned to a particular facility are expected to receive instruction in that facility. This standard is not applicable to dental offices/clinic sites used for clinical/externship practice experience.

Examples of evidence to demonstrate compliance may include:
- Contract with extended campus facilities
- Course and faculty schedules for the off-campus site
- Affiliation agreements and policies/objectives of off-campus site

Classroom Space

4-11 Classroom space must be provided for, and be readily accessible to, the program.

Examples of evidence to demonstrate compliance may include:
- Classroom size accommodates the number of students enrolled in each class.
- Classrooms are designed and appropriately equipped for effective instruction.

Office Space

4-12 Office space must be provided for the program administrator and faculty.

Examples of evidence to demonstrate compliance may include:
- Privacy for student counseling
- A private office for the program administrator
- Student and program records stored to ensure confidentiality and safety

Learning Resources

4-13 The program must provide adequate and appropriately maintained learning resources to support the goals and objectives of the program.

Intent:
Instructional aids and equipment, and institutional learning resources are provided and include access to a diversified collection of current dental, dental assisting and multidisciplinary literature and references necessary to support teaching, student learning needs, services, and research. All students, including those receiving education at a distance site, are provided access to learning resources.

Examples of evidence to demonstrate compliance may include:

- A diversified and current collection may include: anatomy and physiology, anesthesia and pain control, applied psychology, current concepts of dental assistant utilization, dental and oral anatomy, dental materials, diet and nutrition, emergencies, ethics and jurisprudence, history of dentistry, microbiology, operative dentistry, oral health education, oral histology, oral pathology, pharmacology, practice management, preventive dentistry, radiology and radiation safety, sterilization and infection control, tooth morphology and the recognized dental specialties.
- References on educational methodology and medical and dental dictionaries and indices are available.
- Skeletal and anatomic models and replicas, sequential samples of laboratory procedures, slides, films, video and other media which depict current techniques and projection equipment are available for instruction.
- A wide range of electronic resources, printed materials and instructional aids and equipment are available for utilization by students and faculty including: current and back issues of major scientific and professional journals related to dentistry and dental assisting/dental hygiene/dental laboratory technology; a diversified collection of current references on dentistry and related subjects.
- There is a mechanism for program faculty to periodically review and select current titles and instructional aids of acquisition.
- Facility hours and policies are conducive to faculty and student use.
- Student access to a virtual library

Student Services

4-14 There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints, which parallel those established by the sponsoring institution.

Intent:
These policies and procedures protect the students as consumers; provide avenues for appeal and due process; ensure that student records accurately reflect work accomplished, and are maintained in a secure manner; ensure confidentiality of and access to student records is followed; ensure student participation when appropriate. The institution provides services to the allied dental students equal to those available to other students.

Examples of evidence to demonstrate compliance may include:

- Personal, academic and career counseling of students
- Appropriate information about the availability of financial aid and health services
- Student advocacy
- Information about further educational opportunities
- Ethical standards and policies to protect the students as consumers and avenues for appeal and due process

- Student records accurately reflect work accomplished during the program and are maintained in a secure manner.
- Policies concerning confidentiality of and access to student records are followed.

4-15 The program must provide a mechanism to facilitate student remediation when indicated.

Intent:
Students are provided with opportunities to successfully complete the program without compromising the integrity of the program.

Examples of evidence to demonstrate compliance may include:
- Policies and procedures for early identification of "at-risk" students
- Counseling and support services
- Scheduled remediation time
- Skills lab
- Tutor or mentoring program

STANDARD 5 – HEALTH AND SAFETY PROVISIONS

Infectious Disease/Radiation Management

5-1 The program must document its compliance with institutional policy and applicable local, state and federal regulations and/or guidelines related to health and safety.

- **a. Policies must include:**
  - **i) radiation hygiene and protection,**
  - **ii) ionizing radiation,**
  - **iii) hazardous materials, and**
  - **iv) bloodborne and infectious diseases.**
- **b. Policies must be provided to all students, faculty and appropriate support staff and continuously monitored for compliance.**
- **c. Policies on bloodborne and infectious disease(s) must be made available to applicants for admission and patients.**

Intent:
The dental assisting program should establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control and disposal of hazardous waste.

Policies and procedures on the use of ionizing radiation should include criteria for patient selection, frequency of exposing and retaking radiographs on patients, consistent with current, accepted dental practice.

Policies and procedures should be in place to provide for a safe environment for patients, students, faculty and staff. The confidentiality of information pertaining to the health status of each individual is strictly maintained.

This Standard applies to all program sites where laboratory and clinical education is provided.

Examples of evidence to demonstrate compliance may include:
Infectious Disease Management

- Written protocols on preclinical/clinical/laboratory asepsis, infection and biohazard control and disposal of hazardous waste
- Program policy manuals
- Compliance with applicable state and/or federal regulations
- Established post-exposure guidelines as defined by the Centers for Disease Control and Prevention
- Non-discriminatory admissions criteria

Radiation Management

- The program has developed and adheres to a policy on the use of ionizing radiation including criteria for patient selection, frequency of exposing radiographs on patients and retaking radiographs consistent with current accepted dental practice.
- Radiographs are exposed for diagnostic purposes, not solely to achieve instructional objectives.
- All radiographs exposed on patients are utilized while patient care is being provided for integration of radiography with clinical procedures.

5-2 Students, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, hepatitis B and tuberculosis prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and dental personnel.

Examples of evidence to demonstrate compliance may include:

- Forms
- Documentation
- Immunization records
- Declination forms

Emergency Management

5-3 The program must establish and enforce preclinical/clinical/laboratory protocols and mechanisms to ensure the management of emergencies; these protocols must be provided to all students, faculty and appropriate staff.

Examples of evidence to demonstrate compliance may include:

- Emergency equipment, including oxygen, is readily accessible and functional.
- Instructional materials
- Written protocol
- Emergency kit
- Safety devices and equipment are installed and functional.
- A first aid kit for use in managing clinic and/or laboratory accidents is accessible.

5-4 All students, faculty and support staff must be currently certified in basic life support procedures, including cardiopulmonary resuscitation with an Automated External Defibrillator (AED), prior to the direct provision of patient care.

Examples of evidence to demonstrate compliance may include:

- Documentation of current certification in basic life support procedures maintained by the program for students, faculty and support staff involved in the direct provision of patient care.
- Documentation for anyone who is medically or physically unable to perform such services.

STANDARD 6 – PATIENT CARE SERVICES

THIS STANDARD APPLIES WHEN A PROGRAM HAS AN ON-SITE CLINIC AND PROVIDES DENTAL CARE.

Intent:
These standards apply to any dental assisting program operating an on-site or distance site clinic which provides comprehensive dental care to patients (e.g., diagnosis and treatment planning, operative and/or surgical procedures).

6-1 The program must conduct a formal system of quality assurance for the patient care program that demonstrates evidence of:

a. Standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria
b. An ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided

Examples of evidence to demonstrate compliance may include:
- Description of the quality assurance process for the patient care program
- Samples of outcomes assessment measures to assess patients' perceptions of quality care, i.e., patient satisfaction surveys and results
- Results of patient records review and use of results to improve patient care program

6-2 The program must develop and distribute to appropriate students, faculty, staff and each patient a written statement of patients' rights.

6-3 Patients accepted for dental care must be advised of the scope of dental care available at the dental assisting program facilities. Patients must also be advised of their treatment needs and appropriately referred for the procedures that cannot be provided by the program.

Commission on Dental Accreditation

Accreditation Standards for Dental Hygiene Education Programs

Accreditation Standards for Dental Hygiene Education Programs

Commission on Dental Accreditation
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Accreditation Standards for Dental Hygiene Education Programs

Document Revision History

Date	***Item***	***Action***
February 12, 2021	*Accreditation Standards for Dental Hygiene Education Programs*	*Adopted*
August 6, 2021		
January 1, 2022	*Revised Mission Statement*	*Adopted*
	Revised Mission Statement	*Implemented*
July 1, 2022	*Accreditation Standards for Dental Hygiene Education Programs*	*Implemented*
August 5, 2022	*Revision to Standard 1-6 (Institutional Accreditation) Examples of Evidence*	*Adopted and Implemented*
November 7, 2022	*Revision to Standard 1-6 (Institutional Accreditation) Examples of Evidence*	*Adopted and 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: 8/18; 8/13; 8/10, 7/05; Adopted: 1/98

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

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

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

Withdraw: An action taken by the Commission when a program has been unable to demonstrate compliance with the accreditation standards or policies within the time period specified. A final action to withdraw accreditation is communicated to the program and announced to the communities of interest. A statement summarizing the reasons for the Commission's decision and comments, if any, that the affected program has made with regard to this decision, is available upon request from the Commission office. Upon withdrawal of accreditation by the Commission, the program is no longer recognized by the United States Department of Education. In the event the Commission withdraws accreditation from a program, students currently enrolled in the program at the time accreditation is withdrawn and who successfully

complete the program, will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission accredited program. Such graduates may be ineligible for certification/licensure examinations.

Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9

Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

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

Preface

The Accreditation Standards for Dental Hygiene Education Programs represent a revision of Requirements and Guidelines for Accredited Dental Hygiene Education Programs. These standards have been developed for the following reasons: (1) to protect the public welfare, (2) to serve as a guide for dental hygiene program development, (3) to serve as a stimulus for the improvement of established programs, and (4) to provide criteria for the evaluation of new and established programs. To be accredited by the Commission on Dental Accreditation, a dental hygiene program must meet the standards set forth in this document. These standards are national in scope and represent the minimum requirements for accreditation. The importance of academic freedom is recognized by the Commission; therefore, the standards are stated in terms which allow institution flexibility in the development of an educational program. It is expected that institutions which voluntarily seek accreditation will recognize the ethical obligation of complying with the spirit as well as the letter of these standards.

The Commission on Dental Accreditation

From the early 1940's until 1975, the Council on Dental Education was the agency recognized as the national accrediting organization for dentistry and dental-related educational programs. On January 1, 1975, the Council on Dental Education's accreditation authority was transferred to the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, an expanded agency established to provide representation of all groups affected by its accrediting activities. In 1979, the name of the Commission was changed to the Commission on Dental Accreditation.

The Commission is comprised of 30 members. It includes a representative of the American Dental Hygienists' Association (ADHA) and other disciplines accredited by the Commission as well as public representatives.

Specialized Accreditation

Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards. Accreditation standards are developed in consultation with those affected by the standards who represent the broad communities of interest. The Commission on Dental Accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs which provide basic preparation for licensure or certification in dentistry and the related disciplines.

Dental Hygiene Accreditation

The first dental hygiene accreditation standards were developed by three groups: the American Dental Hygienists' Association, the National Association of Dental Examiners and the American Dental Association's Council on Dental Education. The standards were submitted to and approved by the American Dental Association House of Delegates in 1947, five years prior to the launching of the dental hygiene accreditation program in 1952. The first list of accredited dental hygiene programs was published in 1953, with 21 programs. Since then the standards for accreditation have been revised eight times -- in 1969, 1973, 1979, 1991, 1998, 2005, 2007, and 2022.

In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation utilized the following procedures: conducting surveys of communities of interest, holding open hearings and distributing widely a draft of the proposed revision of the standards for review and comment. Prior to approving the revised standards in February 2021, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in July 2022.

Statement of General Policy

Maintaining and improving the quality of dental hygiene education is a primary aim of the Commission on Dental Accreditation. In meeting its responsibilities as a specialized accrediting agency recognized by the dental profession and by the United States Department of Education, the Commission on Dental Accreditation:

1. Evaluates dental hygiene education programs on the basis of the extent to which program goals, institutional objectives and approved accreditation standards are met;

2. Supports continuing evaluation of and improvements in dental hygiene education programs through institutional self-evaluation;

3. Encourages innovations in program design based on sound educational principles;

4. Provides consultation in initial and ongoing program development.

As a specialized accrediting agency, the Commission relies on an authorized institutional accrediting agency's evaluation of the institution's objectives, policies, administration, financial and educational resources and its total educational effort. The Commission's evaluation will be confined to those factors which are directly related to the quality of the dental hygiene program. In evaluating the curriculum in institutions that are accredited by a U.S. Department of Education-recognized regional or national accrediting agency, the Commission will concentrate on those courses which have been developed specifically for the dental hygiene program and core courses developed for related disciplines. When an institution has been granted status or "candidate for accreditation" status by a regional or national accrediting agency, the Commission will accept that status as evidence that the general education and biomedical science courses included in the dental hygiene curriculum meet accepted standards, provided such courses are of appropriate level and content for the discipline.

The importance of institutional academic freedom is recognized by the Commission, and the Accreditation Standards allow institutions considerable flexibility in structuring their educational programs. The Commission encourages the achievement of excellence through curricular innovation and development of institutional individuality. Dependent upon its objectives, resources, and state practice act provisions, the institution may elect to extend the scope of the curriculum to include content and instruction in additional areas.

Programs and their sponsoring institutions are encouraged to provide for the educational mobility of students through articulation arrangements and career laddering (e.g., between dental assisting education programs and dental hygiene education programs).

Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying or proficiency examinations.

This entire document constitutes the Accreditation Standards for Dental Hygiene Education Programs. Each standard is numbered (e.g., 1-1, 1-2) and in bold print. Where appropriate, standards are accompanied by statements of intent that explain the rationale, meaning and significance of the standard. Expanded guidance in the form of examples to assist programs in better understanding and interpreting the "must" statements within the standards follow. This format is intended to clarify the meaning and application of standards for both those responsible for educational programs and those who evaluate these programs for the Commission.

Definitions of Terms Used in Dental Hygiene Accreditation Standards

The terms used in this document indicate the relative weight that the Commission attaches to each statement. Definitions of these terms are provided.

Standard: Offers a rule or basis of comparison established in measuring or judging capacity, quantity, quality, content and value; criterion used as a model or pattern.

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

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

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

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

Competent: The levels of knowledge, skills and values required by new graduates to begin the practice of dental hygiene.

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

Instruction: Describes any teaching, lesson, rule or precept; details of procedure; directives.

Clinical Education: The patient care experiences required for all students in order to attain clinical competence and complete the dental hygiene program. This education is provided in the program's clinical facilities (on campus or extended campus facilities) as defined in the Accreditation Standards and is supervised and evaluated by program faculty according to predetermined criteria.

Laboratory or Preclinical Instruction: Indicates instruction in which students receive supervised experience performing functions using study models, manikins or other simulation methods; student performance is evaluated by faculty according to predetermined criteria.

Enriching Clinical Experiences: Clinical experiences that exceed the clinical education requirements of the program and that are provided to enhance the basic clinical education. Enriching experiences may be provided on campus and/or in extramural clinical facilities and may be supervised by non-program personnel according to predetermined learning objectives and evaluation criteria.

Distance Education: As defined by the United States Department of Education, distance education is "an educational process that is characterized by the separation, in time or place, between instructor and student. The term includes courses offered principally through the use of (1) television, audio or computer transmission; (2) audio or computer conferencing; (3) video cassettes or disks; or (4) correspondence."

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

Post-Degree Certificate: A certificate awarded to students who have previously earned a minimum of an associate's degree and complete all requirements of the accredited educational program in dental hygiene.

Standard of Care: Level of clinical performance expected for the safe, effective and ethical practice of dental hygiene.

Dental Hygiene Diagnosis: Identification of an existing or potential oral health problem that a dental hygienist is qualified and licensed to treat.

Sponsoring Institution: The post-secondary entity that directly sponsors the dental hygiene program and provides immediate administration and local leadership. The sponsoring institution has the overall administrative control and responsibility for the conduct of the program.

Interprofessional Education*: When students and/or professionals from two or more professions learn about, from and with each other to enable effective collaboration to improve health outcomes.

** Definition adapted from the World Health Organization (2010). Framework for Action on Interprofessional Education and Collaborative Practice. Geneva: World Health Organization.*

The Commission's accreditation standards have been stated, purposefully, in terms which allow flexibility, innovation and experimentation. Regardless of the method(s) used to provide instruction, the Commission expects that each accredited program will comply with the spirit as well as the letter of the accreditation standards.

STANDARD 1 - INSTITUTIONAL EFFECTIVENESS

Planning and Assessment

1-1 The program must demonstrate its effectiveness using a formal and ongoing planning and assessment process that is systematically documented by:

a) developing a plan addressing teaching, patient care, research and service;
b) an ongoing plan consistent with the goals of the sponsoring institution and the goals of the dental hygiene program;
c) implementing the plan to measure program outcomes in an ongoing and systematic process;
d) assessing and analyzing the outcomes, including measures of student achievement;
e) use of the outcomes assessment results for annual program improvement and reevaluation of program goals.

Intent:
Assessment, planning, implementation and evaluation of the educational quality of a dental hygiene education program (inclusive of distance education modalities/programs), that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students in an accountable and cost effective manner. The Commission on Dental Accreditation expects each program to define its own goals for preparing individuals in the discipline and that one of the program goals is to comprehensively prepare competent individuals in the discipline.

Examples of evidence to demonstrate compliance may include:
- program completion rates related to outcomes
- employment rates related to outcomes
- success of graduates on state licensing examinations
- success of graduates on national boards
- surveys of alumni, students, employers, and clinical sites
- other benchmarks or measures of learning used to demonstrate effectiveness
- examples of program effectiveness in meeting its goals
- examples of how the program has been improved as a result of assessment
- ongoing documentation of change implementation
- mission, goals and strategic plan document
- assessment plan and timeline

1-2 The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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

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

Financial Support

1-3 The institution must have a strategic plan which identifies stable financial resources sufficient to support the program's stated mission, goals and objectives. A financial statement document must be submitted providing revenue and expense data for the dental hygiene program.

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

Examples of evidence to demonstrate compliance may include:
- program's mission, goals, objectives and strategic plan
- institutional strategic plan
- revenue and expense statements for the program for the past three years
- revenue and expense projections for the program for the next three years

1-4 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

1-5 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

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, faculty financial support

Institutional Accreditation

1-6 Programs must be sponsored by institutions of higher education that are accredited by an institutional accrediting agency (i.e., a regional or appropriate* national accrediting agency) recognized by the United States Department of Education for offering college-level programs.

* Agencies whose mission includes the accreditation of institutions offering allied health education programs.

Intent:
Dental schools, four-year colleges and universities, community colleges, technical institutes, vocational schools, and private schools, which offer appropriate fiscal, facility, faculty and curriculum resources are considered appropriate settings for the program. The institution should offer appropriate fiscal, facility, faculty and curriculum resources to sponsor the dental hygiene educational program.

Examples of evidence to demonstrate compliance may include:

- Accreditation (or candidate status) from a recognized institutional (regional or national) accrediting agency, for example:
  Middle States Commission on Higher Education; New England Commission on Higher Education; Commission on Technical and Career Institutions, New England Association of Schools and Colleges; Higher Learning Commission; Northwest Commission on Colleges and Universities; Southern Association of Colleges and Schools, Commission on Colleges; WASC Accrediting Commission for Community and Junior Colleges; WASC Senior Colleges and University Commission; Accrediting Bureau of Health Education Schools; Accrediting Commission for Career Schools and Colleges; Distance Education Accrediting Commission; The Council on Occupational Education

1-7 All arrangements with co-sponsoring or affiliated institutions must be formalized by means of written agreements which clearly define the roles and responsibilities of each institution involved.

Intent:
The purpose of a formalized written agreement is to protect the dental hygiene program, faculty, and students regarding the roles and responsibilities of the institution(s) that sponsor the dental hygiene program.

Examples of evidence to demonstrate compliance may include:
- affiliation agreement(s)
- flowchart delineating roles and responsibilities of sponsoring institution(s)

Community Resources

1-8 There must be an active liaison mechanism between the program and the dental and allied dental professions in the community. The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest with the educational institution.

Intent:
The purpose of an active liaison mechanism is to provide a mutual exchange of information for improving the program, recruiting qualified students and meeting employment needs of the community. The responsibilities of the advisory body should be defined in writing and the program director, faculty, and appropriate institution personnel should participate in the meetings as non-voting members to receive advice and assistance.

Examples of evidence to demonstrate compliance may include:
- policies and procedures regarding the liaison mechanism outlining responsibilities, appointments, terms and meetings
- membership list with equitable representation if the group represents more than one discipline
- criteria for the selection of advisory committee members
- an ongoing record of committee or group minutes, deliberations and activities

STANDARD 2 - EDUCATIONAL PROGRAM

Instruction

2-1 The curriculum must include at least two academic years of full-time instruction or its equivalent at the postsecondary college-level. The scope and depth of the curriculum must reflect the objectives and philosophy of higher education. The college catalog must list the degree awarded and course titles and descriptions.

In a two-year college setting, the graduates of the program must be awarded an associate degree. In a four-year college or university, graduates of the program must be awarded an associate or comparable degree, post-degree certificate, or baccalaureate degree.

Intent:
The dental hygiene curriculum is comprehensive in scope and depth and requires a minimum of two years of academic preparation. The curriculum should include additional coursework and experiences, as appropriate, to develop competent oral health care providers who can deliver optimal patient care within a variety of practice settings and meet the needs of the evolving healthcare environment.

In a four-year college setting that awards a certificate, admissions criteria should require a minimum of an associate degree. Institutions should provide students with opportunities to continue their formal education through affiliations with institutions of higher education that allow for transfer of course work. Affiliations should include safeguards to maximize credit transfer with minimal loss of time and/or duplication of learning experiences.

General education, social science and biomedical science courses included in associate degree dental hygiene curricula should parallel those offered in four-year colleges and universities. In baccalaureate degree curricula, attention is given to requirements for admission to graduate programs to establish a balance between professional and nonprofessional credit allocations.

Examples of evidence to demonstrate compliance may include:
- copies of articulation agreements
- curriculum documents
- course evaluation forms and summaries
- records of competency examinations
- college catalog

2-2 A process must be established to assure students meet the academic, professional and/or clinical criteria as published and distributed. Academic standards and institutional due process policies must be followed for remediation or dismissal. A college document must include institutional due process policies and procedures.

Intent:
If a student does not meet evaluation criteria, provision should be made for remediation or dismissal. On the basis of designated criteria, both students and faculty can periodically assess progress in relation to the stated goals and objectives of the program.

Examples of evidence to demonstrate compliance may include:
- written remediation policy and procedures
- records of attrition/retention rates related to academic performance
- institutional due process policies and procedures

Admissions

2-3 Admission of students must be based on specific written criteria, procedures and policies. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability must be utilized as criteria in selecting students who have the potential for successfully completing the program. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental hygienists.

Intent:
The dental hygiene education curriculum is a postsecondary scientifically-oriented program which is rigorous and intensive. Because enrollment is limited by facility capacity, special program admissions criteria and procedures are necessary to ensure that students are selected who have the potential for successfully completing the program. The program administrator and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures which are non-discriminatory and ensure the quality of the program.

Examples of evidence to demonstrate compliance may include:
- admissions management policies and procedures
- copies of catalogs, program brochures or other written materials
- established ranking procedures or criteria for selection
- minutes from admissions committee
- periodic analysis supporting the validity of established admission criteria and procedures
- results from institutional research used in interpreting admissions data and criteria and/or correlating data with student performance

- graduation rates
- analysis of attrition
- employment rates

2-4 Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program. Students with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by students regularly enrolled in the program.

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

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

2-5 The number of students enrolled in the program must be proportionate to the resources available.

Intent:
In determining the number of dental hygiene students enrolled in a program (inclusive of distance sites), careful consideration should be given to ensure that the number of students does not exceed the program's resources, including patient supply, financial support, scheduling options, facilities, equipment, technology and faculty.

Examples of evidence to demonstrate compliance may include:
- sufficient number of clinical and laboratory stations based on enrollment
- clinical schedules demonstrating equitable and sufficient clinical unit assignments
- clinical schedules demonstrating equitable and sufficient radiology unit assignments
- faculty full-time equivalent (FTE) positions relative to enrollment
- budget resources and strategic plan
- equipment maintenance and replacement plan

- patient pool availability analysis
- course schedules for all terms

Curriculum

2-6 The dental hygiene program must:

1) **define and list the overall graduation competencies that describe the levels of knowledge, skills and values expected of graduates.**
2) **employ student evaluation methods that measure all defined graduation competencies.**
3) **document and communicate these competencies and evaluation methods to the enrolled students.**

Intent:
The educational competencies for the dental hygiene education program should include the preparation of graduates who possess the knowledge, skills and values to begin the practice of dental hygiene. The evaluation methods used in the dental hygiene program should include process and end-product assessments of student performance, as well as a variety of objective testing measures. These mechanisms will provide student performance data related to measuring defined program competencies throughout the program for the students, faculty and college administration.

Examples of evidence to demonstrate compliance may include:
- a singular document that includes graduation competencies aligned with curriculum
- documentation demonstrating relationship between graduation competencies, course competencies, and evaluation methods

2-7 Course syllabi for dental hygiene courses must be available at the initiation of each course and include:

1) **written course descriptions**
2) **content and topic outlines**
3) **specific instructional objectives**
4) **learning experiences**
5) **evaluation methods**

Intent:
The program should identify the dental hygiene fundamental knowledge and competencies that will be included in the curriculum based on the program goals, resources, current dental hygiene practice responsibilities and other influencing factors. Individual course documentation needs to be periodically reviewed and revised to accurately reflect instruction being provided as well as new concepts and techniques taught in the program.

Examples of evidence to demonstrate compliance may include:

- individual syllabi for each dental hygiene course, excluding general education and basic science courses
- weekly topical outlines and associated instructional objectives
- learning experiences for each class session to include identified didactic, laboratory, pre-clinical and clinical sessions
- the overall evaluation procedures used to determine a final course grade

2-8 The curriculum must include content in the following four areas: general education, biomedical sciences, dental sciences and dental hygiene science. This content must be integrated and of sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies.

Intent:
Foundational knowledge should be established early in the dental hygiene program and of appropriate scope and depth to prepare the student to achieve competence in all components of dental hygiene practice. Content identified in each subject may not necessarily constitute a separate course, but the subject areas are included within the curriculum.

Curriculum content and learning experiences should provide the foundation for continued formal education and professional growth with a minimal loss of time and duplication of learning experiences. General education, social science, and biomedical science courses included in the curriculum should be equivalent to those offered in four-year colleges and universities.

2-8a General education content must include oral and written communications, psychology, and sociology.

Intent:
These subjects provide foundational knowledge for components of the curriculum, which prepare the students to communicate effectively, assume responsibility for individual oral health counseling, and participate in community health programs.

2-8b Biomedical science content must include content in anatomy, physiology, chemistry, biochemistry, microbiology, immunology, general and maxillofacial pathology and/or pathophysiology, nutrition and pharmacology.

Intent:
These subjects provide foundational knowledge for dental and dental hygiene sciences. The subjects are to be of the scope and depth comparable to college transferable liberal arts course work. The program should ensure that biomedical science instruction serves as a foundation for student analysis and synthesis of the interrelationships of the body

systems when making decisions regarding oral health services within the context of total body health.

Biomedical science instruction in dental hygiene education ensures an understanding of basic biological principles consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems. The biomedical knowledge base emphasizes the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

Dental hygienists need to understand abnormal conditions to recognize the parameters of comprehensive dental hygiene care. The program should ensure that graduates have the level of understanding that assures that the health status of the patient will not be compromised by the dental hygiene interventions.

2-8c Dental sciences content must include tooth morphology, head, neck and oral anatomy, oral embryology and histology, oral pathology, radiography, periodontology, pain management, and dental materials.

Intent:
These subjects provide the student with knowledge of oral health and disease as a basis for assuming responsibility for assessing, planning and implementing preventive and therapeutic services. Teaching methodologies should be utilized to assure that the student can assume responsibility for the assimilation of knowledge requiring judgment, decision making skills and critical analysis.

2-8d Dental hygiene science content must include oral health education and preventive counseling, health promotion, patient management, clinical dental hygiene, provision of services for and management of patients with special needs, community dental/oral health, medical and dental emergencies, legal and ethical aspects of dental hygiene practice, infection and hazard control management, and the provision of oral health care services to patients with bloodborne infectious diseases.

Intent:
Dental hygiene sciences provide the knowledge base for dental hygiene and prepares the student to assess, plan, implement and evaluate dental hygiene services as an integral member of the health team. Content in provision of oral health care services to patients with bloodborne infectious diseases prepares the student to assess patients' needs and plan, implement and evaluate appropriate treatment.

2-9 The basic clinical education aspect of the curriculum must include a formal course sequence in scientific principles of dental hygiene practice, which extends throughout the curriculum and is coordinated and integrated with clinical experience in providing dental hygiene services.

Intent:
Learning experiences and practice time in clinical procedures is necessary to assure sufficient opportunity to develop competence in all clinical procedures included in the curriculum. Didactic material on clinical dental hygiene should be presented throughout the curriculum.

2-10 Clinical experiences must be distributed throughout the curriculum. The number of hours of preclinical practice and direct patient care must ensure that students attain clinical competence and develop appropriate judgment.

Intent:
Sufficient practice time and learning experiences should be provided during preclinical and clinical courses to ensure that students attain clinical competence. The number of hours devoted to clinical practice time should increase as the students progress toward the attainment of clinical competence.

The preclinical course should have at least six hours of clinical practice per week. As the first-year students begin providing dental hygiene services for patients, each student should be scheduled for at least eight to twelve hours of direct patient care per week. In the final prelicensure year of the curriculum, each student should be scheduled for at least twelve to sixteen hours of direct patient care per week in the dental hygiene clinic.

Examples of evidence to demonstrate compliance may include:
- program clinical experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation system policy and procedures demonstrating student competencies
- clinic schedules for each term

Patient Care Competencies

2-11 The dental hygiene program must have established mechanisms to ensure a sufficient number of patient experiences that afford all students the opportunity to achieve stated competencies.

Intent:
A system should be developed and implemented to categorize patients according to difficulty level and oral health/disease status. This system should be used to monitor students' patient care experiences to ensure equal opportunities for each enrolled student. Patient assignments should include maintenance appointments to monitor and evaluate the outcome of dental hygiene care. A system should be in place to monitor student patient care experiences at all program sites.

Examples of evidence to demonstrate compliance may include:

- program clinical and radiographic experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation system policy and procedures demonstrating patient care competencies

2-12 Graduates must be competent in providing dental hygiene care for all patient populations including:

1) **child**
2) **adolescent**
3) **adult**
4) **geriatric**
5) **special needs**

Intent:
An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, developmental, intellectual or social conditions may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student.

Clinical instruction and experiences should include the dental hygiene process of care compatible with each of these patient populations.

Examples of evidence to demonstrate compliance may include:

- program definition for each patient population category
- program clinical and radiographic experiences, direct and non-direct patient contact assignments, and off-site enrichments experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- student clinical evaluation mechanism demonstrating student competence in clinical skills, communication and practice management.

2-13 Graduates must be competent in providing the dental hygiene process of care which includes:

a) comprehensive collection of patient data to identify the physical and oral health status;
b) analysis of assessment findings and use of critical thinking in order to address the patient's dental hygiene treatment needs;
c) establishment of a dental hygiene care plan that reflects the realistic goals and treatment strategies to facilitate optimal oral health;
d) provision of comprehensive patient-centered treatment and evidence-based care in a manner minimizing risk and optimizing oral health;
e) measurement of the extent to which goals identified in the dental hygiene care plan are achieved;
f) complete and accurate recording of all documentation relevant to patient care.

Intent:
The dental hygienist functions as a member of the dental team and plays a significant role in the delivery of comprehensive patient health care. The dental hygiene process of care is an integral component of total patient care and preventive strategies. The dental hygiene process of care is recognized as part of the overall treatment plan developed by the dentist for complete dental care.

Examples of evidence to demonstrate compliance may include:
- Program clinical and radiographic experiences
- Patient tracking data for enrolled and past students
- Policies regarding selection of patients and assignment of procedures
- Monitoring or tracking system protocols
- Clinical evaluation system policy and procedures demonstrating student competencies
- Assessment instruments
- Evidence-based treatment strategies
- Appropriate documentation
- Use of risk assessment systems and/or forms to develop a dental hygiene care plan

2-14 Graduates must be competent in providing dental hygiene care for all types of classifications of periodontal diseases including patients who exhibit moderate to severe periodontal disease.

Intent:
The total number and type of patients for whom each student provides dental hygiene care should be sufficient to ensure competency in all components of dental hygiene practice. A patient pool should be available to provide patient experiences in all classifications of periodontal patients, including both maintenance and those newly diagnosed. These experiences should be monitored to ensure equal opportunity for each enrolled student.

Examples of evidence to demonstrate compliance may include:

- program criteria for classification of periodontal disease
- program clinical and radiographic experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation mechanism demonstrating student competence

2-15 Graduates must be competent in interprofessional communication, collaboration and interaction with other members of the health care team to support comprehensive patient care.

Intent:
Students should understand the roles of members of the health-care team and have interprofessional educational experiences that involve working with other health-care professional students and practitioners. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental Hygienists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).

Examples of evidence to demonstrate compliance may include:

- student experiences demonstrating the ability to communicate and collaborate effectively with a variety of individuals, groups and health care providers.
- examples of individual and community-based oral health projects implemented by students during the previous academic year
- evaluation mechanisms designed to assess-knowledge and performance of interdisciplinary communication and collaboration

2-16 Graduates must demonstrate competence in:

a) assessing the oral health needs of community-based programs
b) planning an oral health program to include health promotion and disease prevention activities
c) implementing the planned program, and,
d) evaluating the effectiveness of the implemented program.

Intent:
Population based activities will allow students to apply community dental health principles to prevent disease and promote health.

Examples of evidence to demonstrate compliance may include:

- student projects demonstrating assessing, planning, implementing and evaluating community-based oral health programs

2-17 Graduates must be competent in providing appropriate support measures for medical emergencies that may be encountered in dental hygiene practice.

Intent:
Dental hygienists should be able to provide appropriate support for medical or dental emergencies as providers of direct patient care.

Examples of evidence to demonstrate compliance may include:
- evaluation methods/grading criteria such as classroom or clinic examination, station examination, and performance on emergency simulations

2-18 Where graduates of a CODA accredited dental hygiene program are authorized to perform additional functions defined by the program's state-specific dental board or regulatory agency, required for initial dental hygiene licensure, and the program has chosen to include those functions in the program curriculum, the program must include content at the level, depth, and scope required by the state. Students must be informed of the duties for which they are educated within the program.

Intent:
To ensure functions allowed by the state dental board or regulatory agency for dental hygienists are taught and evaluated at the depth and scope required by the state.

Ethics and Professionalism

2-19 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:
Dental hygienists should understand and practice ethical behavior consistent with the professional code of ethics throughout their educational experiences.

Examples of evidence to demonstrate compliance may include:
- documents which articulate expected behavior of students such as policy manuals, college catalog, etc.
- evaluation of student experiences which promotes ethics, ethical reasoning and professionalism
- evaluation strategies to monitor knowledge and performance of ethical behavior

2-20 Graduates must be competent in applying legal and regulatory concepts to the provision and/or support of oral health care services.

Intent:
Dental hygienists should understand the laws which govern the practice of the dental profession. Graduates should know how to access licensure requirements, rules and regulations, and state practice acts for guidance in judgment and action.

Examples of evidence to demonstrate compliance may include:
- evaluation mechanisms designed to monitor knowledge and performance concerning legal and regulatory concepts
- outcomes assessment mechanisms

Critical Thinking

2-21 Graduates must be competent in the application of self-assessment skills to prepare them for life-long learning.

Intent:
Dental hygienists should possess self-assessment skills as a foundation for maintaining competency and quality assurance.

Examples of evidence to demonstrate compliance may include:
- written course documentation of content in self-assessment skills
- evaluation mechanisms designed to monitor knowledge and performance
- outcomes assessment mechanisms

2-22 Graduates must be competent in the evaluation of current scientific literature.

Intent:
Dental hygienists should be able to evaluate scientific literature as a basis for life-long learning, evidenced-based practice and as a foundation for adapting to changes in healthcare.

Examples of evidence to demonstrate compliance may include:
- written course documentation of content in the evaluation of current and classic scientific literature
- evaluation mechanisms designed to monitor knowledge and performance
- outcomes assessment mechanisms

2-23 Graduates must be competent in problem solving strategies related to comprehensive patient care and management of patients.

Intent:
Critical thinking and decision making skills are necessary to provide effective and efficient dental hygiene services. Throughout the curriculum, the educational program

should use teaching and learning methods that support the development of critical thinking and problem solving skills.

Examples of evidence to demonstrate compliance may include:

- evaluation mechanisms designed to monitor knowledge and performance;
- outcomes assessment mechanisms demonstrating application of critical thinking skills;
- activities or projects that demonstrate student experiences with analysis of problems related to comprehensive patient care;
- demonstration of the use of active learning methods that promote critical appraisal of scientific evidence in combination with clinical application and patient factors.

Curriculum Management

2-24 The dental hygiene program must have a formal, written curriculum management plan, which includes:

a) an annual formal curriculum review and evaluation process with input from faculty, students, administration and other appropriate sources;
b) evaluation of the effectiveness of all courses as they support the program's goals and competencies;
c) a defined mechanism for coordinating instruction among dental hygiene program faculty.

Intent:
To assure the incorporation of emerging information and achievement of appropriate sequencing, the elimination of unwarranted repetition, and the attainment of student competence, a formal curriculum review process should be conducted on at least an annual basis. Periodic workshops and in-service sessions should be held for the dissemination of curriculum information and modifications.

Examples of evidence to demonstrate compliance may include:

- competencies documentation demonstrating relationship of course content to defined competencies of the program
- documentation of ongoing curriculum review and evaluation
- minutes of curriculum management meetings documenting curriculum review and evaluation
- student evaluation of instruction
- curriculum management plan
- documentation of calibration exercises

STANDARD 3 - ADMINISTRATION, FACULTY AND STAFF

3-1 The program must be a recognized entity within the institution's administrative structure which supports the attainment of program goals.

Intent:
The position of the program in the institution's administrative structure should permit direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program. The administration of the program should include formal provisions for program planning, staffing, management, coordination and evaluation.

Examples of evidence to demonstrate compliance may include:
- institutional organizational flow chart
- short and long-range strategic planning documents
- examples of program and institution interaction to meet program goals
- dental hygiene representation on key college or university committees

Program Administrator

3-2 The dental hygiene program administrator must have a full-time appointment as defined by the institution, whose primary responsibility is for operation, supervision, evaluation and revision of the program.

Intent:
To allow sufficient time to fulfill administrative responsibilities, program administrative hours should represent the majority of hours, and teaching contact hours should be limited.

Examples of evidence to demonstrate compliance may include:
- program administrator position description and/or contract
- faculty schedules including contact hours and supplemental responsibilities
- policies of the institution which define teaching load for full-time faculty and administrators
- copies of union regulations and/or collective bargaining agreements

3-3 The program administrator must be a dental hygienist or a dentist who is a graduate of a program accredited by the Commission on Dental Accreditation and possesses a masters or higher degree, who has background in education and the professional experience necessary to understand and fulfill the program goals. A dentist who was appointed as program administrator prior to July 1, 2022 is exempt from the graduation requirement.

Intent:
The program administrator's background should include administrative experience, instructional experience, and professional experience in clinical practice either as a dental hygienist or working with a dental hygienist. The term of interim/acting program administrator should not exceed a two year period.

Examples of evidence to demonstrate compliance may include:
- current allied biosketch of program administrator

3-4 The program administrator must have the authority and responsibility necessary to fulfill program goals including:

a) curriculum development, evaluation and revision;
b) faculty recruitment, assignments and supervision;
c) input into faculty evaluation;
d) initiation of program or department in-service and faculty development;
e) assessing, planning and operating program facilities;
f) input into budget preparation and fiscal administration;
g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.

Examples of evidence to demonstrate compliance may include:
- program administrator position description

Faculty

3-5 The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public.

1. **In preclinical and clinical sessions, the ratio must not exceed one (1) faculty to five (5) students.**
2. **In radiography laboratory sessions, the ratio must not exceed one (1) faculty to five (5) students.**
3. **In other dental sciences laboratory sessions, the ratio must not exceed one (1) faculty to 10 students.**

Intent:
The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and clinical practice sessions rather than by the number of full-time equivalent positions for the program. The faculty to student ratios in clinical and radiographic practice should allow for individualized instruction and evaluation of the process as well as the end results. Faculty are responsible for both ensuring that the clinical and radiographic services delivered by students meet current standards for

dental hygiene care and for the instruction and evaluation of students during their performance of those services.

Examples of evidence to demonstrate compliance may include:

- faculty teaching schedules including student contact loads and supplemental responsibilities
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-6 Full-time and part-time faculty of a dental hygiene program must possess a baccalaureate or higher degree. All part-time clinical and dental science laboratory faculty appointed prior to July 1, 2022 are exempt from the degree requirement.

All dental hygiene program faculty members must have:

a) current knowledge of the specific subjects they are teaching.
b) documented background in current educational methodology concepts consistent with teaching assignments.
c) faculty who are dental hygienists or dentists must be graduates of programs accredited by the Commission on Dental Accreditation. A dentist who was appointed as a faculty prior to July 1, 2022 is exempt from the graduation requirement.
d) evidence of faculty calibration for clinical evaluation.

Intent:

Faculty should have background in current education theory and practice, concepts relative to the specific subjects they are teaching, clinical practice experience and, if applicable, distance education techniques and delivery. These criteria apply to dentists and dental hygienists who supervise students' clinical procedures should have qualifications which comply with the state dental or dental hygiene practice act. Individuals who teach and supervise dental hygiene students in clinical enrichment experiences should have qualifications comparable to faculty who teach in the dental hygiene clinic and are familiar with the program's objectives, content, instructional methods and evaluation procedures.

Examples of evidence to demonstrate compliance may include:

- faculty curriculum vitae with recent professional development activities listed
- evidence of participation in workshops, in-service training, self-study courses, on-line and credited courses
- attendance at regional and national meetings that address education
- mentored experiences for new faculty
- scholarly productivity
- maintenance of existing and development of new and/or emerging clinical skills

3-7 Opportunities must be provided for the program administrator and full-time faculty to continue their professional development.

Intent:
To assure competency in the discipline and educational theory, opportunities to attend professional development activities should be provided regularly for the program administrator and full-time faculty. Workshops should be offered to new faculty to provide an orientation to program policies, goals, objectives and student evaluation. This can be demonstrated through activities such as professional association involvement, research, publishing and clinical/practice experience.

Examples of evidence to demonstrate compliance may include:
- curriculum vitas with recent professional development activities listed
- examples of the program's or college's faculty development offerings
- records of formal in-service programs
- demonstration of funded support for professional development

3-8 A defined faculty evaluation process must exist that ensures objective measurement of the performance of each faculty member.

Intent:
An objective evaluation system including student, administration and peer evaluation can identify strengths and weaknesses for each faculty member (to include those at distance sites) including the program administrator. The results of evaluations should be communicated to faculty members on a regular basis to ensure continued improvement.

Examples of evidence to demonstrate compliance may include:
- sample evaluation mechanisms addressing teaching, patient care, research, scholarship and service
- faculty evaluation policy, procedures and mechanisms

3-9 Opportunities for promotion, tenure, and development must be the same for dental hygiene faculty as for other institutional faculty.

Intent:
The dental hygiene program faculty should be granted privileges and responsibilities as afforded all other institutional faculty.

Examples of evidence to demonstrate compliance may include:
- institution's promotion/tenure policy
- faculty senate handbook
- institutional policies and procedures governing faculty

Support Staff

3-10 Qualified institutional support personnel must be assigned to the program to support both the instructional program and the clinical facilities providing a safe environment for the provision of instruction and patient care.

Intent:
Maintenance and custodial staff should be sufficient to meet the unique needs of the academic and clinical program facilities. Faculty should have access to instructional specialists, such as those in the areas of curriculum, testing, counseling, computer usage, instructional resources and educational psychology. Secretarial and clerical staff should be assigned to assist the administrator and faculty in preparing course materials, correspondence, maintaining student records, and providing supportive services for student recruitment and admissions activities. Support staff should be assigned to assist with the operation of the clinic facility including the management of appointments, records, billing, insurance, inventory, hazardous waste, and infection control.

Examples of evidence to demonstrate compliance may include:
- description of current program support/personnel staffing
- program staffing schedules
- staff job descriptions
- examples of how support staff are used to support students

3-11 Student assignments to clerical and dental assisting responsibilities during clinic sessions must be minimal and must not be used to compensate for limitations of the clinical capacity or to replace clerical or clinical staff.

Intent:
Secretarial and clerical staff should be assigned to assist the administrator and faculty in preparing course materials, correspondence, maintaining student records, and providing supportive services for student recruitment and admissions activities. Support staff should be assigned to assist with the operation of the clinic facility including the management of appointments, records, billing, insurance, inventory, hazardous waste, and infection control.

Examples of evidence to demonstrate compliance may include:
- description of current program support/personnel staffing
- program staffing schedules
- staff job descriptions
- examples of how support staff are used to support students

STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Facilities

4-1 The program must provide sufficient and appropriately maintained facilities to support the academic and clinical purposes of the program that conform to applicable local, state and federal regulations.

Clinical Facilities

The dental hygiene facilities must include the following:

a) sufficient clinical facility with clinical stations for students including conveniently located areas for hand hygiene; equipment allowing display of radiographic images during dental hygiene treatment; a working space for the patient's record adjacent to units; functional equipment; an area that accommodates a full range of operator movement and opportunity for proper instructor supervision;
b) a number of clinical stations based on the number of students admitted to a class (If the number of stations is less than the number of students in the class, one clinical station is available for every student scheduled for each clinical session.);
c) a capacity of the clinic that accommodates individual student practice on a regularly scheduled basis throughout all phases of preclinical technique and clinical instruction;
d) a sterilizing area that includes space for preparing, sterilizing and storing instruments;
e) sterilizing equipment and personal protective equipment/supplies that follow current infection and hazard control protocol;
f) facilities and materials for students, faculty and staff that provide compliance with accepted infection and hazard control protocols;
g) space and furnishings for patient reception and waiting provided adjacent to the clinic;
h) patient records kept in an area assuring safety and confidentiality.

Intent:
The facilities should permit the attainment of program goals and objectives. To ensure health and safety for patients, students, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule. This Standard applies to all sites where students receive clinical instruction.

Radiography Facilities

4-2 Radiography facilities must be sufficient for student practice and the development of clinical competence.

The radiography facilities must contain the following:

a) an appropriate number of radiography exposure rooms which include: equipment for acquiring radiographic images; teaching manikin(s); and conveniently located areas for hand hygiene;
b) equipment for processing radiographic images;
c) equipment allowing display of radiographic images;
d) documentation of compliance with applicable local, state and federal regulations.

Regardless of the number of machines provided, it must be demonstrated that time is available for all students to obtain required experience with faculty supervision and that acceptable faculty teaching loads are maintained.

Intent:
The radiography facilities should allow the attainment of program goals and objectives. Radiography facilities and equipment should effectively accommodate the clinic and/or laboratory schedules, the number of students, faculty and staff, and comply with applicable regulations to ensure effective instruction in a safe environment. This Standard applies to all sites where students receive clinical instruction.

Examples of evidence to demonstrate compliance may include:
- Institutional, local, state and federal agencies related to radiation safety report(s)
- Institutional, local, state and federal quality assurance compliance report(s)

Laboratory Facilities

4-3 A multipurpose laboratory facility must be provided for effective instruction and allow for required laboratory activities. If the laboratory capacity requires that two or more sections be scheduled, time for all students to obtain required laboratory experience must be provided.

Laboratory facilities must conform to applicable local, state and federal regulations and contain the following:

a) placement and location of equipment that is conducive to efficient and safe utilization with ventilation and lighting appropriate to the procedures;
b) student work areas that are designed and equipped for students to work with necessary utilities and storage space;
c) documentation of compliance with applicable local, state and federal regulations.

Intent:
The laboratory facilities should include student work areas with equipment and space for individual student performance of laboratory procedures with instructor supervision. This Standard applies to all sites where students receive laboratory instruction.

Examples of evidence to demonstrate compliance may include:
- Institutional local, state and federal quality assurance compliance report(s)
- Air quality report(s)
- Floor plans

Extended Campus Facilities

4-4 When the institution uses an additional facility for clinical education that includes program requirements then the following conditions must be met in addition to all existing Standards:

a) a formal contract between the educational institution and the facility;
b) a contingency plan developed by the institution should the contract be terminated;
c) a location and time available for use of the facility compatible with the instructional needs of the dental hygiene program;
d) the dental hygiene program administrator retains authority and responsibility for instruction and scheduling of student assignments;
e) clinical instruction is provided and evaluated by calibrated dental hygiene program faculty;
f) all dental hygiene students receive comparable instruction in the facility;
g) the policies and procedures of the facility are compatible with the goals of the educational program.

Intent:
The purpose of extended campus agreements is to ensure that sites that are used to provide clinical education will offer an appropriate educational experience. This standard does not apply to program sites used for enrichment experiences.

Examples of evidence to demonstrate compliance may include:
- contract with extended campus facility
- formal written contingency plan
- course and faculty schedules for clinical programs
- affiliation agreements and policies/objectives for all off-campus sites
- documentation of calibration activities

Classroom Space

4-5 Classroom space which is designed and equipped for effective instruction must be provided for and readily accessible to the program.

Intent:
The classroom facilities should include an appropriate number of student work areas with equipment and space for individual student performance in a safe environment.

Office Space

4-6 Office space which allows for privacy must be provided for the program administrator and all faculty to enable the fulfillment of faculty assignments and ensure privacy for confidential matters. Student and program records must be stored to ensure confidentiality and safety.

Intent:
Office space for full- and part-time faculty should be allocated to allow for class preparation, student counseling and supportive academic activities. Faculty that share offices should have access to available privacy space for confidential matters.

Examples of evidence to demonstrate compliance may include:
- Floor plan showing room allocation
- Office space which provides privacy for the program administrator
- Office space for faculty with duties that involve administrative or didactic teaching responsibilities

Learning Resources

4-7 Instructional aids and equipment must be provided for student learning. Institutional library holdings must include or provide access to a diversified collection of current dental, dental hygiene and multidisciplinary literature and references necessary to support teaching, student learning needs, service, research and development. There must be a mechanism for program faculty to periodically review, acquire and select current titles and instructional aids.

Intent:
The acquisition of knowledge, skill and values for dental hygiene students requires the use of current instructional methods and materials to support learning needs and development. All students, including those receiving education at distance sites, will be assured access to learning resources.

Examples of evidence to demonstrate compliance may include:

- a list of references on education, medicine, dentistry, dental hygiene and the biomedical sciences
- policies and procedures related to learning resource access
- timely electronic access to a wide variety of professional scientific literature
- skeletal and anatomic models and replicas, sequential samples of laboratory procedures, slides, films, video, and other media which depict current techniques
- a wide range of printed materials and instructional aids and equipment available for utilization by students and faculty
- current and back issues of major scientific and professional journals related to dentistry and dental hygiene

Student Services

4-8 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:
All policies and procedures should protect the students as consumers and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect work accomplished and are maintained in a secure manner.

Examples of evidence to demonstrate compliance may include:

- student rights policies and procedures
- student handbook or campus catalog
- ethical standards and policies to protect students as consumers
- student records

STANDARD 5 - HEALTH AND SAFETY PROVISIONS

Infectious Disease/Radiation Management

5-1 The program must document its compliance with institutional policy and applicable regulations of local, state, and federal agencies regarding infectious diseases and radiation management.

A. Policies must include, but not be limited to:
1. **Radiation hygiene and protection,**
2. **Use of ionizing radiation,**
3. **Hazardous materials, and**
4. **Bloodborne and infectious diseases.**

B. Policies must be provided to all students, faculty, and appropriate support staff, and continuously monitored for compliance.

C. Policies on bloodborne and infectious diseases must be made available to applicants for admission and patients.

Intent:
The dental hygiene program should establish and enforce a mechanism to ensure sufficient preclinical/clinical/laboratory asepsis, infection and biohazard control and disposal of hazardous waste.

Policies and procedures on the use of ionizing radiation should include criteria for patient selection, frequency of exposing and retaking radiographs on patients, consistent with current, accepted dental practice. All radiographic exposure should be integrated with clinical patient care procedures.

Policies and procedures should be in place to provide for a safe environment for students, patients, faculty and staff. The confidentiality of information pertaining to the health status of each individual should be strictly maintained.

This Standard applies to all program sites where laboratory and clinical education is provided.

Examples of evidence to demonstrate compliance may include:
- protocols on preclinical/clinical/laboratory asepsis and infection control
- protocols on biohazard control and disposal of hazardous waste
- program policy manuals
- compliance records with applicable state and/or federal regulations
- policies and procedures on the use of ionizing radiation
- policies and procedures regarding individuals with bloodborne infectious diseases
- established post-exposure guidelines as defined by the Centers for Disease Control and Prevention

5-2 Students, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, tuberculosis, varicella and hepatitis B prior to contact with patients and/or infectious objects or materials in an effort to minimize the risk to patients and dental personnel.

Intent:
All individuals who provide patient care or have contact with patients should follow all standards of risk management thus ensuring a safe and healthy environment.

Examples of evidence to demonstrate compliance may include:
- policies and procedures regarding infectious disease immunizations
- immunization compliance records
- declinations forms

Emergency Management and Life Support Certification

5-3 The program must establish, enforce, and instruct students in preclinical/ clinical/laboratory protocols and mechanisms to ensure the management of common medical emergencies in the dental setting. These program protocols must be provided to all students, faculty and appropriate staff.

Faculty, staff and students must be prepared to assist with the management of emergencies. All students, clinical faculty and clinical support staff must be continuously recognized/certified in basic life support procedures, including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED).

Intent:
All individuals involved with patient care or have contact with patients should be trained in the recognition and management of medical emergencies and basic life support procedures.

Examples of evidence to demonstrate compliance may include:
- accessible and functional emergency equipment, including oxygen
- instructional materials
- documentation of simulation drills
- written protocol and procedures for management of medical emergencies
- emergency kit(s)
- installed and functional safety devices and equipment
- first aid kit accessible for use in managing clinic and/or laboratory accidents

- continuous recognition records of students, faculty and support staff involved in the direct provision of patient care
- exemption documentation for anyone who is medically or physically unable to perform such services

STANDARD 6 - PATIENT CARE SERVICES

6-1 The program must have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs. Patients accepted for dental hygiene care must be advised of the scope of dental hygiene care available at the dental hygiene facilities.

Intent:
All dental hygiene patients should receive appropriate care that assures their right as a patient is protected. Patients should be advised of their treatment needs and the scope of care available at the training facility and appropriately referred for procedures that cannot be provided by the program. This Standard applies to all program sites where clinical education is provided.

Examples of evidence to demonstrate compliance may include:
- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided
- quality assurance policy and procedures
- patient bill of rights

6-2 The program must have a formal written patient care quality assurance plan that allows for a continuous systematic review of patient care standards. The quality assurance plan must be applied at least annually and include:

a) standards of care that are patient-centered, focused on comprehensive care, and written in a format that facilitates assessment with measurable criteria;
b) an ongoing audit of a representative sample of patient records to assess the appropriateness, necessity and quality of the care provided;
c) mechanisms to determine the cause of treatment deficiencies;
d) patient review policies, procedure, outcomes and corrective measures.

Intent:
The program should have a system in place for continuous review of established standards of patient care. Findings should be used to modify outcomes and assessed in an on-going manner. This Standard applies to all program sites where clinical education is provided.

Examples of evidence to demonstrate compliance may include:
- evidence of chart audits
- quality assurance policy and procedures
- documentation of policies on scope of care provided, recalls and referrals
- description of the quality assurance process for the patient care program

- samples of outcomes assessment measures that assess patients' perceptions of quality of care, i.e., patient satisfaction surveys and results
- results of patient records review and documentation of corrective measures

6-3 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive dental hygiene patient care.

Intent:
The need for students to satisfactorily complete specific clinical requirements prior to advancement and graduation should not adversely affect the health and care of patients.

Examples of evidence to demonstrate compliance may include:
- patient bill of rights
- documentation that patients are informed of their rights
- continuing care (recall) referral policies and procedures

6-4 The program must develop and distribute a written statement of patients' rights to all patients, appropriate students, faculty, and staff.

Intent:
The primacy of care for the patient should be well established in the management of the program and clinical facility assuring that the rights of the patient are protected. A written statement of patient rights should include:

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

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

Intent:
The program should have a system in place to ensure patient confidentiality. All individuals who have access to patient information will ensure patient confidentiality.

Examples of evidence to demonstrate compliance may include:

- evidence of confidentiality training
- student, faculty and staff attestation to ensure patient confidentiality
- evidence of HIPAA training

Resolution No. 401 New

Report: N/A Date Submitted: May 2023

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF POLICY, COMPREHENSIVE POLICY ON DENTAL LICENSURE

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*2012:370), the Council on Dental Education and Licensure has reviewed the policy, Comprehensive Policy on Dental Licensure (*Trans.*2018:341). This policy was first adopted by the 2018 House of Delegates as the result of the Council's two-year comprehensive review of the Association's numerous policies related to dental licensure. The House of Delegates agreed with the Council's recommendation to eliminate redundancies and lengthy explanations found in 12 policy statements and adopted the new succinct yet comprehensive policy.

Monitoring the ever-changing dental licensure landscape, the Council believes that amendments to the current policy statement should be considered. Highlights include the addition of a statement urging dental boards to ensure all dental board members are free of real or perceived conflicts of interest and should not serve simultaneously as examiners with a clinical testing agency, affirmation that determination of clinical competence may include any of the listed assessment pathways, deletion of the Curriculum Integrated Format (CIF) category because non-patient examination options are now readily available, and the addition of a licensure compacts section to clearly reflect the ADA's support of compacts. Non-substantive editorial changes related to sequencing of the content and alignment with three sections of the document (General Principles, Initial Licensure and Licensure by Credentials) also are proposed.

The Council on Dental Education and Licensure recommends adoption of the following resolution.

Resolution

401. Resolved, that the ADA Policy on Comprehensive Policy on Dental Licensure (*Trans.*2018:341) be amended as follows (additions are <u>underlined</u>; deletions are ~~stricken~~):

Comprehensive Policy on Dental Licensure

General Principles

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.

- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.
- Elimination of patients in the clinical licensure examination process is strongly supported to address ethical and psychometric concerns., ~~, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (Reports 2008:103).~~ State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.
- The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.
- Dental board members who are examiners are encouraged to recuse themselves when selecting a licensing exam for their state. State dental boards are supposed to ensure that all dental board members are free of real and perceived conflicts of interest. ~~The Association believes that dental board members should not serve simultaneously as examiners with a clinical testing agency.~~
- State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.
- Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

Initial Licensure

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.
2. Successful passage of the National Board Dental Examination~~, a valid and reliable written cognitive test~~.
3. A determination of clinical competency for the beginning practitioner, which may include any of the following assessment pathways:
    - Acceptance of clinical examination results from any ~~clinical~~ testing agency that do not involve the use of single encounter procedure-based examinations involving patients; or
    - Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
    - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination that requires candidates to use critical thinking and their clinical knowledge and skills to successfully complete dental procedures; or
    - Completion of a portfolio-type examination ~~(such as employed by the California Dental Board)~~ or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess and document student

competence.~~; or~~

- ~~An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical and skills to successfully complete one or more dental problem-solving tasks~~.

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a two-year advanced dental education program in general dentistry (Advanced Education General Dentistry (AEGD) or General Practice Residency (GPR)) accredited by the Commission on Dental Accreditation. The use of the Advanced Dental Admission Test (ADAT) is encouraged to inform admission decisions to these programs.

~~**Curriculum Integrated Format Clinical Examination**~~

~~A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent "third-party" clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation.~~

~~The curriculum integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards. The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:~~

- ~~A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.~~
- ~~The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.~~
- ~~All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.~~

~~**Graduates of Non-CODA Accredited Dental Education Programs**~~

~~For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.~~

Licensure Compacts

State dental societies and dental boards should support licensure compacts to allow freedom of movement for practitioners across state lines. Licensure

compacts increase licensees' mobility, facilitate quality oral health care for the public, and support relocating challenges for military members and their families. Licensure compacts benefit licensing boards by providing agreement on uniform licensure requirements, a shared data system for access to primary source documentation of applicant credentials and tracking of adverse actions. They enhance cooperation and immediate availability of information between state boards critical to protecting the public.

Licensure by Credentials

In addition to participating in licensure compacts, ~~S~~states also should have provisions for licensure of dentists who do not participate in licensure compacts. These individuals should demonstrate they are currently licensed in good standing and ~~also~~ have not been the subject of final or pending disciplinary action in any state or jurisdiction in which they have been licensed. ~~This should also apply to experienced, internationally trained dentists, who have been licensed in a U.S. jurisdiction, and who may or may not have graduated from a CODA-accredited dental school.~~

Appropriate credentials may include:

- DDS or DMD degree from a dental education program accredited by the Commission on Dental Accreditation
- Specialty certificate/master's degree from an accredited advanced dental education program
- Specialty Board certification
- GPR/AEGD certificate from an accredited advanced dental education program
- Current, unencumbered license in good standing
- ~~Passing grade on~~ Documentation of successful completion of an initial clinical competency assessment. ~~licensure exam, unless initial license was granted via completion of PGY-1, Portfolio examination, or other state-approved pathway for assessment of clinical competency.~~
- Documentation of completion of continuing education

For dentists who hold a current, unencumbered dental license in good standing in any jurisdiction, state dental boards should:

- Not require completion of ~~Accept pathways that allow for licensure without completing~~ an additional clinical examination. ~~,e.g., by credentials, reciprocity, and/or endorsement.~~
- ~~Consider participation in licensure compacts~~
- Implement specialty licensure by credentials and/or specialty licensure to facilitate licensure portability of dental specialists.
- Make provisions available for a limited or volunteer license for dentists who wish to

provide services without compensation to critical needs populations within a state in which they are not already licensed.

- Make provisions available for limited teaching permits for faculty members, including internationally educated faculty members, at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.

- Make provisions available for federal dental services ~~active duty military~~ dentists, ~~military~~ spouses of uniformed service members and/or veterans of the federal dental services ~~armed services~~.

State dental boards are encouraged to grant the same benefits of licensure mobility to internationally educated dentists who are licensed by their respective jurisdictions.

~~**Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs**~~

~~State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)

NOTES