INFORMATIONAL REPORT ON DENTAL HYGIENE PROGRAMS ANNUAL SURVEY CURRICULUM DATA

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

The Curriculum Section of the Commission’s Annual Survey is conducted for dental hygiene education in alternate years. The most recent Curriculum Section was conducted in September/October 2019. Aggregate data of the most recent Curriculum Section for review by the Review Committee on Dental Hygiene Education is provided as an informational report in Appendix 1.

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

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

Prepared by: Ms. Michelle Smith
### Q53. Clock hours for all dental hygiene content areas

#### Didactic instruction clock hours

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</tr>
<tr>
<td>v. Application of anticariogenic agents</td>
<td>98.8% 324</td>
<td>1.2% 4</td>
<td>328</td>
<td></td>
</tr>
<tr>
<td>w. Polish restorations</td>
<td>78.7% 258</td>
<td>21.3% 70</td>
<td>328</td>
<td></td>
</tr>
<tr>
<td>x. Pit and fissure sealants</td>
<td>100.0% 328</td>
<td>0.0% 0</td>
<td>328</td>
<td></td>
</tr>
<tr>
<td>y. Application of topical anesthetic agents</td>
<td>100.0% 328</td>
<td>0.0% 0</td>
<td>328</td>
<td></td>
</tr>
<tr>
<td>z. Administration of local anesthetic: infiltration</td>
<td>83.8% 275</td>
<td>16.2% 53</td>
<td>328</td>
<td></td>
</tr>
</tbody>
</table>
### Q55. Are students taught to perform the service?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>aa. Administration of local anesthetic: block</td>
<td>80.8%</td>
<td>19.2%</td>
<td>63</td>
</tr>
<tr>
<td>bb. Administration of nitrous oxide/analgesia</td>
<td>72.6%</td>
<td>27.4%</td>
<td>90</td>
</tr>
<tr>
<td>cc. Monitoring of nitrous oxide/analgesia</td>
<td>83.2%</td>
<td>16.8%</td>
<td>55</td>
</tr>
<tr>
<td>dd. Periodontal and surgical dressing: place</td>
<td>80.5%</td>
<td>19.5%</td>
<td>64</td>
</tr>
<tr>
<td>ee. Periodontal and surgical dressing: remove</td>
<td>79.9%</td>
<td>20.1%</td>
<td>66</td>
</tr>
<tr>
<td>ff. Suture: place</td>
<td>46.0%</td>
<td>54.0%</td>
<td>177</td>
</tr>
<tr>
<td>gg. Suture: remove</td>
<td>77.4%</td>
<td>22.6%</td>
<td>74</td>
</tr>
<tr>
<td>hh. Closed soft tissue curettage</td>
<td>44.5%</td>
<td>55.5%</td>
<td>182</td>
</tr>
<tr>
<td>ii. Rubber dams: place</td>
<td>75.3%</td>
<td>24.7%</td>
<td>81</td>
</tr>
<tr>
<td>jj. Rubber dams: remove</td>
<td>75.6%</td>
<td>24.4%</td>
<td>80</td>
</tr>
<tr>
<td>kk. Matrices: place</td>
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<td>30.8%</td>
<td>101</td>
</tr>
<tr>
<td>ll. Matrices: remove</td>
<td>69.2%</td>
<td>30.8%</td>
<td>101</td>
</tr>
<tr>
<td>mm. Temporary restorations: place</td>
<td>71.3%</td>
<td>28.7%</td>
<td>94</td>
</tr>
<tr>
<td>nn. Temporary restorations: remove</td>
<td>55.5%</td>
<td>44.5%</td>
<td>146</td>
</tr>
<tr>
<td>oo. Amalgam restorations: place</td>
<td>50.0%</td>
<td>50.0%</td>
<td>164</td>
</tr>
<tr>
<td>pp. Amalgam restorations: carve</td>
<td>49.4%</td>
<td>50.6%</td>
<td>166</td>
</tr>
<tr>
<td>qq. Amalgam restorations: finish</td>
<td>53.7%</td>
<td>46.3%</td>
<td>152</td>
</tr>
<tr>
<td>rr. Composite resin restorations: place</td>
<td>47.0%</td>
<td>53.0%</td>
<td>174</td>
</tr>
<tr>
<td>ss. Composite resin restorations: finish</td>
<td>49.4%</td>
<td>50.6%</td>
<td>166</td>
</tr>
<tr>
<td>tt. Application of cavity liners and bases</td>
<td>59.5%</td>
<td>40.5%</td>
<td>133</td>
</tr>
<tr>
<td>uu. Removal of excess restorative materials</td>
<td>60.4%</td>
<td>39.6%</td>
<td>130</td>
</tr>
<tr>
<td>Q55. If yes, are students taught to clinical competence?</td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>a. Clinical infection control procedures</td>
<td>99.4%</td>
<td>0.6%</td>
<td>2</td>
</tr>
<tr>
<td>b. Medical and dental histories</td>
<td>99.4%</td>
<td>0.6%</td>
<td>2</td>
</tr>
<tr>
<td>c. Vital signs</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>d. Intraoral inspection (including charting carious lesions, periodontal diseases, existing and missing teeth)</td>
<td>99.4%</td>
<td>0.6%</td>
<td>2</td>
</tr>
<tr>
<td>e. Extraoral inspection</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>f. Dental hygiene assessment/dental hygiene treatment planning</td>
<td>99.7%</td>
<td>0.3%</td>
<td>1</td>
</tr>
<tr>
<td>g. Evaluation of dental hygiene services</td>
<td>99.4%</td>
<td>0.6%</td>
<td>2</td>
</tr>
<tr>
<td>h. Radiographs</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>i. Indices</td>
<td>97.5%</td>
<td>2.5%</td>
<td>8</td>
</tr>
<tr>
<td>j. Risk management (i.e., tobacco, systemic, caries)</td>
<td>98.2%</td>
<td>1.8%</td>
<td>6</td>
</tr>
<tr>
<td>k. Impressions for study casts</td>
<td>89.1%</td>
<td>10.9%</td>
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<tr>
<td>l. Occlusal registration for mounting study casts</td>
<td>67.8%</td>
<td>32.2%</td>
<td>79</td>
</tr>
<tr>
<td>m. Pulp vitality testing</td>
<td>24.9%</td>
<td>75.1%</td>
<td>148</td>
</tr>
<tr>
<td>n. Oral health education including health promotion, disease prevention and behavior modification</td>
<td>99.1%</td>
<td>0.9%</td>
<td>3</td>
</tr>
<tr>
<td>o. Clean removable appliances and prostheses</td>
<td>92.3%</td>
<td>7.7%</td>
<td>25</td>
</tr>
<tr>
<td>p. Nutritional counseling</td>
<td>96.9%</td>
<td>3.1%</td>
<td>10</td>
</tr>
<tr>
<td>q. Supragingival scaling</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>r. Subgingival scaling</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>s. Root planing</td>
<td>97.8%</td>
<td>2.2%</td>
<td>7</td>
</tr>
<tr>
<td>t. Coronal polishing</td>
<td>99.7%</td>
<td>0.3%</td>
<td>1</td>
</tr>
<tr>
<td>u. Application of chemotherapeutic agents</td>
<td>95.3%</td>
<td>4.7%</td>
<td>15</td>
</tr>
<tr>
<td>v. Application of anticariogenic agents</td>
<td>98.1%</td>
<td>1.9%</td>
<td>6</td>
</tr>
<tr>
<td>w. Polish restorations</td>
<td>59.0%</td>
<td>41.0%</td>
<td>105</td>
</tr>
<tr>
<td>x. Pit and fissure sealants</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>y. Application of topical anesthetic agents</td>
<td>96.3%</td>
<td>3.7%</td>
<td>12</td>
</tr>
<tr>
<td>z. Administration of local anesthetic: infiltration</td>
<td>95.2%</td>
<td>4.8%</td>
<td>13</td>
</tr>
<tr>
<td>Q55. If yes, are students taught to clinical competence?</td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>aa. Administration of local anesthetic: block</td>
<td>94.7%</td>
<td>5.3%</td>
<td>14</td>
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<tr>
<td>bb. Administration of nitrous oxide/analgesia</td>
<td>79.1%</td>
<td>20.9%</td>
<td>49</td>
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<tr>
<td>cc. Monitoring of nitrous oxide/analgesia</td>
<td>75.2%</td>
<td>24.8%</td>
<td>67</td>
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<tr>
<td>dd. Periodontal and surgical dressing: place</td>
<td>27.0%</td>
<td>73.0%</td>
<td>192</td>
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<tr>
<td>ee. Periodontal and surgical dressing: remove</td>
<td>26.9%</td>
<td>73.1%</td>
<td>190</td>
</tr>
<tr>
<td>ff. Suture: place</td>
<td>9.9%</td>
<td>90.1%</td>
<td>136</td>
</tr>
<tr>
<td>gg. Suture: remove</td>
<td>20.2%</td>
<td>79.8%</td>
<td>202</td>
</tr>
<tr>
<td>hh. Closed soft tissue curettage</td>
<td>45.2%</td>
<td>54.8%</td>
<td>80</td>
</tr>
<tr>
<td>ii. Rubber dams: place</td>
<td>32.8%</td>
<td>67.2%</td>
<td>166</td>
</tr>
<tr>
<td>jj. Rubber dams: remove</td>
<td>33.6%</td>
<td>66.4%</td>
<td>164</td>
</tr>
<tr>
<td>kk. Matrices: place</td>
<td>27.8%</td>
<td>72.2%</td>
<td>164</td>
</tr>
<tr>
<td>ll. Matrices: remove</td>
<td>27.6%</td>
<td>72.4%</td>
<td>163</td>
</tr>
<tr>
<td>mm. Temporary restorations: place</td>
<td>21.8%</td>
<td>78.2%</td>
<td>183</td>
</tr>
<tr>
<td>nn. Temporary restorations: remove</td>
<td>16.5%</td>
<td>83.5%</td>
<td>152</td>
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<tr>
<td>oo. Amalgam restorations: place</td>
<td>22.0%</td>
<td>78.0%</td>
<td>128</td>
</tr>
<tr>
<td>pp. Amalgam restorations: carve</td>
<td>21.6%</td>
<td>78.4%</td>
<td>127</td>
</tr>
<tr>
<td>qq. Amalgam restorations: finish</td>
<td>25.6%</td>
<td>74.4%</td>
<td>131</td>
</tr>
<tr>
<td>rr. Composite resin restorations: place</td>
<td>22.7%</td>
<td>77.3%</td>
<td>119</td>
</tr>
<tr>
<td>ss. Composite resin restorations: finish</td>
<td>23.5%</td>
<td>76.5%</td>
<td>124</td>
</tr>
<tr>
<td>tt. Application of cavity liners and bases</td>
<td>18.2%</td>
<td>81.8%</td>
<td>157</td>
</tr>
<tr>
<td>uu. Removal of excess restorative materials</td>
<td>28.2%</td>
<td>71.8%</td>
<td>140</td>
</tr>
</tbody>
</table>
APPENDIX – Responses to open-ended questions

Q53. Other content areas specified:
ADHA Prof, Ethics
 Adjunctive periodontal therapies
 Adv Topics
 Advanced Clinical Practice
 Advanced Dental Hygiene Theory for the Special Needs Patient
 Advanced Technology
 Advanced Topics in Dental Hygiene
 American Diversity
 Analysis of Dental Literature
 Analysis of Literature
 Applied Com Dentistry
 Basic Instrumentation
 Beginning Algebra
 Behavioral Foundations (2)
 Bioethics
 Biostatistices/Statistics
 Biostatistics
 Board Exam Prep
 Board Review (3)
 Body Ergonomics
 Business Practice
 Capstone Leadership
 Capstone Methods
 Capstone Seminar I
 Career Development (2)
 Career Exploration
 Career/Life Planning
 Cariology (5)
 Case Studies (2)
 case studies/pulp vitality/lasers
 Child,Elder,Domestic Abuse
 Clinic
 Clinical assessment
 Clinical Externship
 Clinical Teaching Methods
 College Algebra
 College Math
 College Transfer Success
 community clinic experience
 Comp Case Studies
 Computer Technology (2)
 Contemporary Healthcare Issues
 Contemporary Issues in Dental Hygiene
 Critical thinking (3)
 Cultural Competence (3)
 Cultural diversity (6)
 Cultural Diversity in Dental Hygiene
Q53. Other content areas specified:
Cultural Perspective in Health and Healing
Current Issues
Current Issues in Dental Hygiene
Dental Health Educ.
Dental Health Safety
Dental Hygiene Practice
Dental Hygiene Pre-Clinical Science
Dental Hygiene Review
Dental Hygiene Topics
Dental Implants
dental literature
Dental Materials
Dental Office Management
Dental Office Practice
Dental Public Health
Dental research
Dental Specialties (11)
Dental Team Communication
DH Pre-Clinical Techniques
DH Seminar
DH Theory I
DH Theory II
Didactic Teaching Methods
Documentation
DXTR Radiographs, intraoral photography/practicum
EBDH in Healthcare
Educational Concepts
Educational Methodology
Educational Program Development (2)
Educational Theories in Dental Hygiene
ELECTIVE
electronic portfolio
Elements of Research
endodontics
Ergonomics (2)
Ethics (2)
Ethics and Jurisprudence
Ethics and Law
Ethics, Jurisprudence, and DH Practice (3)
Ethics-law
Evidence Based (2)
Evidence Based DH Care
Evidence Based Practice
Evidence-Based Dental Hygiene
Evidenced-based Decision Making
Expanded Duties / Functions (11)
Extramural Service Learning
fluoride varnish/service learning
Forensics (2)
Q53. Other content areas specified:
- Foundations of Inter-professional Practice
- Foundations of Physiology, Pathophysiology and Pharmacology
- General Biology
- Geriatric Dentistry
- guest lecturers
- Head and Neck Anatomy (2)
- Health Care Management (2)
- Health Promotions Through the Lifespan
- Healthcare Ethics
- HIPAA (2)
- History Am. Govt
- Humanities (10)
- Implantology
- Independent Study In Dental Hygiene
- Informatics
- Instructional Methods
- Instrumentation
- Interprofessional collaboration (2)
- Inter-Professional Collaborative Practice Field Experience
- Interprofessional Education (2)
- Interviewing Techniques
- Intraoral Photography
- Intraprofessional Edu
- INTRO TO COMPUTERS
- Intro to Dentistry
- Intro to Healthcare
- Introd. to Dentistry
- Introduction to Dental Hygiene
- Introduction to Research Methods
- IPE
- Lasers
- Leadership
- Leadership and Group Dynamics
- Leadership and Professional Development (2)
- Leadership in Administration
- Leadership in Dental Hygiene
- Licensing Board Preparation
- Local Anesthesia
- Local Anesthesia & Pain Control
- Management/Marketing
- Math of Business
- Math/Algebra
- Mathematics (6)
- Medical Terminology
- Microcomputer Concepts
- National Board and Case Review
- National Board Review
- NDHBE Review
- Nitrous Oxide (2)
Q53. Other content areas specified:
Nitrous Oxide Administration
Nitrous Oxide Analgesia
Nitrous Oxide Monitoring
Non-surgical lasers
Occlusion, dental forensics
Office Management (2)
Office Management for the Dental Hygienist
Office Procedures/Practice Management, HIPAA modules
Oral Embryology and Histology
Oral Health Research
Oral Hist/Embryology
Oral Histology
oral maxillofacial
Organic Chemistry
ORIENTATION
Orthodontics
Patient records/EHR procedures
Pediatric Dentistry
Pediatric Dentistry & Orthodontics
Peodontics
Philosophy
Philosophy (ethics)
Placement of Sealants
Placing, carving, and finishing restorations
portfolio capstone
Pract Mgmt
Practice Administration
Practice and Financial Management
Practice Management (14)
Practice Management Technical Math
Practice Mgmt (2)
Practicum
practicum electives
Preclinic
pre-clinical dental hygiene
Preclinical Instruction
Preclinical Theory
Pre-preclinical
Principles of Dental Hygiene
Principles of Practice
Process of Care I
Process of Care II
Process of Care III
Prof Development
Professional Dental Hygiene
Professional development
Professional Development (3)
Professional Issues (4)
PRofessionalism & cultural competency
Q53. Other content areas specified:
- Prosthodontics
- Provision of Amalgam Restorations
- Provision of Composite Restorations
- Public Health Electives (2)
- Quantitative Analysis
- Religion
- Remedial tasks
- Remote Supervision
- Research (9)
  - Research & Study Skills - 12 hrs.; Professional Seminars - 14.5 hrs.
  - Research analysis and writing
  - Research design
  - Research in Dental Hygiene
  - Research Methodologies (13)
  - Research, EBDH
  - Research, Evidence-Based Decision Making (3)
  - Research/evidence
  - Research/statistics
- Restorative Dentistry (9)
- Restorative Lab I
- Restorative Lab II
- Resume Writing
- Resume Writing & Interviewing
- Review of Dental Hygiene
- Review of dental hygiene
- Rubber Dam, Matrix, and Base and liner placement
- Scientific Comm
- Scientific Methods (2)
- Senior Hygiene Seminar
- Skills for Pt & Fam-Cntr Care
- Smoking Cessation
- Spanish for DH
- Statistics (6)
- Statistics and Research
- Statistics I
- Substance Abuse
  - technology/documentation/discussion board
- Testing and Board Review
- Transition to the Dental Profession
- Treatment and Evaluation in Dental Hygiene
- Trends and Issues in DH
- Upper division GE (2)
- Writing for Healthcare Professional
- Written Communication
#53i. and j. Microbiology and Immunology are taught together so I took the total number of lecture hours (45) and the total number of lab hours (30) and divided them between the two fields. #53 k. and r. General and oral/maxillofacial pathophysiology are taught together, hence I did the same thing, i.e. divided the total number in half.

1. ‘e’ (Anatomy) and f. (Physiology) are combined into one course in two parts (I and II). 2. ‘g’ (Chemistry) and h. (Biochemistry) are combined into one course. 3. ‘j’ (Immunology), k. (General and/or pathophysiology), l’ (Head, neck and oral anatomy) and ‘m’ (Oral embryology and histology) are part of the Phase II curriculum. 4. ‘n’ (Legal and ethical aspects of dental hygiene). The program does not have an Ethics and Jurisprudence course, however, legal and ethical aspects of dental hygiene are taught in all Phase II courses/labs.

53a. Note: 9 cr Written Communications taken as prerequisite b. an additional 3 cr Speech course is taken as a prerequisite; only documented 1 credit Oral Health Literacy and Communication course taken in DH program c. and 3 cr Psychology and cr Sociology taken as prerequisite. e, f, g, h, i and j. 8 cr Anatomy & Physiology with labs, 4 cr General or Inorganic Chemistry with lab, 4 cr. Organic & Biochemistry with lab, and 4 credits General Microbiology and Immunology with lab taken as prerequisites before entering DH program.

53a. Note: 9 cr Written Communications taken as prerequisite b. an additional 3 cr Speech course is taken as a prerequisite; only documented 1 credit Oral Health Literacy and Communication course taken in DH program c. and 3 cr Psychology and cr Sociology taken as prerequisite. e, f, g, h, i and j. 8 cr Anatomy & Physiology with labs, 4 cr General or Inorganic Chemistry with lab, 4 cr. Organic & Biochemistry with lab, and 4 credits General Microbiology and Immunology with lab taken as prerequisites before entering DH program.

53a-j. These courses are pre-requisites at [local college]. 53k. General and oral pathology are taught together as a core Dental Hygiene course. 53l. Includes 30 hours of Head and Neck Anatomy (DH 1330) and 15 hours of Dental Anatomy (DH 1340).

a) Written communication (i.e., English), e) anatomy, f) physiology, and i) microbiology are required prerequisites. Per instructions, required prerequisite courses were not included.

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

a.-d. are general education courses. e.-i. are covered in the pre-requisite courses.

After accreditation we added 3 hours of biochemistry to Pharmacology with 3 additional student learning outcomes.

A-K are included as prerequisites and total 345 didactic instruction hrs approx.
Question 53, items a – n comments

Anatomy and Physiology are not separate courses. It is reported in the Anatomy section 53-e. Oral embryology and histology is taught with head, neck and oral anatomy. These are not separate courses. Reported in 53-l.

Anatomy and Physiology are one course. There is Anatomy and Physiology I and II with laboratories. Head and Neck Anatomy is one course and Oral anatomy is a separate course. Legal and ethical aspect of dental hygiene is part of Dental Hygiene Theory I, Techniques in Pain Control, and Dental Hygiene Theory II, Dental Hygiene Theory III, Dental Hygiene Theory IV.

Anatomy and Physiology is a combined course, Psychology has two different courses, Immunology and General Pathology are combined into one course. I tried to separate the timeout for each topic listed

Anatomy and Physiology is taught in one course. Biochemistry is taught in Chemistry and Nutrition. Immunology is taught in Oral Histology and Embryology, Periodontology and Oral Pathology.

Biochemistry material is covered in the Nutrition course summer (7 week) term.

c.-g. = pre-requisite courses

Calculated using ICCB rules: Theory: 1 credit for every 15 clock hours.
Lab: 1 credit for every 30 clock hours Biochemistry is embedded in CHM 110 and in Nutrition courses

Calculation of clock hours is based on a 15 week semester. Although semesters are 16 weeks, students have a one week break in the fall and spring semesters.

Certain courses do not require labs.

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

Chemistry is a prerequisite course- 60 didactic clock hours, and 30 lab clock hours are required prior to entering the dental hygiene program.

Chemistry, Microbiology & Anatomy & Physiology-I are pre-requisites

Courses with no didactic instruction are prerequisites for the dental hygiene program.

G & H CHM1032 is 48 hours and includes 16 hours of biochemistry N --DEA1003 18 hours and DEH2804-2

Head and Neck Anatomy is taught with Oral Embryology and Histology with 27 clock hours of lecture and 27 clock hours of lab, split between I and m in reporting. The Oral Communications listed is a Communications course for Dental Hygienists separate from a prerequisite that we also require.
Question 53, items a – n comments

Head and Neck is one course of 3 CR hours and Dental Anatomy is a separate course at 2CR hours. Legal and ethical aspects of dental hygiene is embedded within the curriculum but most widely discussed during the senior year during principles of practice.

Historically, the didactic instruction and laboratory instruction clock hours for this section were misreported as they included prerequisite course instruction. These numbers were reviewed and revised to accurately reflect the number of didactic instruction and laboratory instruction clock hours for our accredited dental hygiene program only.

Immunology is covered in "k" General Pathology/Oral Pathology- 65 clock hours of instruction.

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

Immunology: 10 hours are taught in Periodontology General and/or pathophysiology: 10 hours are taught in Oral and General Pathology A 1:20 ratio is used for laboratory portions of courses in which there is a computer lab/virtual lab

Legal and ethical aspects of dental hygiene is covered in many courses (DHYGN 230-232 Clinic I-III, DHYGN 246 Transitions, DHYGN 226 Local Anesthetic)

letters a - i are program pre-requisites

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

M. Oral embryology and histology are taught in the developmental dentistry course. N. Legal and ethical aspects of dental hygiene are combined and taught in the Dental Hygiene Clinic IV seminar course.

Many of the content areas above are taught within our pre-requisite requirements.

Many of the courses in the dental hygiene program at Hocking College are in a combined course format and will have didactic and clinical according to the scheduled course and the amount of information in each course that is taught for each subject.

Microbiology and Anatomy and Physiology are pre-requisites to the dental hygiene program. Humanities elective is required by the college for graduation and is not listed here.

n. Legal and ethical aspects of dental hygiene is covered throughout our curriculum within several courses (didactic and clinical).

oral communication, psychology, sociology, anatomy, physiology, chemistry, microbiology, immunology are all pre-requisite courses for the program.

Our Microbiology course covers immunology and biochemistry within the 45 hour course. General and/or pathophysiology is covered in Oral Pathology class, which is 45 hours.

Preclinic lab has a ratio of 1:4.8 Radiography lab has a ratio of 1:4 Dental materia lab has a ratio of 1:6

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

Psychology and sociology are combined into 1, 48 clock hour course "Social Psychology"

Since the last survey involving curriculum, some courses that were prerequisite courses are now co-requisite courses. The curriculum has remained the same except for the change of math courses which was reported to CODA.

Students are required to take pre-requisite courses BIO 199 Anatomy and Physiology I (45 hrs didactic, 30 hours lab 1:15 lab faculty/student ratio) and BIO 204 Anatomy and Physiology II (45 hrs didactic, 30 hours lab 1:15 lab faculty/student ratio)

The courses that are marked as NA, are all prerequisite courses for this program.

The dental hygiene program requires a college level chemistry course as a prerequisite to entering the dental hygiene program.

The Ethics course is 16 clock hours of instruction. The other 32 hours are cases, resume review, coding, interviewing techniques and licensing applications.

The majority of the courses listed above are prerequisite courses; therefore didactic instruction hours not included.

The reported ratios for the lab hours are an educated guess.

There are no assigned clinical hours to pathology or h/n anatomy, however we do require application of subject knowledge during our clinical session.

This does not account for the skills learned and reinforced through direct patient treatment.

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

This question is a bit confusing, we did our best to understand what is being asked.

Written and oral communications are a small component of many courses within the curriculum. Student's orally present the following items to the peers/faculty while in the program: perio presentation, pico question presentation, storyboard presentation, behavior modification presentation, dental anomaly presentation, oral path presentation, motivational interviewing videos, mind map presentation. Written communication occurs in the form of journals, discussion groups via CANVAS and papers. In addition, there are pre-reqs that focus particularly on those two skills.
Written and oral communications are both covered within one course, CCM 145. Anatomy and physiology are covered within one course, BIO 115. Chemistry and Biochemistry are covered within one course, CHM 125. Microbiology and Immunology are covered within one course, BIO 145. Oral embryology and histology is covered within RDH 186 along with tooth morphology. General and/or pathophysiology is covered within RDH 220 along with oral and maxillofacial pathology. Legal and ethical aspects are covered in RDH 291 as well as various other courses.

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

Written communications, psychology, sociology, anatomy, physiology, chemistry and microbiology are required prerequisites.
**Question 53, items o – jj and Question 54 comments**

#53 cc. and dd. the answers to these questions are estimates re: the total amount of formal instruction in these topic areas. In reality, infection & hazard control management and oral health services to patients with bloodborne infectious diseases are taught starting in pre-clinic and then instruction continues throughout the rest of the clinical program.

#54. 3rd year: Clinical Term 1=200, Clinical Term 2=200

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

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

1st Year: Term 1 Fall Semester; Term 2 Winter Intersession; Term 3 Spring Semester; Term 4 Summer Session 2nd Year: Term 1 Fall Semester, Term 2 Winter Intersession; Term 3 Spring Semester

2ND YEAR TERM 1 IS SUMMER SEMESTER

53 aa. The community class field experiences allow for a group of students to work with a site manager at a 1:5 ratio.

53 ee DHYGN 132 - lectures and labs for instrumentation 117 Specialties lec 53 ff DHYGN 131 - Theory 53 gg. Includes lectures associated with clinical content 222 Preventive 228 New Dimensions 54 B Term 3 1st year clinical is summer semester

53. bb., cc., dd., are combined into a dental health safety class listed under ee.

53 u. clinical instruction for pain management utilizes student partners

53A-K. many of those courses are specific pre-reqs. Any hours noted are those topics covered within the DH curriculum 530-dd. Topics will continue to be covered in the clinical portion even after didactic instruction has been completed.

53a-k. Many of those courses are specific pre-reqs. Any hours noted are those topics covered within the DH curriculum 53o-dd. Topics will continue to be covered in the clinical portion even after didactic instruction has been completed.

53cc & dd: areas addressed in PreClinic Techniques and Annual Compliance/Safety Training (Mandatory)

53o. Note: 3 credits Nutrition prerequisite required before entering program is an additional 45 clock hours not tallied in o. w. Oral Health Literacy in addition to didactic and clinical applications applied aa. 2 Community Oral Health Service-Learning courses at 3 credits each (135 total hours of service-learning) plus the didactic Community Oral Health course were tallied together since the didactic and 2 service-learning course complement each other. O. 3 credits (45 hrs) Nutrition prerequisite was not tallied

53O. Note: 3 credits Nutrition prerequisite required before entering program is an additional 45 clock hours not tallied in O w. Oral Health Literacy in addition to didactic and clinical applications applied aa.
Question 53, items o – jj and Question 54 comments

2 Community Oral Health Service-Learning courses at 3 credits each (135 total hours of service-learning) plus the didactic Community Oral Health course were tallied together since the didactic and 2 service-learning course complement each other. O. 3 credits (45 hrs) Nutrition prerequisite was not tallied.

53o. Nutrition is a pre-requisite course. 53q. Tooth morphology is taught in DH 1340 Dental Anatomy for 15 hours; 5 hours are spent on this subject in DH 2450 Periodontology. 53r. General and oral pathology are taught together as a Dental Hygiene core course. 54c. Includes minor activity enrichment rotation sites.

53y-lab hours based on Pre-Clinic lab instructional clock hours of 6 hours for 15 weeks & clinical lab instructional clock hours are based on 15 weeks. All other course clock hours are based on 16 weeks (students attend for 16 weeks). 54-Clock hours are based on 15 weeks.

54. In addition, winter and summer sessions are offered for the students interested in the extra clinical hours. For 1st year pre-clinical 54 hours, 2nd year clinical, 108 hours.

54. Term 2 is summer of the first year. An omission in last year’s survey was an error in not including the 64 hours for Term 2 (this is not an increase in hours). 53v. CODA approved the increase in hours for Dental Materials on 3/4/2019.

54: There are five semesters in our program

54b. Term 2 is an 8 week summer session. 54c. Term 1- Fall, Term 2-Spring, Term 3- Summer, Term 4- Fall

All numbers were reviewed and revised for our program to more accurately estimate didactic, laboratory, and clinical instruction for all categories presented.

Answers to question 53 are for the entire program clock hours.

Clarification and correction of error from previous survey 53.v. dental materials is a 1:10 ratio y. Clinical is 1:5 ratio. Clinic hours do not include preclinic hours Restorative labs and restorative clinic are separated out separately for sections gg, hh, ii. Question 54. 2nd year clinical term 3 includes restorative clinic as well as hygiene clinic as in previous survey. Restorative clinic is 60 and hygiene is 180, total is noted.

Clinic rotations for 2nd year are scheduled over the entire year and are individual specific per semester. The average total is divided by 2.

Community Dental Health (aa) was increased from 41 to 48 hours to include instruction in biostatistics and epidemiology

DHG 104 30 hrs/ DHG 105 30 hrs/ DHG 191 60 hrs/ DHG 192 60 hrs/ DHG 193 60 hrs/ DHG 194 60 hrs/ DHG 195 60 hrs/ DHG 196 60 hrs/ DHG 291 60 hrs/ DHG 292 84 hrs/ DHG 293 60 hrs/ DHG 294 84 hrs/ DHG 295 60 hrs/ DHG 296 84 hrs

Did our best to understand the question.

Faculty student ratio in clinic is 1:4.7
Question 53, items o – jj and Question 54 comments

ff: Extramural rotations have a maximum 1:5 ratio. o. through dd., except "y" are integrated within "y" clinic and applied throughout patient care.

First year term 1 - 12 hours per week rotating through simulation and patient experience. First year term 2 - 8 hours per week with patient care. Second year term 1 - 12 hours per week patient care. Second year term 2 - 14 hours per week patient care. DEN 100 - Introduction to Dental Hygiene is a new course designed to introduce students to the Dental Hygiene Profession.

I took each TCSG standard for time allotment for each course. Many of our scheduled courses incorporate more contact time due to student needs.

In addition, DHY 208, 8 hours per week x 6 weeks = 48 during Summer Session

It is difficult to tally the time students may spend on some of the items in clinic as they are done as needed for patient care, so not all items above show clinical instruction (ie Radiology). The time in Clinical Dental Hygiene incorporates several of the other topic areas.

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

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

Lecture is not included in the above hours for the Preclinic and Clinical courses. They each have 32 additional hours at 2 hours per week except for Process 4 final term of Clinic

Medical Emergencies is 15 hours, BLS is taught outside of the course in an 8 hour class.

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

Nutrition is taught in the course entitled Dietary Analysis for the Dental Hygienist/ Seminar I, II & III. There are three 1.5 credit hour courses that meet Summer of the 1st year and Spring & Fall of the 2nd year.

o. DH212 Nutrition: 3 hours of clinical instruction constitutes chairside nutritional counseling in three parts and is taught to clinical competency. t. Periodontology is taught in DH225 Clinic II and Periodontology Seminar (30 hours), and in DH235 Clinic III and Advanced Periodontology Seminar (30 hours). Periodontology is also covered at the introductory level in class and clinic in LS194 Microbiology. X. Patient Management is introduced in DH100 - Introduction to Dental Hygiene through the ADPIED method of the Process of Care, put into practice in DH105 - Preclinic and Infection Control and refined in all clinics: DH215 Clinic I, DH225 Clinic II, DH235 Clinic III. Z. Provision of services for and management of patients with special needs: 3 hours in DH100 Introduction to Dental Hygiene, 3
Question 53, items o – jj and Question 54 comments

- Hours in DH215 Seminar, 3 hours in DH240 Oral Health Education and Promotion. Students are also required to work with 3 special needs patients in clinic, equalling 12 hours of clinic time.

- bb. Medical Emergencies: Students take DH102 Medical Emergencies as a stand-alone course. Additionally, students are trained in CPR and Basic Life Support on-site upon matriculation (6 hours).

- cc. Infection and hazard control management: Didactic instruction takes place in the following courses: 1 hour is taught in DH100 Introduction to Dental Hygiene at an introductory level, 18 hours are taught in DH105 Preclinic and Infection Control. Infection Control measures are taught to competency and practiced in DH105 lab. Every patient encounter in all clinics are taught to competency and graded.

- dd. Provision of oral health services to patients with bloodborne infectious diseases: Didactic instruction is handled in the following courses: 6 hours in DH210 General, Oral, and Maxillofacial Pathology, 3 hours in LS194 Microbiology, and 2 hours in Periodontology. Students are introduced to infection control procedures in LS197 Microbiology lab (6 hours), and infection control procedures are taught to clinical competency in DH215 Clinic I.

- One semester of pre-clinical and three semesters of clinical.

- o-Nutrition is a required prerequisite (not included per instructions). Students also receive approximately 12 didactic hours on nutrition and oral health in Preventive Dentistry.

- q- Tooth morphology was included in head, neck and oral anatomy (l) on the previous page.

- y- Total clinical instruction hours = 656. Per instructions, clinical instruction hours on specific content hours where students were evaluated (formative or summative) were deducted from the total clinical dental hygiene hours (656-216 = 656).

- Oral embryology and histology is covered within RDH 186 along with tooth morphology. General and/or pathophysiology is covered within RDH 220 along with oral and maxillofacial pathology. Cariology is covered within RDH 209 with Nutrition. Preclinical course occurs in semester 2; clinic I in semester 3; clinic II in semester 4 (technically, 2nd year); clinic III in semester 5; and clinic IV in semester 6. All in all, there are 720 clinical hours.

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

- Our seminars are divided into 8 week terms.

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

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

- Patient management is introduced in DH10/100.1, Introduction to Clinical Dental Hygiene and reinforced in DH 20.1 Clinical Dental Hygiene Seminar, DH 30 and DH 40 Advanced Clinical Dental Hygiene Seminar. In the laboratory component of DH 100.1, instructor ratios are 1:5 as students are supervised reviewing health histories and risk factors. Medical Emergencies, Infection control, and blood borne infectious diseases are also covered in these courses.
Question 53, items o – jj and Question 54 comments

Patient management, Provision of services for special needs patients, medical emergencies, infection control, and hazard management, and provision of services to patients with bloodborne diseases are all covered in other courses.

Please note: numbers of clock hours reported are different than in past reporting years due to now only reporting pre-clinical and clinical hours in specific content areas in the clinical practice section unless those hours were not reflected as part of clinical practice already.

Pre-clinic = 7 hrs x 16 weeks = 112 1st yr. clinic /Term 2 = 9 hrs. x 16 weeks = 144 Term 3 (summer session) = 12 hrs x 5 weeks = 60 2nd yr. clinic = 12 hrs. x 16 weeks = 192

Program consists of fall, spring, summer, fall, and spring terms

Program sessions are semesters. Semesters 1-3 are considered first year which is inclusive of preclinical and 1st year clinic for a total of 210 clinic hours within the first year. Semester 4-6 are considered second year for a total of 510 clinic hours within the second year.

Question 53x and 53y - Clinical dental hygiene hours are combined with patient management. Hence the bulk of the hours are listed under clinical dental hygiene. Question 54. First year clinical Term 3 is our summer semester of 7 weeks.

RE: 54.b- Term 2 is the 6 weeks summer program. 7.5 clinical hrs/week=45 student contact hrs.

s. Radiology didactic 1:18 but lab is split into two groups with faculty ratio 4:10 and 4:8 v. Dental Materials faculty ratio 2:9 class of 18 split into two groups

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

Second year clinical dental hygiene includes an 8 week summer semester (96 hours) Fall and Spring semester each 16 weeks for a total of 384 hours.

Some content is covered in multiple courses and all content reinforced during clinical activities.

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

Students enrolled in the Community Dental Health take part in 12 hours of Service Learning. Clinical courses: 6 hours pre-clinic, 8 hours 2nd clinic, 12 hours 3rd and 4th clinics. Certain courses do not require labs. For clinical courses 2nd, 3rd, and 4th semesters-ratios have been 1:3 clinical instructors to compensate for implementation of TalEval grade system.

Term 1 is fall semester. Term 2 is spring semester. Term three is summer semester.

Term 3 = Eight Week Summer Session
Question 53, items o – jj and Question 54 comments

Term 3 in Question 54 is the Summer semester.

Term 3 in the chart above refers to the summer session between first and second year.

Term 3 would be students repeating a clinical course.

Term III is transitional clinic, officially listed as Fall1 but occurs in July (4 weeks in length)

The clinical hours were added in the term 2 to comply with accreditation guidelines for an introduction to clinical experience.

The dental hygiene students in their DH3 year do not have preclinical courses in the first semester. Second semester of the DH3 year, preclinical courses occur. Then the students matriculate into their DH4 year in the Summer Semester of the DH4 year. This is why we have three clinical terms listed in the 2nd year: clinical section (#54, letter C)

The DH program is a 1 + 1, and as such there is only one year.

The didactic, lab and clinic hours are estimates across the curriculum and where things are emphasized in the clinic or lab including the time spent in a specific scheduled lab. For example, drug cards are used in all clinics and preclinical to reinforce learning of pharmacology principles and the medication/drugs impact on dental treatment.

The Hocking College Dental Hygiene program is a new program and many of the courses are combined including in the clinic and pre-clinic settings. The students will have 96 hours of pre-clinic along with 32 hours of radiology lab the first semester, the second semester is during the summer semester and will total 120 clinic hours, the third and fourth semesters will combined total 384 hours. The content areas are divided among the clinic hours in different proportions in each semester.

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

The reported preclinical and clinical clock hours are estimates. There are many topics covered and overlapped in various courses. We introduce, practice, and master different topics throughout the program.

The state of Georgia does not allow dental hygienists to administer local anesthesia or nitrous oxide.

There are 550 clinic hours throughout the 4 clinical terms. I split this time between patient management and clinical dental hygiene to notate the hours twice. In pre-clinic (45 hour course) all of these things are covered: infectious diseases, hazard control management, clinical dental hygiene, patient management, and preventive counseling. I split the hours to note how much time is spent on these topics within pre-clinic.

This does not account for skills learned and reinforced through direct patient treatment.

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

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

We have a 3 year program - in the third year Term 1 they have 180 hours and in Term 2 they have 180 hours

Worked on the hours. Last time I included finals week for 16 weeks. I put the curriculum on a 15 week schedule for calculations. Worked on changes of hours for more accuracy reflected for information requested. The program has a summer session for Anesthesia and Pain control that has an additional 48 clinical hours. I included the hours from summer in the 2nd year clinical Term 1 as we don't have a term 3.

x, y, and z. Adjustment of didactic and lab hours to reflect the dental hygiene schedule and courses.

x, z, bb, cc, and dd are incorporated into either pre-clinical or clinical dental hygiene didactic coursework & clinical rotation experiences.

x. Patent management is taught in all clinical courses within Phase II.

y. Two adjunct instructors work in clinic on different days.
Question 55 comments

55mm. In California, Dental Hygienists are able to place Interim Therapeutic Restoration (ITR). Some students opted to learn this skill to clinical competency but opted out of the certification.

55ee-uu. These services are taught using typodonts only.

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

bb and cc; nitrous oxide is not yet in scope of practice in CT

bb. and cc. The second-year students take a course in Nitrous Oxide Sedation expanded functions that is given through [local college] Extended Course Training program.

Clarification ff: we discuss and teach the students the different types of suture placement in theory courses but it is not within our scope to place sutures on patients.

For the items above associated with dental materials, the "yes" indicates that they receive didactic information but they do not practice the item in a lab or clinic setting. They are taught to recognize different materials radiographic and clinically to clinic competence but not perform any of the procedures.

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

ii through ss are expanded dental assisting functions. Dental hygiene students have the option to take that curriculum starting in the last semester in the dental hygiene program, but since not all students enroll in the EFDA program, I answered NO to those skills.

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

Instead of root planing, current standard of care is taught, which is periodontal therapy,

ITEMS OO-SS are taught in the didactic portion of the class.

Local anesthesia/nitrous oxide analgesia (block and infiltration) theory is taught in the core curriculum; the lab portion which is required for the post certificate is taught immediately following graduation to provide all requisite coursework requirements and clinical assessments for the NYS post certificate license and certification for the provision of Infiltration Local Anesthesia/Nitrous oxide analgesia. All dental materials functions listed

Marked no responses to clinical competence - are taught in Dental Materials lecture but students do not perform in lab.

Matrices placement and removal; Temporary restorations placement and removal - are taught and evaluated with lab competency criteria only.
Question 55 comments

Nitrous Oxide administration and monitoring requires certification through a State Board approved course. This is the first year that we will require this certification as a part of the curriculum.

Our State Practice Act does not permit many of these services for hygienists.

Periodontal dressing, rubber dam, temporary restorations are completed in Dental Materials on a typodont. All students complete a lab competency for these services.

Please disregard second column answers of "no," when first column answer is "no." Unable to deselect these answers. Called CODA and was told this is a glitch in the system.

rr & tt: As a part of Dental Materials course, students mix composite restorations, but do not place them. uu: This is done on stone models (combined w/ amalgam placement)

s- We teach scaling and root debridement (i.e, removal of calculus) versus root planing (i.e, removal of rough cementum) which is contraindicated according to research. w- We only polish restorations with non-abrasive prophy paste.

Select dental biomaterial services are taught to laboratory competency and include the following: Temporary restoration placement, rubber dam placement and removal, matrices placement and removal, suture placement and removal and periodontal dressing placement and removal

Students are taught to place and remove sutures in the Dental Materials lab, but do not place or remove them from patient's mouths. Soft tissue curettage is not recognized as a valid procedure. Students are taught to place and remove matrices on a simulator in the Dental Materials lab, but do not place or remove them on a patient. Students are taught to place temporary restorations in Dental Materials lab, but do not place them in patient mouths. Students are taught to place and carve amalgam in Dental Materials lab, but do not do this in clinic. Students are taught to place cavity liners and bases in Dental Materials lab, but do not do this in clinic.

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

The dental hygiene students at UMMC are participants in a pilot project between the School of Dentistry and the Mississippi Board of Dental Examiners where the dental hygiene students are administering infiltration and block local anesthesia to patients of record in the dental hygiene clinic.

The [school name] Dental Hygiene Program does not provide the Expanded Functions Dental Assistant program for dental hygiene program at this time, but does provide pain control and anesthesia courses.

The scope of practice in Texas does not allow for the administration of nitrous oxide or local anesthesia by an RDH. These services are taught on a manikin.

The services from (dd) and (uu) are taught in a dental materials laboratory setting. These are not within the scope for hygienists in our state.

The soft tissue curettage is with lasers not curets.

The state of Georgia does not allow dental hygienists to administer local anesthesia, administer nitrous oxide; place, carve, or finish restorations; or place sutures.
**Question 55 comments**

The state of Maryland does not permit certain functions.

uu. REMOVAL OF OVERHANGS GG. REMOVAL OF SUTURES IS DONE ON A HOTDOG NOT IN ORAL CAVITY DAM PLACEMENT IS DONE ON TYPODONT

We aren't legally allowed to give anesthesia, so we cover the topics didactically but not clinically.

We discus in lecture about the general dentist and/or periodontist performing above procedures. We do not allow our hygiene students to perform task outside of Ga scope of practice. The state of GA does not allow RDH to administer anesthesia. We show students on a typodont, but will not teach practice on a live person. The dentist administered anesthesia.

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

z, aa, ff, hh, kk through uu are not legal duties for hygienists in the state of Texas. bb requires advanced certificate
CONSIDERATION OF PROPOSED REVISIONS TO THE ACCREDITATION
STANDARDS FOR DENTAL HYGIENE EDUCATION PROGRAMS RESULTING
FROM THE VALIDITY AND RELIABILITY STUDY

**Background:** The Accreditation Standards for Dental Hygiene Education Program were adopted by the Commission on Dental Accreditation at its February 1, 2013 meeting for implementation on January 1, 2014.

According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” In accordance with this policy, the Validity and Reliability Study for the Accreditation Standards for Dental Hygiene Education Programs was conducted in 2019, with results considered at the Commission’s Summer 2019 meeting.

In Summer 2019, the Dental Hygiene Review Committee (DH RC) conducted an initial review of the validity and reliability study report. The Review Committee concluded that further study of the survey data was warranted. The DH RC discussed several Standards that may need revisions to language, the intent statements and/or examples of evidence, including: Standards 2-7, 2-10, 2-12, 2-14, 2-18, 2-24, 3-2, and 3-5. As the Review Committee’s discussion was lengthy, the Review Committee suggested that a full review of the Standards be assigned to a workgroup so that time could be afforded for potential revisions to the Standards. The Commission concurred and directed the appointment of a workgroup composed of five (5) Dental Hygiene Review Committee members, including a few members whose term ended in fall 2019, to further study the findings of the Dental Hygiene Validity and Reliability Study, with a report to the DH RC and Commission in Winter 2020.

The workgroup members included Dr. Susan Kass (workgroup chair), Dr. Susan Callahan Barnard, Ms. Tamara Grzesikowski, Dr. Sally Mauriello, and Dr. Sheila Vandenbush. The workgroup conducted four (4), two-hour meetings on October 3, October 25, November 15, and November 19, 2019. Although the appointment terms for Dr. Susan Callahan Barnard and Dr. Sally Mauriello ended in fall 2019, these members were assigned to the workgroup to bring continuity to the review of the Accreditation Standards.

During the first meeting, the workgroup reviewed its charge, discussed the history of the current standards, discussed the validity and reliability study results, and began to focus on identification of specific standards that should be further considered based upon study results and trends in dental hygiene education. The workgroup noted that the Commission adopted revised Standards for dental hygiene during its summer 2019 meeting; therefore, the workgroup utilized the Standards document including those standards to take effect in July 1, 2020 as the basis of its comprehensive review. Assignments were made for development of proposed revisions that were subsequently presented at future workgroup meetings. Each subsequent workgroup meeting focused on a detailed review of the Accreditation Standards, with proposed draft
language presented and considered by workgroup members. At its November 19, 2019 meeting, the workgroup concluded its review of each standard.

**Summary:** At this meeting, the Dental Hygiene Review Committee (DH RC) and Commission are asked to consider the proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs (Appendix 1) submitted by the dental hygiene workgroup as a result of the 2019 Validity and Reliability Study. The DH RC may propose further revisions to the Accreditation Standards for Dental Hygiene Education Programs. The DH RC may also recommend the proposed revisions be circulated to the communities of interest for review and comment. Hearings could be conducted at the 2020 American Dental Education Association (ADEA) Annual Session, the 2020 American Dental Hygienists’ Association (ADHA) Annual Meeting, and the 2020 American Dental Association (ADA) Annual Meeting. Comments could be reviewed at the Commission’s Winter 2021 meeting.

**Recommendation:**

Prepared by: Dr. Sherin Tooks and Ms. Michelle Smith
Accreditation Standards for
Dental Hygiene Education Programs

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

Effective January 1, 2013-TBD

Last Revised: August 2019
### Accreditation Standards for Dental Hygiene Education Programs

#### Document Revision History

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Mission Statement of the
Commission on Dental Accreditation

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

Commission on Dental Accreditation

Adopted August 5, 2016
Accreditation Status Definitions

1. 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.

2. 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).

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
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.

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.

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.
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 Standards
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 five eighth times -- in 1969, 1973, 1979, 1991, 1998, and 2005, 2007, and TBD.

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 July 2007 TBD, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in January 2009 TBD.
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 Standards; 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.

**Basic 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 basic 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.

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.

**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.

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 which are consistent with the goals of the sponsoring institution and appropriate to dental hygiene education.

b) implementing the plan;

c) assessing the outcomes, including measures of student achievement;

d) using the results for program improvement.

a) developing a plan addressing teaching, patient care and service;

b) an ongoing plan consistent with the goals of the sponsoring institution and the goals of the dental hygiene program;

b) 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

Dental Hygiene Standards
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

1-2-3-3 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
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.

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

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:
  - Commission on Higher Education, Middle States Association of Colleges and Schools; Commission on Institutions of Higher Education, New England Association of Schools and Colleges; Commission on Technical and Career Institutions, New England Association of Schools and Colleges; Commission on Institutions of Higher Education, North Central Association of Colleges and Schools; Commission on Colleges, Northwest Association of Schools and Colleges; Commission on Colleges, Southern Association of Colleges and Schools; Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges; Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges; Accrediting Bureau of Health Education Schools; Accrediting

Dental Hygiene Standards

-16-
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)

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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

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Dental Hygiene Standards
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
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
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 define and list the competencies needed for graduation. The dental hygiene program must employ student evaluation methods that measure all defined program competencies. These competencies and evaluation methods must be written and communicated to the enrolled students.

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
• competencies documentation demonstrating relationship between graduation competencies, course competencies, and evaluation methods and program competencies
• process and product evaluation forms
2.7 Written course descriptions, content outlines, including topics to be presented, specific instructional objectives, learning experiences, and evaluation procedures must be provided to students at the initiation of each dental hygiene course.

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 course offered within the dental hygiene program
- 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. A curriculum document must be submitted for each course included in the dental hygiene program for all four content areas.

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 prerequisite background foundation 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 background 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 The number of hours of clinical practice scheduled must ensure that students attain clinical competence and develop appropriate judgment. Clinical practice experience must be distributed throughout the curriculum and include the following to ensure students attain clinical competence:
   a) at least 6 hours of clinical practice per week for preclinical course(s)
   b) at least 8-12 hours of clinical practice time per week for first year dental hygiene students in clinical courses with patients
   c) 12-16 hours of practice per week for second and/or final year dental hygiene students in clinical courses with patients.

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 clinical practice time per week. In the final prelicensure year of the curriculum, each second-year student should be scheduled for at least twelve to sixteen hours of practice with patients 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 student patient care competencies

Patient Care Competencies

2-12 Graduates must be competent in providing dental hygiene care for the child, adolescent, adult, geriatric, and special needs patient populations.

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 criteria for patient population
- 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 communicating, and collaborating, and interacting 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). Students should understand the roles of members of the health-care team and have educational experiences that involve working with other health-care professional students and practitioners.

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
- examples of community-based oral health programs implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance

2-17 Graduates must be competent in providing appropriate life 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 basic life support 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, basic life support certification/recognition

2-18 Where graduates of a CODA accredited dental hygiene program are authorized to perform additional functions required for initial dental hygiene licensure as defined by the program’s state specific dental board or regulatory agency, program curriculum must include content at the level, depth, and scope required by the state. Further, curriculum content must include didactic and laboratory/preclinical/clinical objectives for the additional dental hygiene skills and functions. Students must demonstrate laboratory/preclinical/clinical competence in performing these skills.

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. The inclusion of additional functions cannot compromise the length and scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.
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 ongoing 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.

d) a defined mechanism to calibrate dental hygiene faculty for student clinical evaluation.

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 an ongoing and regular 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, teaching contact hours should be limited and should not take precedent over administrative responsibilities.

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, or is currently enrolled in a masters or higher degree program or a dentist who has background in education and the professional experience necessary to understand and fulfill the program goals.
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:
• curriculum vitae current 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 number and distribution of faculty and staff must be sufficient to meet the dental hygiene program’s stated purpose, goals and objectives.

Intent:
Student contact loads should allow the faculty sufficient time for class preparation, student evaluation and counseling, development of subject content and appropriate evaluation criteria and methods, program development and review, and professional development.

Examples of evidence to demonstrate compliance may include:
• faculty schedules including student contact loads and supplemental responsibilities

3-63-5 The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public. In preclinical, clinical and radiographic clinical and laboratory sessions, the ratio must not exceed one (1) faculty member to five (5) students, there must not be less than
one faculty for every five students. In laboratory sessions the ratio must not exceed one (1) faculty for every 10 students for dental materials courses, and there must not be less than one faculty for every ten students to ensure the development of clinical competence and maximum protection of the patient, faculty and students.

Intent:
The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and 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 commitments schedules including student contact loads and supplemental responsibilities
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-7-3-6 The full-time and part-time faculty of a dental hygiene program must possess a baccalaureate or higher degree.

Part-time faculty providing didactic instruction must have earned at least a baccalaureate degree or be currently enrolled in a baccalaureate degree program.

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 dental hygiene programs accredited by the Commission on Dental Accreditation.
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

3-83-7 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 vitae 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

3-93-8 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

3-103-9 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

3-113-10 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

3-123-11 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 adhere to the standard of care and include the following:

a) sufficient clinical facility with clinical stations for students including conveniently located hand-washing sinks areas for hand hygiene; equipment allowing display of radiographic images during dental hygiene treatment; and view boxes and/or computer monitors, a working space for the patient's record adjacent to units; functional, modern 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 sufficient 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.
4-2 Radiography facilities must be sufficient for student practice and the
development of clinical competence.

The radiography facilities must **adhere to the standard of care and** contain the following:

a) an appropriate number of radiography exposure rooms which include:
   modern dental radiography units; equipment for acquiring radiographic images; teaching manikin(s); and conveniently located hand-washing sinks areas for hand hygiene;

b) modern processing and/or scanning equipment; equipment for processing radiographic images;

c) an area for mounting and viewing radiographs; 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 adhere to the standard of care 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 stations work areas that are designed and equipped for students to work while seated including sufficient ventilation and lighting, with necessary utilities, and storage space, and an adjustable chair;
c) documentation of compliance with applicable local, state and federal regulations.

Intent:
The laboratory facilities should include student stations 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 clinical 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 The educational institution must provide physical facilities and equipment which are sufficient to permit achievement of program objectives. If the institution finds it necessary to contract for use of an existing facility for basic clinical education and/or distance education, When the institution uses an additional facility for clinical education that includes program requirement 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 two-year notice for termination of the contract stipulated to ensure that instruction will not be interrupted or;
c) a contingency plan developed by the institution should the contract be terminated;
d) a location and time available for use of the facility compatible with the instructional needs of the dental hygiene program;

e) the dental hygiene program administrator retains authority and responsibility for instruction and scheduling of student assignments;

f) clinical instruction is provided and evaluated by calibrated dental hygiene program faculty;

g) all dental hygiene students receive comparable instruction in the facility;

h) 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

**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 stations with equipment and space for individual student performance in a safe environment.

### Office Space

**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 including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all students, faculty, and appropriate support staff, and continuously monitored for compliance. Policies on bloodborne and infectious diseases must be made available to applicants for admission and patients.

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 exposures 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.

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 includes:

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 review of a representative sample of patients and 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 ongoing manner. 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 evidence of chart audits
- quality assurance policy and procedures
- patient bill of rights

Dental Hygiene Standards
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 All students, faculty and support staff involved with the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED).

Intent:
The need for students to be able to provide basic life support procedures is essential in the delivery of health care.
Examples of evidence to demonstrate compliance may include:

- 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

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. The use of student employees as secretarial staff does not preclude the essential need for 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
CONSIDERATION OF THE USE OF THE TERM “SHOULD” WITHIN THE ACCREDITATION STANDARDS

**Background:** At its Winter 2019 meeting, the Predoctoral Dental Education Review Committee (PREDOC RC) recommended, and the Commission on Dental Accreditation directed, that the Standing Committee on Documentation and Policy Review consider the term “Should” within the Definition of Terms of Accreditation Standards, among all disciplines under the Commission’s purview, to ensure consistent application and interpretation of the Commission’s expectation, with a report for review by the Commission in Summer 2019.

At its Summer 2019 meeting, the Standing Committee on Documentation and Policy Review considered background information provided and noted that the definition of “Should” is inconsistent among all disciplines under CODA’s purview. For example, predoctoral dental education and dental therapy education program standards state that “Should: Indicates an expectation” while some of the advanced dental education standards state that “Should: Indicates a suggested way to meet the standard; highly desirable, but not mandatory” or “Should: Indicates a method to achieve the standards.” The Committee also noted that dental hygiene standards state: “Should: Indicates a method to achieve the Standards,” while dental laboratory technology and dental assisting standards do not include a definition for “Should.”

The Standing Committee also recalled that the PREDOC RC was concerned that the term “Should,” defined as “indicates an expectation” in the predoctoral dental education and dental therapy standards has the potential for inconsistent application and review of educational programs because some CODA site visitors mistakenly use the intent statement as the requirement by which a program is evaluated, rather than the “must” statement which has historically been viewed by CODA as the mandatory compliance requirement.

Following further consideration of the various definitions of “Should,” the Standing Committee agreed that the following statement be used to define “Should” and applied to the Accreditation Standards of all disciplines under the Commission’s purview (Underline is new language):

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

The Standing Committee also noted the potential impact the revised definition may have on the Accreditation Standards including the possibility that changing the definition of “Should” may result in the need to convert previous “Should” statements to “Must” statements within discipline specific Accreditation Standards documents. Therefore, the Standing Committee recommended that the Commission direct each review committee to review the use of “Should” in its Accreditation Standards and consider the possible impact, if any, with a report to the Commission for the Winter 2020 meeting. In doing so, the Standing Committee recognized that some discipline-specific standards are currently being assessed for validity and reliability or may undergo review in the near future; therefore, it may be advisable for each Review Committee to
Consideration of the Use of the Term “Should” Within the Accreditation Standards
Dental Hygiene RC
CODA Winter 2020

consider timing its review and revision of the term “Should” to correlate with other revision activities.

At its Summer 2019 meeting, the Commission carefully considered the report of the Standing Committee and concurred with its conclusions and recommendations. The Commission directed the revision or addition, as applicable, of the definition of “Should,” as noted above, within the Definition of Terms used by the Commission in the Accreditation Standards for all disciplines within the Commission’s purview, with consideration of this change in Winter 2020, and application within a time frame to correlate with other revision activities.

At this meeting, the Review Committee on Dental Hygiene Education (DH RC) is requested to review the use of the term “Should” within the Accreditation Standards for Dental Hygiene Education Programs (Appendix 1). The Review Committee has been directed to revise the term “Should,” and consider additional revisions to the Accreditation Standards that may be warranted as a result of the revised definition of the term “Should,” which CODA approved in Summer 2019. If the Review Committee will conduct a review of its Accreditation Standards through a validity and reliability study, the Committee may consider incorporating the revisions related to the term “Should” within its overall review of the Standards.

Summary: The DH RC is requested to review the Accreditation Standards found in Appendix 1 related to the Commission’s directive to redefine the term “Should.” If the discipline-specific standards are currently being assessed for validity and reliability or may undergo review in the near future; the Review Committee may consider the timing of its review and revision of the term “Should” to correlate with other revision activities.

Review Committee Recommendation:

Prepared by: Ms. Michelle Smith
Commission on Dental Accreditation

Accreditation Standards for Dental Hygiene Education Programs
### Accreditation Standards for Dental Hygiene Education Programs

#### Document Revision History

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<td>July 26, 2007</td>
<td>Accreditation Standards for Dental Hygiene Education Programs</td>
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<td>Standards to Ensure Program Integrity Examples of Evidence Modified: Standard 1-3</td>
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<td>February 3, 2012</td>
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<td>August 1, 2014</td>
<td>Renumbered Standards 2-9 through 2-12 to be subsection a, b, c and d of 2-8</td>
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<td>February 6, 2015</td>
<td>Revised Standards 2-4, 3-6, 3-7,b</td>
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<td>February 6, 2015</td>
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Dental Hygiene Standards
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<td>Revised Standards 2-15 and 4-4</td>
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<td>Definition of Terms (Patients with special needs) and Standard 2-12</td>
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Mission Statement of the Commission on Dental Accreditation

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

Commission on Dental Accreditation
Adopted August 5, 2016
1. **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

2. **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 Dental Hygiene Standards.
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).

Reaffirmed: 8/10; Revised: 7/08; 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 Standards -8-
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 five times -- in 1969, 1973, 1979, 1991, 1998 and 2005.

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 July 2007, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in January 2009.
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 Standards.

**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.

**Basic 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 basic 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.

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.

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.
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 which are consistent with the goals of the sponsoring institution and appropriate to dental hygiene education.
b) implementing the plan;
c) assessing the outcomes, including measures of student achievement;
d) using the results for program improvement.

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
- employment rates
- 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
Financial Support

1-2 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

1-3 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 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 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:
  Commission on Higher Education, Middle States Association of Colleges and Schools; Commission on Institutions of Higher Education, New England Association of Schools and Colleges; Commission on Technical and Career Institutions, New England Association of Schools and Colleges; Commission on Institutions of Higher Education, North Central Association of Colleges and Schools; Commission on Colleges, Northwest Association of Schools and Colleges; Commission on Colleges, Southern Association of Colleges and Schools; Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges; Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges; Accrediting Bureau of Health Education Schools; Accrediting Commission of Career Schools and Colleges of Technology; Accrediting Commission of the Distance Education and Training Council; The Council on Occupational Education; Accrediting Council for Independent Colleges and Schools

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.

Examples of evidence to demonstrate compliance may include:
- affiliation agreement(s)
Community Resources

1-7 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 define and list the competencies needed for graduation. The dental hygiene program must employ student evaluation methods that measure all defined program competencies. These competencies and evaluation methods must be written and communicated 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:
- competencies documentation demonstrating relationship between evaluation methods and program competencies
- process and product evaluation forms

2-7 Written course descriptions, content outlines, including topics to be presented, specific instructional objectives, learning experiences, and evaluation procedures must be provided to students at the initiation of each dental hygiene course.

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.

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. A curriculum document must be submitted for each course included in the dental hygiene program for all four content areas.
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 prerequisite background for components of the curriculum, which prepare the students to communicate effectively, assume responsibility for individual oral health counseling, and participate in community health programs.

2-8b 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 background for dental and dental hygiene sciences. The subjects are to be of the scope and depth comparable to college transferable liberal arts coursework. 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, periodontontology, 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 The number of hours of clinical practice scheduled must ensure that students attain clinical competence and develop appropriate judgment. Clinical practice must be distributed throughout the curriculum.

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 clinical practice time per week. In the final prelicensure year of the curriculum, each second-year student should be scheduled for at least twelve to sixteen hours of practice with patients 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

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. 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 student competencies

Patient Care Competencies

2-12 Graduates must be competent in providing dental hygiene care for the child, adolescent, adult, geriatric, and special needs patient populations.

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 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 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 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 communicating and collaborating with other members of the health care team to support comprehensive patient care.

Intent:
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). Students should understand the roles of members of the health-care team and have educational experiences that involve working with other health-care professional students and practitioners.

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
- examples of community-based oral health programs implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance

2-17 **Graduates must be competent in providing appropriate life support measures for medical emergencies that may be encountered in dental hygiene practice.**

Intent:
*Dental hygienists should be able to provide appropriate basic life support 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, performance on emergency simulations, basic life support certification/recognition

2-18 Where graduates of a CODA accredited dental hygiene program are authorized to perform additional functions required for initial dental hygiene licensure as defined by the program’s state specific dental board or regulatory agency, program curriculum must include content at the level, depth, and scope required by the state. Further, curriculum content must include didactic and laboratory/preclinical/clinical objectives for the additional dental hygiene skills and functions. Students must demonstrate laboratory/preclinical/clinical competence in performing these skills.

Intent: *Functions allowed by the state dental board or regulatory agency for dental hygienists are taught and evaluated at the depth and scope required by the state. The inclusion of additional functions cannot compromise the length and scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.*

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 ongoing 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.
d) a defined mechanism to calibrate dental hygiene faculty for student clinical evaluation.

**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 an ongoing and regular 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 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, teaching contact hours should be limited and should not take precedent over administrative responsibilities.

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 who is a graduate of a program accredited by the Commission on Dental Accreditation and possesses a masters or higher degree or is currently enrolled in a masters or higher degree program or a dentist who has background in education and the professional experience necessary to understand and fulfill the program goals.
**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:
- curriculum vitae 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 number and distribution of faculty and staff must be sufficient to meet the dental hygiene program’s stated purpose, goals and objectives.

**Intent:**
*Student contact loads should allow the faculty sufficient time for class preparation, student evaluation and counseling, development of subject content and appropriate evaluation criteria and methods, program development and review, and professional development.*

Examples of evidence to demonstrate compliance may include:
- faculty schedules including student contact loads and supplemental responsibilities

**3-6** The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public. In preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every five students. In laboratory sessions for dental materials courses, there must not be less than one faculty for every ten students to ensure the
development of clinical competence and maximum protection of the patient, faculty and students.

**Intent:**
The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and 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 commitments
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-7 The full time faculty of a dental hygiene program must possess a baccalaureate or higher degree.

Part-time faculty providing didactic instruction must have earned at least a baccalaureate degree or be currently enrolled in a baccalaureate degree program.

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 must be graduates of dental hygiene programs accredited by the Commission on Dental Accreditation.

**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. 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

3-8 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 vitae 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

3-9 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

3-10 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

3-11 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

3-12 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

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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 regulations.

Clinical Facilities

The dental hygiene facilities must include the following:

a) sufficient clinical facility with clinical stations for students including conveniently located hand washing sinks and view boxes and/or computer monitors; a working space for the patient's record adjacent to units; functional, modern 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 sufficient 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: modern dental radiography units; teaching manikin(s); and conveniently located hand-washing sinks;
b) modern processing and/or scanning equipment;
c) an area for mounting and viewing radiographs;
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.

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 contain the following:

a) placement and location of equipment that is conducive to efficient and safe utilization;
b) student stations that are designed and equipped for students to work while seated including sufficient ventilation and lighting, necessary utilities, storage space, and an adjustable chair;
c) documentation of compliance with applicable local, state and federal regulations.

Intent:
The laboratory facilities should include student stations with equipment and space for individual student performance of laboratory procedures with instructor supervision. This Standard applies to all sites where students receive clinical instruction.
Extended Campus Facilities

4-4 The educational institution must provide physical facilities and equipment which are sufficient to permit achievement of program objectives. If the institution finds it necessary to contract for use of an existing facility for basic clinical education and/or distance education, 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 two-year notice for termination of the contract stipulated to ensure that instruction will not be interrupted or;
c) a contingency plan developed by the institution should the contract be terminated;
d) a location and time available for use of the facility compatible with the instructional needs of the dental hygiene program;
e) the dental hygiene program administrator retains authority and responsibility for instruction and scheduling of student assignments;
f) clinical instruction is provided and evaluated by calibrated dental hygiene program faculty;
g) all dental hygiene students receive comparable instruction in the facility;
h) the policies and procedures of the facility are compatible with the goals of the educational program.

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

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 stations 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 faculty. 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.

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.

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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 including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all students, faculty, and appropriate support staff, and continuously monitored for compliance. 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.

Dental Hygiene Standards
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

5-3 The program must establish, enforce, and instruct students in preclinical/clinical/laboratory protocols and mechanisms to ensure the management of emergencies. These 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.

Examples of evidence to demonstrate compliance may include:

- accessible and functional emergency equipment, including oxygen
- instructional materials
- written protocol and procedures
- emergency kit(s)
- installed and functional safety devices and equipment
- first aid kit accessible for use in managing clinic and/or laboratory accidents
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 includes:

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;
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. 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
- documentation of policies on scope of care provided, recalls and referrals
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 All students, faculty and support staff involved with the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED).

Intent:
The need for students to be able to provide basic life support procedures is essential in the delivery of health care.
Examples of evidence to demonstrate compliance may include:
- 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

6-6 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. The use of student employees as secretarial staff does not preclude the essential need for patient confidentiality.