INFORMATIONAL REPORT ON THE CONDUCT OF A VALIDITY AND RELIABILITY STUDY FOR THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

**Background:** The Accreditation Standards for Dental Education Programs were adopted by the Commission on Dental Accreditation at its August 2010 meeting for implementation July 1, 2013.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1), the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula:

\[
\text{The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.}
\]

Thus, the validity and reliability of the new standards for a one-year program will be assessed after four years, while standards applying to programs four years in length will be assessed seven years after implementation.

According to the Commission’s timetable for validity and reliability studies, the Commission will conduct the Validity and Reliability Study for Dental Education in Spring 2020. The Commission will utilize the Health Policy Institute (HPI) of the American Dental Association (ADA), whose staff assist the Commission in developing and distributing the electronic surveys and preparing the data reports.

The validity and reliability study includes input from the broad communities of interest. The communities will be surveyed to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.

**Methodology and Survey Design for Dental Education:** In cooperation with the ADA’s HPI, a timetable will be developed, surveys will be distributed to the audiences, and responses will be due to the HPI within two weeks of receipt of the survey. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2020.
Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2020 meeting.

A survey instrument will be developed to obtain evaluations of each of the requirements in the current standards. Respondents will be asked to indicate the relevance of each criterion to the dental education curriculum:

- Relevant/ Too demanding: Criterion relevant but too demanding
- Retain as is: Retain criterion as is
- Relevant/ Not demanding: Criterion relevant but not sufficiently demanding
- Not relevant: Criterion not relevant
- No opinion. No opinion on this criterion

In addition, they will be asked to add and provide a rationale for any issues that they believe should be added to the standards. A sample format of the survey is presented in Appendix 2.

The following alternatives might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

If it is determined that revisions to the accreditation standards is warranted, further analysis of the data obtained in the validity and reliability study would be conducted to provide more in-depth information for the revision process. In addition, other resources could provide further information, including:

- The annual Frequency of Citings Reports of Accreditation Standards for Dental Education Programs.
- Data identifying trends in accredited dental education programs.
- Issues related to dental education.
- Requests for standards revisions received but postponed until the regular validity and reliability study.
- Relevant reports from the higher education and practice communities, e.g., Institute of Medicine Report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce.”

When a comprehensive revision of an accreditation standards document is required, the new document is developed with input from the communities of interest in accordance with Commission policies. The document is drafted using resources such as those noted above. When the document is finalized, it is shared with the communities of interest. In addition, open
hearings are held at the annual meetings of the American Dental Education Association, and the American Dental Association. Written and oral comments from the hearings and written comments received during the comment period are reviewed when considering the document for adoption. An implementation date is specified when the document is adopted.

**Recommendation:** This report is informational in nature and no action is required.
POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of standards are made to reflect significant changes in disease and practice patterns, scientific or technological advances, or in response to changing professional needs for which the Commission has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year after the validity and reliability of the standards has been assessed, the Commission will conduct a study to determine whether the accreditation standards continue to be appropriate to the discipline. This study will include input from the broad communities of interest. The communities will be surveyed and invited to participate in some national forum, such as an invitational conference, to assist the Commission in determining whether the standards are still relevant and appropriate or whether a comprehensive revision should be initiated.
The following alternatives, resulting in a set of new standards, might result from the assessment of the adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with Commission policies. An implementation date is specified and copyright privileges are sought when the document is adopted. Assessment of the validity and reliability of these new standards will be scheduled in accord with the policy specified above. Exceptions to the prescribed schedule may be approved to ensure a consistent timetable for similar disciplines (e.g. advanced dental education programs and/or allied dental education programs.

Revised: 8/18; 7/07, 07/00; Reaffirmed: 8/12, 8/10, 7/06; Adopted: 12/88
SAMPLE DENTAL EDUCATION PROGRAM VALIDITY AND RELIABILITY SURVEY

Listed below are the accreditation standards by which the Commission on Dental Accreditation and its site visitors evaluate Dental Education programs for accreditation purposes. For each standard, please circle the appropriate number that corresponds to your rating in terms of its relevance of the criterion to the curriculum. Please note that certain standards have multiple items to be rated.

**Definition**
Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law.

<table>
<thead>
<tr>
<th>Definition</th>
<th>For each of the five-point rating scales use:</th>
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<tr>
<td>Dentistry</td>
<td>1 = criterion relevant but too demanding</td>
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<td></td>
<td>2 = retain criterion as is</td>
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<td>3 = criterion relevant but not sufficiently demanding</td>
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<td>4 = criterion not relevant</td>
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<td>5 = no opinion</td>
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**STANDARD 1 – INSTITUTIONAL EFFECTIVENESS**

1. List Standards in this column

1  2  3  4  5

List comments related to Standard 1 – Institutional Effectiveness.

**STANDARD 2 – EDUCATIONAL PROGRAM**

1. List Standards in this column

1  2  3  4  5

List comments related to Standard 2 – Educational Program

**STANDARD 3 – FACULTY AND STAFF**

1. List Standards in this column

1  2  3  4  5

List comments related to Standard 3 – Faculty and Staff
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

1. List Standards in this column

List comments related to Standard 4 – Educational Support Services

STANDARD 5 – PATIENT CARE SERVICES

1. List Standards in this column

List comments related to Standard 5 – Patient Care Services

STANDARD 6 – RESEARCH PROGRAM

1. List Standards in this column

List comments related to Standard 6 – Research Program
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 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 Predoctoral Dental Education (PREDOC RC) is requested to review the use of the term “Should” within the Accreditation Standards for Dental Education Programs (Appendix 1) and Accreditation Standards for Dental Therapy Education Programs (Appendix 2). 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 PREDOC RC is requested to review the Accreditation Standards found in Appendix 1 and Appendix 2 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: Dr. Sherin Tooks
Consideration of the Use of the Term “Should” Within the Accreditation Standards
Predoctoral Dental RC
CODA Winter 2020

Commission on Dental Accreditation

Accreditation Standards
For Dental Education Programs
## Accreditation Standards for Dental Education Programs

**Commission on Dental Accreditation**  
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Chicago, Illinois 60611-2678  
(312) 440-4653  
www.ada.org/coda

### Document Revision History

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<tr>
<th>Date</th>
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<tr>
<td>August 6, 2010</td>
<td>Accreditation Standards for Dental Education Programs</td>
<td>Approved</td>
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<tr>
<td>February 1, 2012</td>
<td>Revised Compliance with Commission Policies section (Complaint)</td>
<td>Approved</td>
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<tr>
<td>February 3, 2012</td>
<td>Revision to Standard 2-23 e and 3-2</td>
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<tr>
<td>August 10, 2012</td>
<td>Revised Mission Statement</td>
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<tr>
<td>July 1, 2013</td>
<td>Accreditation Standards for Dental Education Programs</td>
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<td>July 1, 2013</td>
<td>Revision to Standard 2-23 e and 3-2</td>
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<tr>
<td>August 9, 2013</td>
<td>Revised Policy on Accreditation of Off-Campus Sites</td>
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<td>January 29, 2014</td>
<td>Revised Policy on Accreditation of Off-Campus Sites</td>
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<td>January 30, 2014</td>
<td>Revision to Policy on Complaints (Anonymous)</td>
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<tr>
<td>February 2015</td>
<td>Revision to Standard 4-3 and 5-8</td>
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<td>August 2015</td>
<td>Revision to Standard 4-6</td>
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<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
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<tr>
<td>July 1, 2016</td>
<td>Revision to Standard 4-6</td>
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## Consideration of the Use of the Term “Should” Within the Accreditation Standards

**Predoctoral Dental RC**  
**CODA Winter 2020**

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<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
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<td>Revised Intent Statements Standards 2-20 and 2-24; New Intent Statement Standard 2-9</td>
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<td>Definition of Terms (Research and Health Literacy); Standard 2-17; Standard 6-Research</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
Accreditation Status Definitions

Programs Which Are Fully Operational

APPROVAL (without reporting requirements): An accreditation classification granted to an education 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 time frame 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: 2/16; Reaffirmed: 8/10, 7/05; Revised: 1/99; 5/12 Adopted: 1/98

Programs Which Are Not Fully Operational

The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “Initial Accreditation.”

Initial Accreditation: Initial Accreditation is the accreditation classification granted to any dental, advance dental or allied dental education program which is in the planning and early stages of development or an intermediate stage of program implementation and 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 program for the specific occupational DEP Standards

-6-
area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s) and until the program is fully operational.
Introduction

Accreditation
Accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. 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
The Commission on Dental accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related disciplines.

Standards
Dental education programs leading to the D.D.S. or D.M.D. degree must meet the standards delineated in this document to achieve and maintain accreditation.

Standards 1 through 6 constitute The Accreditation Standards for Dental Education by which the Commission on Dental Accreditation and its consultants evaluate Dental Education Programs for accreditation purposes. This entire document also serves as a program development guide for institutions that wish to establish new programs or improve existing programs. Many of the goals related to the educational environment and the corresponding standards were influenced by the work of the American Dental Education Association Commission on Change and Innovation and by best practices in accreditation from other health professions.

The standards identify those aspects of program structure and operation that the Commission regards as essential to program quality and achievement of program goals. They specify the minimum acceptable requirements for programs and provide guidance regarding alternative and preferred methods of meeting standards.
Although the standards are comprehensive and applicable to all institutions that offer dental education programs, the Commission recognizes that methods of achieving standards may vary according to the mission, size, type and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission recognizes the importance of academic freedom, and an institution is allowed considerable flexibility in structuring its educational program so that it can meet the Standards. No curriculum has enduring value, and a program will not be judged by conformity to a given type. The Commission also recognizes that schools organize their faculties in a variety of ways. Instruction necessary to achieve the prescribed levels of knowledge and skill may be provided by the educational unit(s) deemed most appropriate by each institution.

The Commission has an obligation to the public, the profession and prospective students to assure that accredited Dental Education Programs provide an identifiable and characteristic core of required education, training and experience.

**Format of the Standards**

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. 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.
Goals

The assessment of quality in educational programs is the foundation for the Standards. In addition to the emphasis on quality education, the Accreditation Standards for Dental Education Programs are designed to meet the following goals:

1. to protect the public welfare;
2. to promote an educational environment that fosters innovation and continuous improvement;
3. to guide institutions in developing their academic programs;
4. to guide site visit teams in making judgments regarding the quality of the program and;
5. to provide students with reasonable assurance that the program is meeting its stated objectives.

Specific objectives of the current version of the Standards include:

- streamlining the accreditation process by including only standards critical to the evaluation of the quality of the educational program;
- increasing the focus on competency statements in curriculum-related standards; and
- emphasizing an educational environment and goals that foster critical thinking and prepare graduates to be life-long learners.

To sharpen its focus on the quality of dental education, the Commission on Dental Accreditation includes standards related to institutional effectiveness. Standard 1, “Institutional Effectiveness,” guides the self-study and preparation for the site visit away from a periodic approach by encouraging establishment of internal planning and assessment that is ongoing and continuous. Dental education programs are expected to demonstrate that planning and assessment are implemented at all levels of the academic and administrative enterprise. The Standards focus, where necessary, on institutional resources and processes, but primarily on the results of those processes and the use of those results for institutional improvement.
The following steps comprise a recommended approach to an assessment process designed to measure the quality and effectiveness of programs and units with educational, patient care, research and services missions. The assessment process should include:

1. establishing a clearly defined purpose/mission appropriate to dental education, patient care, research and service;
2. formulating goals consistent with the purpose/mission;
3. designing and implementing outcomes measures to determine the degree of achievement or progress toward stated goals;
4. acquiring feedback from internal and external groups to interpret the results and develop recommendations for improvement (viz., using a broad-based effort for program/unit assessment);
5. using the recommendations to improve the programs and units; and
6. re-evaluating the program or unit purpose and goals in light of the outcomes of this assessment process.

Implementation of this process will also enhance the credibility and accountability of educational programs.

It is anticipated that the Accreditation Standards for Dental Education Programs will strengthen the teaching, patient care, research and service missions of schools. These Standards are national in scope and represent the minimum requirements expected for a dental education program. However, the Commission encourages institutions to extend the scope of the curriculum to include content and instruction beyond the scope of the minimum requirements, consistent with the institution’s own goals and objectives.

The foundation of these Standards is a competency-based model of education through which students acquire the level of competence needed to begin the unsupervised practice of general dentistry. Competency is a complex set of capacities including knowledge, experience, critical thinking, problem-solving, professionalism, personal integrity and procedural skills that are necessary to begin the independent and unsupervised practice of general dentistry. These components of competency become an integrated whole during the delivery of patient care. Professional competence is the habitual and judicious use of communication, knowledge, critical appraisal, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities served. Accordingly, learning experiences help students blend the various dimensions of competency into an integrated performance for the benefit of the patient, while the assessment process focuses on measuring the student’s overall capacity to function as an entry-level, beginning general dentist rather than measuring individual skills in the assessment standards.
isolation.
In these *Standards* the competencies for general dentistry are described broadly. The Commission expects each school to develop specific competency definitions and assessment methods in the context of the broad scope of general dental practice. These competencies must be reflective of an evidence-based definition of general dentistry. To assist dental schools in defining and implementing their competencies, the Commission strongly encourages the development of a formal liaison mechanism between the dental school and the practicing dental community.

The objectives of the Commission are based on the premise that an institution providing a dental educational program will strive continually to enhance the standards and quality of both scholarship and teaching. The Commission expects an educational institution offering such a program to conduct that program at a level consistent with the purposes and methods of higher education and to have academic excellence as its primary goal.
Among the factors that may influence predoctoral curricula are expectations of the parent institution, standing or emerging scientific evidence, new research foci, interfaces with specialty or other dental-related education programs, approaches to clinical education, and pedagogical philosophies and practices. In addition, the demographics of our society are changing, and the educational environment must reflect those changes. People are living longer with more complex health issues, and the dental profession will routinely be expected to provide care for these individuals. Each dental school must also have policies and practices to achieve an appropriate level of diversity among its students, faculty and staff. While diversity of curricula is a strength of dental education, the core principles below promote an environment conducive to change, innovation, and continuous improvement in educational programs. Application of these principles throughout the dental education program is essential to achieving quality.

**Comprehensive, Patient-Centered Care**

The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching and oral health care delivery. Administration, faculty, staff and students are expected to develop and implement definitions, practices, operations and evaluation methods so that patient-centered comprehensive care is the norm.

Institutional definitions and operations that support patient-centered care can have the following characteristics or practices:

1. ensure that patients’ preferences and their social, economic, emotional, physical and cognitive circumstances are sensitively considered;
2. teamwork and cost-effective use of well-trained allied dental personnel are emphasized;
3. evaluations of practice patterns and the outcomes of care guide actions to improve both the quality and efficiency of care delivery; and
4. general dentists serve as role models for students to help them learn appropriate therapeutic strategies and how to refer patients who need advanced therapies beyond the scope of general dental practice.
Critical Thinking
Critical thinking is foundational to teaching and deep learning in any subject. The components of critical thinking are: the application of logic and accepted intellectual standards to reasoning; the ability to access and evaluate evidence; the application of knowledge in clinical reasoning; and a disposition for inquiry that includes openness, self-assessment, curiosity, skepticism, and dialogue. In professional practice, critical thinking enables the dentist to recognize pertinent information, make appropriate decisions based on a deliberate and open-minded review of the available options, evaluate outcomes of diagnostic and therapeutic decisions, and assess his or her own performance. Accordingly, the dental educational program must develop students who are able to:

- Identify problems and formulate questions clearly and precisely;
- Gather and assess relevant information, weighing it against extant knowledge and ideas, to interpret information accurately and arrive at well-reasoned conclusions;
- Test emerging hypotheses against evidence, criteria, and standards;
- Show intellectual breadth by thinking with an open mind, recognizing and evaluating assumptions, implications, and consequences;
- Communicate effectively with others while reasoning through problems.

Self-Directed Learning
The explosion of scientific knowledge makes it impossible for students to comprehend and retain all the information necessary for a lifetime of practice. Faculty must serve as role models demonstrating that they understand and value scientific discovery and life-long learning in their daily interactions with students, patients and colleagues. Educational programs must depart from teacher-centered and discipline-focused pedagogy to enable and support the students’ evolution as independent learners actively engaged in their curricula using strategies that foster integrated approaches to learning. Curricula must be contemporary, appropriately complex and must encourage students to take responsibility for their learning by helping them learn how to learn.

Humanistic Environment
Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic pedagogy inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising and small group interaction. A dental school environment characterized by respectful professional relationships between and among faculty and students establishes a context for the development of interpersonal skills necessary for learning, for patient care, and for making meaningful contributions to the profession.
Scientific Discovery and the Integration of Knowledge
The interrelationship between the basic, behavioral, and clinical sciences is a conceptual cornerstone to clinical competence. Learning must occur in the context of real health care problems rather than within singular content-specific disciplines. Learning objectives that cut across traditional disciplines and correlate with the expected competencies of graduates enhance curriculum design. Beyond the acquisition of scientific knowledge at a particular point in time, the capacity to think scientifically and to apply the scientific method is critical if students are to analyze and solve oral health problems, understand research, and practice evidence-based dentistry.

Evidence-based Care
Evidence-based dentistry (EBD) is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences. EBD uses thorough, unbiased systematic reviews and critical appraisal of the best available scientific evidence in combination with clinical and patient factors to make informed decisions about appropriate health care for specific clinical circumstances. Curricular content and learning experiences must incorporate the principles of evidence-based inquiry, and involve faculty who practice EBD and model critical appraisal for students during the process of patient care. As scholars, faculty contribute to the body of evidence supporting oral health care strategies by conducting research and guiding students in learning and practicing critical appraisal of research evidence.

Assessment
Dental education programs must conduct regular assessments of students’ learning throughout their educational experiences. Such assessment not only focuses on whether the student has achieved the competencies necessary to advance professionally (summative assessment), but also assists learners in developing the knowledge, skills, attitudes, and values considered important at their stage of learning (formative assessment). In an environment that emphasizes critical thinking and humanistic values, it is essential for students to develop the capacity to self-assess. Self-assessment is indicative of the extent to which students take responsibility for their own learning. To improve curricula, assessment involves a dialogue between and among faculty, students, and administrators that is grounded in the scholarship of teaching and learning. Data from program outcomes, assessment of student learning, and feedback from students and faculty can be used in a process that actively engages both students and faculty.

Application of Technology
Technology enables dental education programs to improve patient care, and to revolutionize all aspects of the curriculum, from didactic courses to clinical instruction. Contemporary dental education programs regularly assess their use of technology and explore new applications of technological advances to enhance student learning and to assist faculty as facilitators of learning and designers of learning environments. Use of technology must include systems and processes to safeguard the quality of patient care and ensure the integrity of student performance. Technology has the potential to reduce expenses for teaching and learning and help to alleviate increasing demands on faculty and student time. Use of technology in dental education programs can support learning in different ways, including self-directed, distance and asynchronous learning.

Faculty Development
Faculty development is a necessary condition for change and innovation in dental education. The environment of higher education is changing dramatically, and with it health professions education. Dental education programs can re-examine the relationship between what faculty do and how students learn to change from the sage authority who imparts information to a facilitator of learning and designer of learning experiences that place students in positions to learn by doing. Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.

Collaboration with other Health Care Professionals
Access to health care and changing demographics are driving a new vision of the health care workforce. Dental curricula can change to develop a new type of dentist, providing opportunities early in their educational experiences to engage allied colleagues and other health care professionals. Enhancing the public’s access to oral health care and the connection of oral health to general health form a nexus that links oral health care providers to colleagues in other health professions. Health care professionals educated to deliver patient-centered care as members of an interdisciplinary team present a challenge for educational programs. Patient care by all team members will emphasize evidence-based practice, quality improvement approaches, the application of technology and emerging information, and outcomes assessment. Dental education programs are to seek and take advantage of opportunities to educate dental school graduates who will assume new roles in safeguarding, promoting, and caring for the health care needs of the public.
Diversity
Diversity in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas and from various geographic regions; and have a wide variety of interests, talents, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogeneous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines.

Summary
These principles create an environmental framework intended to foster educational quality and innovation in ways that are unique to the mission, strengths, and resources of each dental school. The Commission believes that implementation of the guidance incorporated in this document will ensure that dental education programs develop graduates who have the capacity for life-long and self-directed learning and are capable of providing evidence-based care to meet the needs their patients and of society.
Definition of Terms Used in Accreditation Standards for Dental Education Programs

Community-based experience: Refers to opportunities for dental students to provide patient care in community-based clinics or private practices. Community-based experiences are not intended to be synonymous with community service activities where dental students might go to schools to teach preventive techniques or where dental students help build homes for needy families.

Comprehensive patient care: The system of patient care in which individual students or providers, examine and evaluate patients; develop and prescribe a treatment plan; perform the majority of care required, including care in several disciplines of dentistry; refer patients to recognized dental specialists as appropriate; and assume responsibility for ensuring through appropriate controls and monitoring that the patient has received total oral care.

Competencies: Written statements describing the levels of knowledge, skills and values expected of graduates.

Competent: The levels of knowledge, skills and values required by the new graduates to begin independent, unsupervised dental practice.

Cultural competence: Having the ability to provide care to patients with diverse backgrounds, values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers’ understanding the relationship between diversity of culture, values, beliefs, behavior and language and the needs of patients.

Dimensions of Diversity: The dimensions of diversity include: structural, curriculum and institutional climate.

Structural: Structural diversity, also referred to as compositional diversity, focuses on the numerical distribution of students, faculty and staff from diverse backgrounds in a program or institution.
Curriculum: Curriculum diversity, also referred to as classroom diversity, covers both the diversity-related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.

Institutional Climate: Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.

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

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

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

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

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

Intent: Intent statements are presented to provide clarification to dental education programs in the application of and in connection with compliance with the Accreditation Standards for Dental 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.

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

Predoctoral: Denotes training leading to the DDS or DMD degree.
Quality assurance: A cycle of PLAN, DO, CHECK, ACT that involves setting goals, determining outcomes, and collecting data in an ongoing and systematic manner to measure attainment of goals and outcomes. The final step in quality assurance involves identification and implementation of corrective measures designed to strengthen the program.

Service learning: A structured experience with specific learning objectives that combines community service with academic preparation. Students engaged in service learning learn about their roles as dental professions through provision of patient care and related services in response to community-based problems.

Should: Indicates an expectation.

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.

Research: The process of scientific inquiry involved in the development and dissemination of new knowledge.

Health literacy: “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (Institute of Medicine. 2004. Health Literacy: A Prescription to End Confusion. Washington, DC: The National Academies Press. https://doi.org/10.17226/10883.)
Accreditation Standards for Dental Education Programs

STANDARD 1-INSTITUTIONAL EFFECTIVENESS

1-1 The dental school must develop a clearly stated purpose/mission statement appropriate to dental education, addressing teaching, patient care, research and service.

Intent:
A clearly defined purpose and a mission statement that is concise and communicated to faculty, staff, students, patients and other communities of interest is helpful in clarifying the purpose of the institution.

1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness at the dental school must be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.

Intent:
Assessment, planning, implementation and evaluation of the educational quality of a dental education program that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students. The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of general dentistry.
1-3 The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

**Intent:**
The dental education 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

1-4 The dental school must have policies and practices to:
- achieve appropriate levels of diversity among its students, faculty and staff;
- engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and
- systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

**Intent:**
The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.
1-5 The financial resources must be sufficient to support the dental school’s stated purpose/mission, goals and objectives.

Intent:
The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, reference material and teaching aids as reflected in annual operating budget. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes 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.

1-6 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:
- Written agreement(s)
- Contracts between the institution/program and sponsor(s) (For example: contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)

1-7 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

1-8 The dental school must be a component of a higher education institution that is accredited by a regional accrediting agency.

1-9 The dental school must show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems.
STANDARD 2-EDUCATIONAL PROGRAM

Instruction

2-1 In advance of each course or other unit of instruction, students must be provided written information about the goals and requirements of each course, the nature of the course content, the method(s) of evaluation to be used, and how grades and competency are determined.

2-2 If students do not meet the didactic, behavioral and/or clinical criteria as published and distributed, individual evaluations must be performed that lead to an appropriate decision in accordance with institutional due process policies.

Curriculum Management

2-3 The curriculum must include at least four academic years of instruction or its equivalent.

2-4 The stated goals of the dental education program must be focused on educational outcomes and define the competencies needed for graduation, including the preparation of graduates who possess the knowledge, skills and values to begin the practice of general dentistry.
2-5 The dental education program must employ student evaluation methods that measure its defined competencies.

Intent:
Assessment of student performance should measure not only retention of factual knowledge, but also the development of skills, behaviors, and attitudes needed for subsequent education and practice. The education program should assess problem solving, clinical reasoning, professionalism, ethical decision-making and communication skills. The evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills but also assess the process and procedures which will be necessary for entry level practice.

Examples of evidence to demonstrate compliance may include:
- Narrative descriptions of student performance and professionalism in courses where teacher-student interactions permit this type of assessment
- Objective structured clinical examination (OSCE)
- Clinical skills testing

2-6 Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.

Examples of Evidence to demonstrate compliance may include:
- On-going faculty training
- Calibration Training Manuals
- Periodic monitoring for compliance
- Documentation of faculty participation in calibration-related activities

2-7 Biomedical, behavioral and clinical science instruction must be integrated and of sufficient depth, scope, timeliness, quality and emphasis to ensure achievement of the curriculum’s defined competencies.

2-8 The dental school must have a curriculum management plan that ensures:
a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;

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b. evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;

c. elimination of unwarranted repetition, outdated material, and unnecessary material;

d. incorporation of emerging information and achievement of appropriate sequencing;

e. incorporation of emerging didactic and clinical technologies to support the dental education program curriculum.

2-9 The dental school **must** ensure the availability of adequate patient experiences that afford all students the opportunity to achieve its stated competencies within a reasonable time.

**Intent:**

*The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice.*

**Critical Thinking**

2-10 Graduates **must** be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry and research methodology.

**Intent:**

*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:**

- Explicit discussion of the meaning, importance, and application of critical thinking
- Use of questions by instructors that require students to analyze problem etiology, compare and evaluate alternative approaches, provide rationale for plans of action, and predict outcomes
- Prospective simulations in which students perform decision-making
- Retrospective critiques of cases in which decisions are reviewed to identify errors, reasons for errors, and exemplary performance

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- Writing assignments that require students to analyze problems and discuss alternative theories about etiology and solutions, as well as to defend decisions made
- Asking students to analyze and discuss work products to compare how outcomes correspond to best evidence or other professional standards
- Demonstration of the use of active learning methods, such as case analysis and discussion, critical appraisal of scientific evidence in combination with clinical application and patient factors, and structured sessions in which faculty and students reason aloud about patient care

**Self-Assessment**

**2-11** Graduates must demonstrate the ability to self-assess, including the development of professional competencies and the demonstration of professional values and capacities associated with self-directed, lifelong learning.

**Intent:**

*Educational program should prepare students to assume responsibility for their own learning. The education program should teach students how to learn and apply evolving and new knowledge over a complete career as a health care professional. Lifelong learning skills include student assessment of learning needs.*

**Examples of evidence to demonstrate compliance may include:**
- Students routinely assess their own progress toward overall competency and individual competencies as they progress through the curriculum
- Students identify learning needs and create personal learning plans
- Students participate in the education of others, including fellow students, patients, and other health care professionals, that involves critique and feedback
Biomedical Sciences

2-12 Biomedical science instruction in dental education must ensure an in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems.

2-13 The biomedical knowledge base must emphasize the oro-facial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

2-14 In-depth information on abnormal biological conditions must be provided to support a high level of understanding of the etiology, epidemiology, differential diagnosis, pathogenesis, prevention, treatment and prognosis of oral and oral-related disorders.

2-15 Graduates must be competent in the application of biomedical science knowledge in the delivery of patient care.

Intent:

Biological science knowledge should be of sufficient depth and scope for graduates to apply advances in modern biology to clinical practice and to integrate new medical knowledge and therapies relevant to oral health care.

Behavioral Sciences

2-16 Graduates must be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving and maintaining oral health.

2-17 Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

Intent:
Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:

- basic principles of culturally competent health care;
- basic principles of health literacy and effective communication for all patient populations
- recognition of health care disparities and the development of solutions;
- the importance of meeting the health care needs of dentally underserved populations, and;
- the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.

Practice Management and Health Care Systems

2-18 Graduates must be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.

2-19 Graduates must be competent in applying the basic principles and philosophies of practice management, models of oral health care delivery, and how to function successfully as the leader of the oral health care team.

2-20 Graduates must be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

Intent:
In attaining competence, students should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences, that involve working with other healthcare professional students and practitioners. Students should have educational experiences in which they coordinate patient care within the health care system relevant to dentistry.

Ethics and Professionalism
2-21 Graduates must be competent in the application of the principles of ethical decision making and professional responsibility.

**Intent:**
Graduates should know how to draw on a range of resources, among which are professional codes, regulatory law, and ethical theories. These resources should pertain to the academic environment, patient care, practice management and research. They should guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

**Clinical Sciences**

2-22 Graduates must be competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care.

**Intent:**
The education program should introduce students to the basic principles of clinical and translational research, including how such research is conducted, evaluated, applied, and explained to patients.

2-23 Graduates must be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.

2-24 At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;

b. screening and risk assessment for head and neck cancer;

c. recognizing the complexity of patient treatment and identifying when referral is indicated;

d. health promotion and disease prevention, including caries management;

e. local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;

f. restoration of teeth;

g. communicating and managing dental laboratory procedures in support of
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patient care;
h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;
i. periodontal therapy;
j. pulpal therapy;
k. oral mucosal and osseous disorders;
l. hard and soft tissue surgery;
m. dental emergencies;
n. malocclusion and space management; and
o. evaluation of the outcomes of treatment, recall strategies, and prognosis

Intent:
Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school’s goals, resources, accepted general practitioner responsibilities and other influencing factors. Programs should define overall competency, in order to measure the graduate’s readiness to enter the practice of general dentistry.

2-25 Graduates must be competent in assessing and managing the treatment of patients with special needs.

Intent:
An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. As defined by the school, these individuals may include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques including the use of respectful nomenclature, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.

2-26 Dental education programs must make available opportunities and encourage
students to engage in service learning experiences and/or community-based learning experiences.

**Intent:**
Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.
STANDARD 3- FACULTY AND STAFF

3-1 The number, distribution and qualifications of faculty and staff must be sufficient to meet the dental school’s stated purpose/mission, goals and objectives, at all sites where required educational activity occurs. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.

Intent: Faculty should have knowledge and experience at an appropriate level for the curriculum areas for which they are responsible. The collective faculty of the dental school should have competence in all areas of the dentistry covered in the program.

3-2 The dental school must show evidence of an ongoing faculty development process.

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

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching and learning
- 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
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Records of Calibration of Faculty
3-3 Faculty must be ensured a form of governance that allows participation in the school’s decision-making processes.

3-4 A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

3-5 The dental school must have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.
STANDARD 4-EDUCATIONAL SUPPORT SERVICES

Admissions

4-1 Specific written criteria, policies and procedures must be followed when admitting predoctoral students.

4-2 Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program.

4-3 Students with advanced standing must receive an individualized assessment and an appropriate curriculum plan that results in the same standards of competence for graduation 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

4-4 Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.

Intent 4-1 to 4-4:

The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the
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selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.

Facilities and Resources

4-5 The dental school must provide adequate and appropriately maintained facilities and learning resources to support the purpose/mission of the dental school and which are in conformance with applicable regulations.

Written Agreements

4-6 Any site not owned by the sponsoring institution where required educational activity occurs must have a written agreement that clearly defines the roles and responsibilities of the parties involved.

Student Services

4-7 Student services must include the following:
   a. personal, academic and career counseling of students;
   b. assuring student participation on appropriate committees;
   c. providing appropriate information about the availability of financial aid and health services;
   d. developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;
   e. student advocacy;
   f. maintenance of the integrity of student performance and evaluation records; and
   g. Instruction on personal debt management and financial planning.

Intent:
All policies and procedures should protect the students and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect the work accomplished and are maintained in a secure manner. Students should have available the necessary support to provide career information and guidance as to practice, post-graduate and research opportunities.

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Student Financial Aid

4-8 At the time of acceptance, students **must** be advised of the total expected cost of their dental education.

**Intent:**
Financial information should include estimates of living expenses and educational fees, an analysis of financial need, and the availability of financial aid.

4-9 The institution **must** be in compliance with all federal and state regulations relating to student financial aid and student privacy.

Health Services

4-10 The dental school **must** advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental studies.

4-11 There **must** be a mechanism for ready access to health care for students while they are enrolled in dental school.

4-12 Students **must** be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.
STANDARD 5- PATIENT CARE SERVICES

5-1 The dental school must have a published policy addressing the meaning of and commitment to patient-centered care and distribute the written policy to each student, faculty, staff, and patient.

Intent:
A written statement of patient rights should include:
- considerate, respectful and confidential treatment;
- continuity and completion of treatment;
- access to complete and current information about his/her condition;
- advance knowledge of the cost of treatment;
- informed consent;
- explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;
- treatment that meets the standard of care in the profession.

5-2 Patient care must be evidenced-based, integrating the best research evidence and patient values.

Intent:
The dental school should use evidence to evaluate new technology and products and to guide diagnosis and treatment decisions.
5-3 The dental school must conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:
   a. standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;
   b. an ongoing review and analysis of compliance with the defined standards of care;
   c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
   d. mechanisms to determine the cause(s) of treatment deficiencies; and
   e. implementation of corrective measures as appropriate.

Intent:
Dental education programs should create and maintain databases for monitoring and improving patient care and serving as a resource for research and evidence-based practice.

5-4 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive patient care.

5-5 The dental school must ensure that active patients have access to professional services at all times for the management of dental emergencies.

5-6 All students, faculty and support staff involved in the direct provision of patient care must be continuously certified in basic life support (B.L.S.), including cardiopulmonary resuscitation, and be able to manage common medical emergencies.

5-7 Written policies and procedures must be in place to ensure the safe use of ionizing radiation, which include criteria for patient selection, frequency of exposing radiographs on patients, and retaking radiographs consistent with current, accepted dental practice.

5-8 The dental school must establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste, consistent with accepted dental practice.

5-9 The school’s policies and procedures must ensure that the confidentiality of DEP Standards
information pertaining to the health status of each individual patient is strictly maintained.
STANDARD 6- RESEARCH PROGRAM

6-1 Research, the process of scientific inquiry involved in the development and dissemination of new knowledge, **must** be an integral component of the purpose/mission, goals and objectives of the dental school.

**Intent:**
*The institution should develop and sustain a research program on a continuing basis. The dental school should develop strategies to address the research mission and regularly assess how well such expectations are being achieved. Annual evaluations should provide evidence of innovations and advances which reflect research leadership within research focus areas of the institution.*

**Examples of evidence to demonstrate compliance may include:**
- Established research areas and ongoing funded support of the research activities
- Commitment to research reflected in institution mission statement, strategic plan, and financial support
- Evidence of regular ongoing research programmatic review
- Extramural grant and/or foundation support of the research program
- Other evidence of the global impact of the research program

6-2 The dental school faculty, as appropriate to meet the school’s purpose/mission, goals and objectives, **must** engage in research or other forms of scholarly activity.

**Intent:**
*Schools should establish focused, significant, and sustained programs to recruit and retain faculty suitable to the institution’s research themes, and or scholarly activity. The program should employ an adequate number of full-time faculty with time dedicated to the research mission of the institution. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty.*
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Examples of evidence to demonstrate compliance may include:

- Faculty roster of full-time equivalents dedicated to research  
- Extramural funding of faculty  
- Documentation of research faculty recruitment efforts  
- Peer reviewed scholarly publications (manuscripts, abstracts, books, etc.) based on original research  
- Presentation at scientific meetings and symposia  
- Other evidence of the impact of the research program and research productivity

Dental education programs must provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.

Intent:

The dental education program should provide students with opportunities to experience research including, but not limited to, biomedical, translational, educational, epidemiologic and clinical research. Such activities should align with clearly defined research mission and goals of the institution. The dental education program should introduce students to the principles of research and provide elective opportunities beyond basic introduction, including how such research is conducted and evaluated, and where appropriate, conveyed to patients and other practitioners, and applied in clinical settings.

Examples of evidence to demonstrate compliance may include:

- Formal presentation of student research at school or university events  
- Scholarly publications with student authors based on original research  
- Presentation at scientific meetings  
- Research abstracts and table clinics based on student research
Commission on Dental Accreditation

Accreditation Standards for Dental Therapy Education Programs
Accreditation Standards for Dental Therapy Education Programs

Commission on Dental Accreditation
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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

Programs Which 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 must be demonstrated within 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.

**Programs Which 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 DTEP Standards.
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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).
Introduction

Accreditation
Accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. 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
The Commission on Dental Accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related disciplines.

Dental Therapy Accreditation
The first dental therapy accreditation standards were developed by the Commission on Dental Accreditation in 2013. In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation used 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 standards in February 2015, the Commission carefully considered comments received from all sources. The accreditation standards were implemented in August 2015.

Standards
Dental therapy education programs must meet the standards delineated in this document to achieve and maintain accreditation.

Standards 1 through 5 constitute The Accreditation Standards for Dental Therapy Education Programs by which the Commission on Dental Accreditation and its consultants evaluate Dental Therapy Education Programs for accreditation purposes. This entire document also serves as a program development guide for institutions that wish to establish new programs or improve existing programs. Many of the goals related to the educational environment and the
corresponding standards were influenced by best practices in accreditation from other health professions.

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

Although the standards are comprehensive and applicable to all institutions that offer dental therapy education programs, the Commission recognizes that methods of achieving standards may vary according to the mission, size, type and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required education and training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission recognizes the importance of academic freedom, and an institution is allowed considerable flexibility in structuring its educational program so that it can meet the Standards. No curriculum has enduring value, and a program will not be judged by conformity to a given type. The Commission also recognizes that schools organize their faculties in a variety of ways. Instruction necessary to achieve the prescribed levels of knowledge and skill may be provided by the educational unit(s) deemed most appropriate by each institution.

The Commission has an obligation to the public, the profession and prospective students to assure that accredited Dental Therapy Education Programs provide an identifiable and characteristic core of required education, training and experience.

Format of the Standards
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. 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.
Statement of General Policy

Maintaining and improving the quality of dental therapy 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 therapy 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 therapy 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 therapy 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 therapy program and core courses developed for related disciplines. When an institution has been granted “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 therapy 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 therapy education programs and dental hygiene or dental assisting 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 Therapy 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.
Goals

The assessment of quality in educational programs is the foundation for the Standards. In addition to the emphasis on quality education, the Accreditation Standards for Dental Therapy Education Programs are designed to meet the following goals:

1. to protect the public welfare;
2. to promote an educational environment that fosters innovation and continuous improvement;
3. to guide institutions in developing their academic programs;
4. to guide site visit teams in making judgments regarding the quality of the program and;
5. to provide students with reasonable assurance that the program is meeting its stated objectives.

Specific objectives of the current version of the Standards include:

- streamlining the accreditation process by including only standards critical to the evaluation of the quality of the educational program;
- increasing the focus on competency statements in curriculum-related standards; and
- emphasizing an educational environment and goals that foster critical thinking and prepare graduates to be life-long learners.

To sharpen its focus on the quality of dental therapy education, the Commission on Dental Accreditation includes standards related to institutional effectiveness. Standard 1, “Institutional Effectiveness,” guides the self-study and preparation for the site visit away from a periodic approach by encouraging establishment of internal planning and assessment that is ongoing and continuous. Dental therapy education programs are expected to demonstrate that planning and assessment are implemented at all levels of the academic and administrative enterprise. The Standards focus, where necessary, on institutional resources and processes, but primarily on the results of those processes and the use of those results for institutional improvement.
The following steps comprise a recommended approach to an assessment process designed to measure the quality and effectiveness of programs and units with educational, patient care, research and service missions. The assessment process should include:

1. establishing a clearly defined purpose/mission appropriate to dental therapy education, patient care, research and service;
2. formulating goals consistent with the purpose/mission;
3. designing and implementing outcomes measures to determine the degree of achievement or progress toward stated goals;
4. acquiring feedback from internal and external groups to interpret the results and develop recommendations for improvement (viz., using a broad-based effort for program/unit assessment);
5. using the recommendations to improve the programs and units; and
6. re-evaluating the program or unit purpose and goals in light of the outcomes of this assessment process.

Implementation of this process will also enhance the credibility and accountability of educational programs.

It is anticipated that the Accreditation Standards for Dental Therapy Education Programs will strengthen the teaching, patient care, research and service missions of schools. These Standards are national in scope and represent the minimum requirements expected for a dental therapy education program. However, the Commission encourages institutions to extend the scope of the curriculum to include content and instruction beyond the scope of the minimum requirements, consistent with the institution’s own goals and objectives.

The foundation of these Standards is a competency-based model of education through which students acquire the level of competence needed to begin the practice of dental therapy. Competency is a complex set of capacities including knowledge, experience, critical thinking, problem-solving, professionalism, personal integrity and procedural skills that are necessary to begin the practice of dental therapy. These components of competency become an integrated whole during the delivery of patient care. Professional competence is the habitual and judicious use of communication, knowledge, critical appraisal, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities served. Accordingly, learning experiences help students blend the various dimensions of competency.
into an integrated performance for the benefit of the patient. The assessment process focuses on measuring the student’s overall capacity to function as an entry-level, beginning dental therapist rather than measuring individual skills in isolation.

In these *Standards* the competencies for dental therapy are described broadly. The Commission expects each school to develop specific competency definitions and assessment methods in the context of the broad scope of dental therapy practice. These competencies must be reflective of an evidence-based definition of dental therapy. To assist schools in defining and implementing their competencies, the Commission strongly encourages the development of a formal liaison mechanism between the school and the practicing dental community.

The objectives of the Commission are based on the premise that an institution providing a dental therapy educational program will strive continually to enhance the standards and quality of both scholarship and teaching. The Commission expects an educational institution offering such a program to conduct that program at a level consistent with the purposes and methods of higher education and to have academic excellence as its primary goal.
Definition of Terms Used in Accreditation Standards for Dental Therapy Education Programs

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 or a duty; an essential or indispensable item; mandatory.

**Should:** Indicates an expectation.

**Intent:** Intent statements are presented to provide clarification to dental therapy education programs in the application of, and in connection with, compliance with the *Accreditation Standards for Dental Therapy 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.

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

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

**Competent:** The levels of knowledge, skills and values required by the new graduates to begin dental therapy practice.

**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.
Dental Therapy: Denotes education and training leading to dental therapy practice.

Community-based experience: Refers to educational opportunities for dental therapy students to provide patient care in community-based clinics or private practices under the supervision of faculty licensed to perform the treatment in accordance with the state dental practice act. Community-based experiences are not intended to be synonymous with community service activities where dental therapy students might go to schools to teach preventive techniques or where dental therapy students help build homes for needy families.

Evidence-based dentistry (EBD): An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the clinician’s expertise and the patient's treatment needs and preferences.

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

Quality assurance: A cycle of PLAN, DO, CHECK, ACT that involves setting goals, determining outcomes, and collecting data in an ongoing and systematic manner to measure attainment of goals and outcomes. The final step in quality assurance involves identification and implementation of corrective measures designed to strengthen the program.

Service learning: A structured experience with specific learning objectives that combines community service with academic preparation. Students engaged in service learning learn about their roles as dental therapists through provision of patient care and related services in response to community-based problems.

Advanced Standing: Programs and their sponsoring institutions are encouraged to provide for educational mobility of students through articulation arrangements and career laddering (e.g. between dental therapy education programs and dental hygiene or dental assisting 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.
Advanced standing means the program has the authority to grant full or partial course credit for a specific course toward the completion of the dental therapy program. This may apply to one or more courses in the dental therapy program curriculum.

**Humanistic Environment:** Dental therapy programs are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic pedagogy inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising and small group interaction. A dental therapy program environment characterized by respectful professional relationships between and among faculty and students establishes a context for the development of interpersonal skills necessary for learning, for patient care, and for making meaningful contributions to the profession.

**Health literacy:** “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (Institute of Medicine. 2004. *Health Literacy: A Prescription to End Confusion.* Washington, DC: The National Academies Press. [https://doi.org/10.17226.10883.])
STANDARD 1-INSTITUTIONAL EFFECTIVENESS

1-1 The program must develop a clearly stated purpose/mission statement appropriate to dental therapy education, addressing teaching, patient care, research and service.

Intent: A clearly defined purpose and a mission statement that is concise and communicated to faculty, staff, students, patients and other communities of interest is helpful in clarifying the purpose of the program.

1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness must be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.

Intent: Assessment, planning, implementation and evaluation of the educational quality of a dental therapy education program that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students. The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of dental therapy.

Examples of evidence to demonstrate compliance may include:

- program completion rates
- employment rates
- success of graduates on licensing examinations
- 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
The dental therapy education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

**Intent:** The dental therapy education 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

The program must have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty and staff;
b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and
c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

**Intent:** The program should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The program should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Programs could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Programs should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.
The financial resources **must** be sufficient to support the program’s stated purpose/mission, goals and objectives.

**Intent:** *The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, reference material and teaching aids as reflected in an annual operating budget. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes 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 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 therapy representation on key college or university committees
1-7 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.

1-8 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)

1-9 The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

**Examples of evidence to demonstrate compliance may include:**
- Written agreement(s)
- Contracts between the institution/program and sponsor(s) (For example: contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)

1-10 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

1-11 The program **must** show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems.
Community Resources

1-12 There **must** be an active liaison mechanism between the program and the dental and allied dental professions in the community.

**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

The dental therapist is a member of the oral healthcare team. The curriculum for dental therapy programs will support the overall education, training and assessment to a level of competency within the scope of dental therapy practice.

2-1 The curriculum must include at least three academic years of full-time instruction or its equivalent at the postsecondary college-level.

**Intent:** The scope and depth of the curriculum should reflect the objectives and philosophy of higher education. The time necessary for psychomotor skill development and the number of required content areas require three academic years of study and is considered the minimum preparation for a dental therapist. This could include documentation of advanced standing. However, the curriculum may be structured to provide opportunity for students who require more time to extend the length of their instructional program.

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 outlining course titles and descriptions
- documentation of advanced standing requirements

2-2 The stated goals of the program must be focused on educational outcomes and define the competencies needed for graduation, including the preparation of graduates who possess the knowledge, skills and values to begin the practice of dental therapy.

2-3 The program must have a curriculum management plan that ensures:
   a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;
   b. evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;
c. elimination of unwarranted repetition, outdated material, and unnecessary material;
d. incorporation of emerging information and achievement of appropriate sequencing.

2-4 The dental therapy education program must employ student evaluation methods that measure its defined competencies and are written and communicated to the enrolled students.

**Intent:** Assessment of student performance should measure not only retention of factual knowledge, but also the development of skills, behaviors, and attitudes needed for subsequent education and practice. The evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills but also assess the process and procedures which will be necessary for entry level practice.

2-5 Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.

**Examples of Evidence to demonstrate compliance may include:**
- On-going faculty training
- Calibration training manuals
- Periodic monitoring for compliance
- Documentation of faculty participation in calibration-related activities

2-6 In advance of each course or other unit of instruction, students must be provided written information about the goals and requirements of each course, the nature of the course content, the method(s) of evaluation to be used, and how grades and competency are determined.

**Intent:** The program should identify the dental therapy fundamental knowledge and competencies that will be included in the curriculum based on the program goals, resources, current dental therapy 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.
2-7 Academic standards and institutional due process policies and procedures must be provided in written form to the students and followed for remediation or dismissal.

**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

2-8 Graduates must demonstrate the ability to self-assess, including the development of professional competencies related to their scope of practice and the demonstration of professional values and capacities associated with self-directed, lifelong learning.

**Intent:** Educational program should prepare students to assume responsibility for their own learning. The education program should teach students how to learn and apply evolving and new knowledge over a complete career as a health care professional. Lifelong learning skills include student assessment of learning needs.

Examples of evidence to demonstrate compliance may include:
- Students routinely assess their own progress toward overall competency and individual competencies as they progress through the curriculum
- Students identify learning needs and create personal learning plans
- Students participate in the education of others, including fellow students, patients, and other health care professionals, that involves critique and feedback

2-9 Graduates must be competent in the use of critical thinking and problem-solving, related to the scope of dental therapy practice including their use in the care of patients and knowledge of when to consult a dentist or other members of the healthcare team.
Consideration of the Use of the Term “Should” Within the Accreditation Standards
Predoctoral Dental RC
CODA Winter 2020

Intent: 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:
- Explicit discussion of the meaning, importance, and application of critical thinking
- Use of questions by instructors that require students to analyze problem etiology, compare and evaluate alternative approaches, provide rationale for plans of action, and predict outcomes
- Prospective simulations in which students perform decision-making
- Retrospective critiques of cases in which decisions are reviewed to identify errors, reasons for errors, and exemplary performance
- Writing assignments that require students to analyze problems and discuss alternative theories about etiology and solutions, as well as to defend decisions made
- Asking students to analyze and discuss work products to compare how outcomes correspond to best evidence or other professional standards

Curriculum

2-10 The curriculum must include content that is integrated with sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies in the following three areas: general education, biomedical sciences, and dental sciences (didactic and clinical).

Intent: Foundational knowledge should be established early in the dental therapy program and be of appropriate scope and depth to prepare the student to achieve competence in defined components of dental therapy 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 taught at the postsecondary level.

DTEP Standards
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Programs and their sponsoring institutions are encouraged to provide for educational mobility of students through articulation arrangements and career laddering (e.g. between dental therapy education programs and dental hygiene or dental assisting education programs) that results in advanced standing permitted for dental hygienists or dental assistants.

2-11 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.

2-12 Biomedical science instruction in dental therapy education must ensure an understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems in each of the following areas:

a. head and neck and oral anatomy  
b. oral embryology and histology  
c. physiology  
d. chemistry  
e. biochemistry  
f. microbiology  
g. immunology  
h. general pathology and/or pathophysiology  
i. nutrition  
j. pharmacology

**Intent:** These subjects provide background for both didactic and clinical dental 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. The biomedical knowledge base emphasizes the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

Dental therapists need to recognize abnormal conditions to understand the parameters of dental therapy 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 therapy interventions.

2-13 Didactic dental sciences content must ensure an understanding of basic dental principles, consisting of a core of information in each of the following areas within the scope of dental therapy:

a. tooth morphology  
b. oral pathology  
c. oral medicine  
d. radiology  
e. periodontology  
f. cariology  
g. atraumatic restorative treatment (ART)  
h. operative dentistry  
i. pain management  
j. dental materials  
k. dental disease etiology and epidemiology  
l. preventive counseling and health promotion  
m. patient management  
n. pediatric dentistry  
o. geriatric dentistry  
p. medical and dental emergencies  
q. oral surgery  
r. prosthodontics  
s. infection and hazard control management, including provision of oral health care services to patients with bloodborne infectious diseases.

**Intent:** These subjects provide the student with knowledge of oral health and disease as a basis for assuming responsibility for 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.

2-14 Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.
**Intent:** Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:

- basic principles of culturally competent health care;
- basic principles of health literacy and effective communication for all patient populations;
- recognition of health care disparities and the development of solutions;
- the importance of meeting the health care needs of dentally underserved populations, and;
- the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.

Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. 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 therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).

**Examples of evidence to demonstrate compliance may include:**

- student projects demonstrating the ability to communicate effectively with a variety of individuals and groups.
- examples of individual and community-based oral health projects implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance

**2-15** Graduates **must** be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

**Intent:** In attaining competence, students should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences that involve working with other healthcare professional students and practitioners. Students
should have educational experiences in which they participate in the coordination of patient care within the health care system relevant to dentistry.

Ethics and Professionalism

2-16 Graduates must be competent in the application of the principles of ethical decision making and professional responsibility.

Intent: Graduates should know how to draw on a range of resources, among which are professional codes, regulatory law, and ethical theories. These resources should pertain to the academic environment, patient care, practice management and research. They should guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

2-17 Graduates must be competent in applying legal and regulatory concepts to the provision and/or support of oral health care services.

Intent: Dental therapists 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

Clinical Sciences

2-18 Graduates must be able to access, critically appraise, apply, and communicate information as it relates to providing evidence-based patient care within the scope of dental therapy practice.

Intent: The education program should introduce students to the basic principles of research and its application for patients.
2-19 The program must ensure the availability of adequate patient experiences that afford all students the opportunity to achieve its stated competencies within a reasonable time.

Intent: Sufficient practice time and learning experiences should be provided during preclinical and clinical courses to ensure that students attain clinical competence. Recognizing that there is a single standard of dental care, the care experiences provided for patients by students should be adequate to ensure competency in all components of dental therapy.

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

2-20 Graduates must be competent in providing oral health care within the scope of dental therapy to patients in all stages of life.

The dental therapist provides care with supervision at a level specified by the state dental practice act. The curriculum for dental therapy programs will support the following competencies within the scope of dental therapy practice.

2-21 At a minimum, graduates must be competent in providing oral health care within the scope of dental therapy practice with supervision as defined by the state practice acts, including:

a. identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals
b. comprehensive charting of the oral cavity
c. oral health instruction and disease prevention education, including nutritional counseling and dietary analysis
d. exposing radiographic images  
e. dental prophylaxis including sub-gingival scaling and/or polishing procedures  
f. dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider  
g. applying topical preventive or prophylactic agents (i.e. fluoride), including fluoride varnish, antimicrobial agents, and pit and fissure sealants  
h. pulp vitality testing  
i. applying desensitizing medication or resin  
j. fabricating athletic mouthguards  
k. changing periodontal dressings  
l. administering local anesthetic  
m. simple extraction of erupted primary teeth  
n. emergency palliative treatment of dental pain limited to the procedures in this section  
o. preparation and placement of direct restoration in primary and permanent teeth  
p. fabrication and placement of single-tooth temporary crowns  
q. preparation and placement of preformed crowns on primary teeth  
r. indirect and direct pulp capping on permanent teeth  
s. indirect pulp capping on primary teeth  
t. suture removal  
u. minor adjustments and repairs on removable prostheses  
v. removal of space maintainers  

**Intent:** *Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dental therapy at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school’s goals, resources, accepted dental therapy responsibilities and other influencing factors. Programs should define overall competency, in order to measure the graduate’s readiness to enter the practice of dental therapy.*

**Additional Dental Therapy Functions**

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DTEP Standards

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Where graduates of a CODA-accredited dental therapy program are authorized to perform additional functions 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 therapy 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 therapists are taught and evaluated at the depth and scope required by the state. The inclusion of additional functions cannot compromise the scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.

Dental therapy program learning experiences must be defined by the program goals and objectives.

Dental therapy education programs must have students engage in service learning experiences and/or community-based learning experiences.

**Intent:** Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.
STANDARD 3- FACULTY AND STAFF

3-1 The program director must have a full-time administrative appointment as defined by the institution and have primary responsibility for operation, supervision, evaluation and revision of the Dental Therapy educational program.

**Intent:** To allow sufficient time to fulfill administrative responsibilities, teaching contact hours should be limited for the program director and should not take precedent over administrative responsibilities.

3-2 The program director must be a licensed dentist (DDS/DMD) or a licensed dental therapist possessing a master’s or higher degree. The director must be a graduate of a program accredited by the Commission on Dental Accreditation and who has background in education and the professional experience necessary to understand and fulfill the program’s mission and goals.

**Intent:** The program director’s background should include administrative experience, instructional experience, and professional experience in general dentistry. The term of interim/acting program director should not exceed a two year period.

**Examples of evidence to demonstrate compliance may include:**
- bio sketch of program director.

3-3 The program director 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 director position description
3-4 The number and distribution of faculty and staff must be sufficient to meet the program’s stated purpose/mission, goals and objectives, at all sites where required educational activity occurs.

**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

3-5 The faculty to student ratio for preclinical, clinical and radiographic clinical and laboratory sessions must not exceed one to six. The faculty to student ratio for laboratory sessions in the dental science courses must not exceed one to ten 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 supervised patient care clinics rather than by the total 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 assessment of students’ progression toward competency. Faculty are also responsible for ensuring that the patient care services delivered by students meet the program’s standard of care.

**Examples of evidence to demonstrate compliance may include:**
- faculty teaching commitments
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-6 All faculty of a dental therapy program must be educationally qualified for the specific subjects they are teaching.

**Intent:** Faculty should have current background in 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, dental therapists, dental hygienists, and expanded function dental assistants who supervise
students’ clinical procedures should have qualifications which comply with the state dental practice act. Individuals who teach and supervise students in clinical experiences should have qualifications comparable to faculty who teach in the main program 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

3-7 The program must show evidence of an ongoing faculty development process.

Intent: Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession. Effective teaching requires not only content knowledge, but an understanding of pedagogy, including knowledge of curriculum design and development, curriculum evaluation, and teaching methodologies.

Examples of evidence to demonstrate compliance may include:
- 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
- records of calibration of faculty

3-8 The faculty, as appropriate to meet the program’s purpose/mission, goals and objectives, must engage in scholarly activity.

3-9 Faculty must be ensured a form of governance that allows participation in the school’s decision-making processes.

3-10 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

**3-11** The dental therapy program faculty **must** be granted privileges and responsibilities as afforded all other comparable institutional faculty.

**Examples of evidence to demonstrate compliance may include:**
- institution’s promotion/tenure policy
- faculty senate handbook
- institutional policies and procedures governing faculty

**3-12** 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
STANDARD 4-EDUCATIONAL SUPPORT SERVICES

Admissions

4-1 Specific written criteria, policies and procedures must be followed when admitting students.

Intent: The dental therapy education curriculum is a postsecondary scientifically-oriented program which is rigorous and intensive. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability should be utilized as criteria in selecting students who have the potential for successfully completing the program. Applicants should 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 therapists.

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
- advanced standing policies and procedures, if appropriate

4-2 Admission policies and procedures must be designed to include recruitment and admission of a diverse student population.
**Intent:** Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.

4-3 Admission of students with advanced standing **must** be based on the same standards of achievement required by students regularly enrolled in the program. Advanced standing requirements for career laddering into a dental therapy program **must** meet advanced standing requirements of the college or university offering advanced standing for dental therapy.

**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.

4-4 Students with advanced standing **must** receive an individualized assessment and an appropriate curriculum plan that results in the same standards of competence for graduation required by students regularly enrolled in the 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
4-5 The number of students enrolled in the program must be proportionate to the resources available.

**Intent:** In determining the number of dental therapy 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

**Facilities and Resources**

4-6 The program must provide adequate and appropriately maintained facilities and learning resources to support the purpose/mission of the program and which are in conformance with applicable regulations.

**Intent:** The classroom facilities should include an appropriate number of student stations with equipment and space for individual student performance in a safe environment.

4-7 The clinical 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; functional, equipment; an area that accommodates a full range of operator movement and opportunity for proper instructor supervision;

b) a capacity of the clinic that accommodates individual student practice on a regularly scheduled basis throughout all phases of preclinical technique and clinical instruction;
c) a sterilizing area that includes sufficient space for preparing, sterilizing and storing instruments;
d) sterilizing equipment and personal protective equipment/supplies that follow current infection and hazard control protocol;
e) facilities and materials for students, faculty and staff that provide compliance with accepted infection and hazard control protocols;
f) 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.

4-8 Radiography facilities must be sufficient for development of clinical competence and contain the following:

a) an appropriate number of radiography exposure rooms which include: dental radiography units; teaching manikin(s); and conveniently located hand-washing sinks;
b) processing and/or imaging equipment;
c) an area for viewing radiographs;
d) documentation of compliance with applicable local, state and federal regulations.

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.

4-9 A multipurpose laboratory facility must be provided for effective instruction and allow for required laboratory activities and 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.
Consideration of the Use of the Term “Should” Within the Accreditation Standards Predoctoral Dental RC CODA Winter 2020

**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.

4-10 Office space which allows for privacy **must** be provided for the program administrator and faculty

**Intent:** Office space for full- and part-time faculty should be allocated to allow for class preparation, student counseling and supportive academic activities. Student and program records should be stored to ensure confidentiality and safety.

4-11 Instructional aids, equipment, and library holdings **must** be provided for student learning.

**Intent:** The acquisition of knowledge, skills and values for 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, should be assured access to learning resources. Institutional library holdings should include or provide access to a diversified collection of current dental and medical literature and references necessary to support teaching, student learning needs, service, research and development. There should be a mechanism for program faculty to periodically review, acquire and select current titles and instructional aids.

**Examples of evidence to demonstrate compliance may include:**
- a list of references on education, medicine, dentistry, dental therapy, dental hygiene, dental assisting 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 medicine, dentistry, dental therapy, dental hygiene, dental assisting and the biomedical sciences
Student Services

4-12  Student services **must** include the following:
   a. personal, academic and career counseling of students;
   b. assuring student participation on appropriate committees;
   c. providing appropriate information about the availability of financial aid and health services;
   d. developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;
   e. student advocacy; and
   f. maintenance of the integrity of student performance and evaluation records.

**Intent:** All policies and procedures should protect the students and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect the work accomplished and are maintained in a secure manner. Students should have available the necessary support to provide career information and guidance as to practice, post-graduate and research opportunities.

Student Financial Aid

4-13  At the time of acceptance, students **must** be advised of the total expected cost of their education and opportunities for employment.

**Intent:** Financial information should include estimates of living expenses and educational fees, an analysis of financial need, and the availability of financial aid.

4-14  The institution **must** be in compliance with all federal and state regulations relating to student financial aid and student privacy.
**Health Services**

**4-15** The dental therapy program **must** advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental therapy studies.

**4-16** There **must** be a mechanism for ready access to health care for students while they are enrolled in dental therapy school.

**4-17** Students **must** be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.

**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
STANDARD 5 – HEALTH, SAFETY, AND PATIENT CARE PROVISIONS

5-1 Written policies and procedures must be in place to ensure the safe use of ionizing radiation, which include criteria for patient selection, frequency of exposing radiographs on patients, and retaking radiographs consistent with current standard of care.

Intent: All radiographic exposure should be integrated with clinical patient care procedures.

5-2 Written policies and procedures must establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste.

Intent: Policies and procedures should be in place to provide for a safe environment for students, patients, faculty and staff.

5-3 The school’s policies and procedures must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

5-4 All students, faculty and support staff involved in the direct provision of patient care must be continuously certified in basic life support (B.L.S.), including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED), and be able to manage common medical 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
5-5 The program must conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:
   a. standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;
   b. an ongoing review and analysis of compliance with the defined standards of care;
   c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
   d. mechanisms to determine the cause(s) of treatment deficiencies; and
   e. implementation of corrective measures as appropriate.

Intent: Programs should create and maintain databases for monitoring and improving patient care and serving as a resource for research and evidence-based practice.

5-6 The program must have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs and the scope of dental therapy care available at the dental therapy facilities.

Intent: All patients should receive appropriate care that assures their rights as a patient are 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

5-7 The program must develop and distribute a written statement of patients’ rights and commitment to patient-centered care 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.

5-8 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of 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

5-9 Patient care must be evidenced-based, integrating the best research evidence and patient values.

**Intent:** The program should use evidence to evaluate new technology and products and to guide treatment decisions.

5-10 The program must ensure that active patients have access to professional services at all times for the management of dental emergencies.
CONSIDERATION OF PROPOSED REVISION TO STANDARD 2-24N OF THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

Background: At its Summer 2019 meeting, the Commission on Dental Accreditation (CODA) considered a request from Dr. Carla Evans, a current member of the Predoctoral Dental Education Review Committee, proposing that the CODA review Standard 2-24n of the Accreditation Standards for Dental Education Programs related to “malocclusion and space management.” While data and a narrative describing Dr. Evans’ concern with Standard 2-24n was provided, the PREDOC RC and Commission noted that there was no proposed revision submitted with the documentation. As such, the Commission directed that there be no change to the Accreditation Standards at that time.

On November 25, 2019, the Commission on Dental Accreditation (CODA) received a subsequent request from Dr. Carla Evans proposing deletion of CODA Standard 2-24n and insertion of a new standard related to “malocclusion and space concerns” within the Accreditation Standards for Dental Education Programs. Dr. Evans’ request is found in Appendix 1.

Summary: The Predoctoral Dental Education Review Committee and Commission are requested to consider the proposed revision to the Accreditation Standards for Dental Education Programs (Appendix 1) submitted by Dr. Carla Evans. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks
I’ve been working on proposed changes to Standard 2-24n since the last Predoctoral Review Committee meeting in July. You’ll find my proposals in the attachment called “CODA – predoc proposals 2-24n, 2-xx”; it deletes 2-24n and adds a new standard. My reasons are explained in the attached letter that was sent last June.

Carla Evans
caevans@bu.edu
May 30, 2019

Sherin Tooks, Ed.D., M.S.
Director, Commission on Dental Accreditation
211 E. Chicago Ave.
Chicago, IL 60611

Dear Dr. Tooks,

Dental education in the United States is based on a dynamic collaboration between students, faculty, institutions, organizations and the business community, and aims to prepare graduates for the independent, unsupervised practice of general dentistry\(^1,2\). However, the scope of general dental practice is vague, and blurring of the boundaries between general and specialty practice has increased. A prime example of the lack of consensus is the divergence of opinions about the place of clinical orthodontics within the scope of general dental practice. Legally, a general dentist can practice orthodontics if the results are within the standard of care, but much of dental education is based on the concept of referral of orthodontic problems to a specialist\(^3\).

The word “orthodontics” is not found in the 2020 CODA Accreditation Standards for Dental Education Programs\(^4\). Instead, Standard 2-24n references “malocclusion and space management” with an overall caveat that “the graduate must be competent in providing oral health care within the scope of general dentistry, as defined by the school.” That’s a beginning. However, the ADEA Surveys of Senior Dental Students\(^5\) show that for ALL years from 2006 through 2018, dental graduates feel most unprepared in the area of orthodontics. Appendix A to this letter gives the summary data from the ADEA Surveys of Senior Dental Students and the last column gives the ranking of orthodontics in comparison to other subjects taught in dental school. The total number of subjects varies due to year-to-year changes in groupings in the surveys, but every year orthodontics is ranked last. Other sources of evidence for overall curricular effectiveness include reports of changes in clinical practice, objective measures obtained from national examinations and licensing procedures, as well as reports such as those prepared for predoctoral accreditation and curriculum surveys.

It is difficult for members of accreditation site visit teams to ascertain competence for Standard 2-24n at a general dentist level because: 1. The members are not specialists and vary markedly in their orthodontic knowledge and skills, 2. the ADEA references\(^1,2\) are not prescriptive, and 3. dental faculty focus on preparing their graduates for licensing examinations based primarily on other topics. So general dentists and non-orthodontist specialists who wish to address malocclusion in their practices learn from short continuing education courses, vendors, published materials or their colleagues – sometimes putting the public at risk. Data exist to show that non-orthodontists are undertaking significant orthodontic treatment in increasing numbers\(^6,7\) and that even the public is becoming involved in do-it-yourself orthodontic treatment\(^8\).

To address the needs of the public and dental students with respect to orthodontics, an accreditation site visit should evaluate foundation knowledge in the curriculum (e.g. growth and development, physiology of bone and the periodontium, biology of therapeutic tooth movement, orthodontic
materials, biomechanics, facial and dental esthetics and iatrogenic harm). In the clinical realm, at a minimum a dental graduate should be able to document and interpret a patient’s condition, treatment changes, and relapse by using dental models, radiographs, photographs, etc. In addition, a dental graduate should be able to utilize digital technology, communicate potential orthodontic outcomes and risks to patients and evaluate their own abilities before embarking on treatment interventions.

It’s important that dental education be improved to reflect the changes occurring in the world of dental practice and prepare graduates so that they are ready to work and counsel patients. Perhaps the issues discussed in this letter can be addressed by additions to CODA standards or intent statements. Also, it is possible that the annual Survey of Predoctoral Curriculum managed by JACDEI (Joint Advisory Committee on Dental Education Information) and CODA could help identify current shortcomings.

Sincerely,

Carla A. Evans, DDS, DMSc
Clinical Professor of Orthodontics
Henry M. Goldman School of Dental Medicine
Boston University
ciaevans@bu.edu

APPENDIX:

A. Summary Data (Orthodontics) – ADEA Surveys of Senior Dental Students (2006-2018)

REFERENCES:

6. ADA Health Policy Institute, Dental Fees: Results from the 2018 Survey of Dental Fees.
### SUMMARY DATA (ORTHODONTICS) – ADEA SURVEYS OF SENIOR DENTAL STUDENTS 2006-2018

<table>
<thead>
<tr>
<th>Year</th>
<th>Time devoted to orthodontics</th>
<th>Preparedness for practice (orthodontics)</th>
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<tr>
<td></td>
<td>Excessive (%)</td>
<td>Appropriate (%)</td>
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<tr>
<td>2006</td>
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<td>2007</td>
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<tr>
<td>2010</td>
<td>4.3</td>
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</tr>
<tr>
<td>2011</td>
<td>4.4</td>
<td>47.4</td>
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From: ADEA Surveys of Senior Dental Students 2006-2018, [https://www.adea.org/data/seniors/](https://www.adea.org/data/seniors/)
<table>
<thead>
<tr>
<th>Year</th>
<th>Not at all confident</th>
<th>Somewhat confident</th>
<th>Modestly confidence</th>
<th>Highly confident</th>
<th>Moderately to Highly confident</th>
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<tr>
<td>2012</td>
<td>4/0</td>
<td>60.5</td>
<td>34.0</td>
<td>1.6</td>
<td>20/23</td>
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<tr>
<td>2013</td>
<td>4.0</td>
<td>63.2</td>
<td>32.6</td>
<td>0.2</td>
<td>22/24</td>
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<tr>
<td>2014</td>
<td>3.6</td>
<td>65.6</td>
<td>30.6</td>
<td>0.2</td>
<td>22/24</td>
</tr>
<tr>
<td>2015</td>
<td>3.4</td>
<td>66.0</td>
<td>30.3</td>
<td>0.3</td>
<td>21/24</td>
</tr>
<tr>
<td>2016</td>
<td>3.2</td>
<td>67.8</td>
<td>28.8</td>
<td>0.2</td>
<td>21/24</td>
</tr>
<tr>
<td>2017</td>
<td>4.1</td>
<td>65.9</td>
<td>29.5</td>
<td>0.5</td>
<td>21/24</td>
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The 2018 survey substituted “malocclusion” for “orthodontics” and rating scales from “preparedness” to “confidence.”
EXISTING:

Standard 2-24

At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;

b. screening and risk assessment for head and neck cancer;

c. recognizing the complexity of patient treatment and identifying when referral is indicated;

d. health promotion and disease prevention;

e. local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;

f. restoration of teeth;

g. communicating and managing dental laboratory procedures in support of patient care;

h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;

i. periodontal therapy;

j. pulpal therapy;

k. oral mucosal and osseous disorders;

l. hard and soft tissue surgery;

m. dental emergencies; and

n. malocclusion and space management; and

o. evaluation of the outcomes of treatment, recall strategies, and prognosis

Intent:

Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school’s goals, resources, accepted general practitioner responsibilities and other influencing factors. Programs should define overall competency, in order to measure the graduate’s readiness to enter the practice of general dentistry.
NEW

Standard 2-xx:

Graduates must be competent in assessing and managing the treatment of patients with malocclusion and space concerns.

Intent:

- The new dental graduate should be able to carry out 2D and 3D documentation and diagnosis of dental, skeletal, functional and esthetic aspects of malocclusion, including evaluation of treatment and post-treatment changes.
- The judgment, skills and experience of the new dental graduate should be adequate for presentation of advice and treatment options, including the need for consultations and/or referrals that are consistent with the standard of care and the best interests of the patient.

Examples of evidence to demonstrate compliance may include instruction on these topics:

- Biology of therapeutic tooth movement, basic biomechanical principles, orthodontic materials, orthodontic appliances.
- Principles of craniofacial growth and development as applied to diagnosis and appropriate treatment options for children, adolescents and adults, including iatrogenics and limitations.
- Behavior management including adherence strategies, communication skills, and informed consent.
- Integration of limited and comprehensive orthodontic tooth movement into comprehensive dental care.
- Utilization of technology for digital case submission and laboratory prescriptions.
CONSIDERATION OF PROPOSED REVISION TO THE SELF-STUDY GUIDE FOR DENTAL EDUCATION PROGRAMS

**Background:** On November 20, 2019, the Commission on Dental Accreditation (CODA) received a request from the Council of Deans of the American Dental Education Association (ADEA) proposing removal of the “Table 14 Biosketch” from the Self-Study Guide for Dental Education Programs. The Council of Deans believed that in lieu of the biosketch for each faculty, the dental education programs provide a copy of faculty members’ Curriculum Vitae (CV) for on-site review during a CODA accreditation site visit. The ADEA Council of Deans’ proposal is found in Appendix 1. Portions of the Commission’s Self-Study Guide for Dental Education Programs related to Standard 3-Faculty and Staff are found in Appendix 2.

**Summary:** The Predoctoral Dental Education Review Committee and Commission are requested to consider the proposed revision to the Self-Study Guide for Dental Education Programs (Appendix 1) submitted by the ADEA Council of Deans. If proposed revisions are made to the Commission’s Self-Study Guide for Dental Education Programs, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
November 20, 2019

Dr. Sherin Tooks
Commission on Dental Accreditation
211 E. Chicago Avenue
Suite 1900
Chicago, IL 60611

Re: Replacement of the Biosketch Table for Predoctoral Programs

Dear Dr. Tooks:

At a recent meeting of the ADEA Council of Deans, a recommendation was made to remove “Table 14 BioSketch” from the *Self-Study Guide for Dental Education Programs*. While the dental school deans will be providing more comprehensive recommendations as part of the regular re-validation process, the deans are specifically recommending that this change be made as soon as possible.

Table 14 in the self-study guide is a template for faculty biosketches. While programs are not required to use this table, many programs follow the guide and have put these biosketches together. Developing these biosketches requires an extraordinary word processing effort. While the self-study guide does provide flexibility, many schools feel obligated to follow the guide. We recommend that the biosketch template be removed from the self-study guide.

We believe that instead of the biosketch table, programs be asked to have current Curriculum Vitae (CVs) of their faculty on site, which include education, licenses, board certification, previous and current teaching appointments, current teaching responsibilities, hospital experiences, membership and leadership roles in professional organizations, and publications. These CVs would be made available on site (electronically and on paper if requested).

Table 5: Departmental Course Offerings already includes faculty teaching by course, and Tables 8: Alphabetical Listing of Full-Time Faculty and 9: Alphabetical Listing of Part-Time Faculty list all faculty with their educational credentials, academic ranks and board certification status.

As Chair of the ADEA Board of Directors and ADEA President and CEO, we are submitting this request on behalf of the ADEA Council of Deans. Attached are the signatures of the deans supporting this recommendation.

In advance, thank you for making this change.

Sincerely,

President and CEO Chair of the ADEA Board of Directors

Attachment: Signatures of Dental School Deans
## Replacement of the Biosketch Table for Predoctoral Programs

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Dental College/School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mert N. Arsu</td>
<td>MortonGreen</td>
<td>Detroit Mercy</td>
</tr>
<tr>
<td>Scott S. DeRossi</td>
<td>Scott Rell</td>
<td>UNC Adams School of Dentistry</td>
</tr>
<tr>
<td>Clark Stanford</td>
<td>Clark Stanford</td>
<td>University of Illinois at Chicago, College of Dentistry</td>
</tr>
<tr>
<td>Nader Nader Shah</td>
<td>Nader Shah</td>
<td>UOP Dugoni School</td>
</tr>
<tr>
<td>Cecile Feldman</td>
<td>Cecile Feldman</td>
<td>Rutgers University</td>
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### Replacement of the Biosketch Table for Predoctoral Programs

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<tr>
<td>Mark Wolfe</td>
<td>Wolfe</td>
<td>Penn Dental Medicine</td>
</tr>
<tr>
<td>Jeffrey H. Hutter</td>
<td>Hutter</td>
<td>Boston Univ. Henry M. Goldman School of Dental Medicine</td>
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<tr>
<td>Nadeem Karmakar</td>
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<td>Tufts Univ. Scl. of Dentistry</td>
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<tr>
<td>Raymond Cohlinia</td>
<td>Cohlinia</td>
<td>University of Oklahoma College of Dentistry</td>
</tr>
<tr>
<td>Greg Czarnecki</td>
<td>Czarnecki</td>
<td>East Carolina University School of Dental Medicine</td>
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The table continues with additional names, signatures, and dental college/school information.
## Replacement of the Biosketch Table for Predoctoral Programs

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<tr>
<td>Robert Handiges</td>
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<tr>
<td>T-Gerard Bradley</td>
<td></td>
<td>University of Louisville School of Dentistry</td>
</tr>
<tr>
<td>Michael Restly</td>
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<td>U of California, San Francisco</td>
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<tr>
<td>S. Hunga</td>
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<td>MD, Unv, South Carolina</td>
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<tr>
<td>Dwight E. McLeod</td>
<td></td>
<td>ATSU - MOSDOH</td>
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<td>Andrea D. Jackson</td>
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<td>Howard University College of Dentistry</td>
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<tr>
<td>Janet Guthmiller</td>
<td>Janet M. Guthmiller</td>
<td>[UNMC College of Dentistry]</td>
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<td>Phillip Manucho</td>
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<td>[OHSU School of Dentistry]</td>
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<tr>
<td>Bernard J. Costello</td>
<td></td>
<td>Univ. of Pittsburgh</td>
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<tr>
<td>Lily T. Garcia</td>
<td>Lily T. Garcia</td>
<td>UNLV School of Dental Medicine</td>
</tr>
<tr>
<td>Denise Kassem</td>
<td></td>
<td>Univ of Colorado</td>
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<tr>
<td>James C. Ragain Jr.</td>
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<td>Univ of Tennessee HSC College of Dentistry</td>
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## Replacement of the Biosketch Table for Predoctoral Programs

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<td>William K. Lobb</td>
<td>Marquette University School of Dentistry</td>
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<tr>
<td>Richard C. Black</td>
<td>Richard C. Black</td>
<td>Texas Tech Health SDM</td>
</tr>
<tr>
<td>José R. Matoz</td>
<td></td>
<td>School of Dental Medicine Univ. Puerto Rico</td>
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## Replacement of the Biosketch Table for Predoctoral Programs

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<tr>
<td>KEVIN KEATING</td>
<td></td>
<td>California Northstate Univ. College of Dental Medicine</td>
</tr>
<tr>
<td>SHARON GORDON</td>
<td></td>
<td>UConn School of Dental Medicine</td>
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<td>David Jomson</td>
<td>David Jomson</td>
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<tr>
<td>Russell Taichman</td>
<td>Russell Taichman</td>
<td>University of Alabama at Birmingham</td>
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<td>Renee Myers</td>
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<td>Texas College of Dental Medicine</td>
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<td>Peter Leurer</td>
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<td>UT Health San Antonio</td>
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<tr>
<td>Mark Latino</td>
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<td>Creighton University School of Dentistry</td>
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<td>CarolAnne Murdoch-Kinch</td>
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<td>Indiana University School of Dentistry</td>
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<td>Robert Troubek</td>
<td>[Signature]</td>
<td>AT Still Univ.</td>
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Replacement of the Biosketch Table for Predoctoral Programs

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<td>Steven Kaltman</td>
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<td>University of Michigan</td>
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<td>Henry Tremillion</td>
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<td>LSU</td>
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<tr>
<td>Cherea Farmer-Dixon</td>
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<td>Meharry Medical College</td>
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Standard 3-Faculty and Staff of the Self-Study Guide for Dental Education Programs
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<tr>
<td>August 5, 2016</td>
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<td>August 4, 2017</td>
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<td>Areas of Oversight at Sites Where Educational Activity Occur</td>
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<tr>
<td>February 8, 2019</td>
<td>Revised Intent Statements Standards 2-20 and 2-24; New Intent Statement Standard 2-9</td>
<td>Approved</td>
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<td>February 8, 2019</td>
<td>Definition of Terms (Research and Health Literacy); Standard 2-17; Standard 6-Research</td>
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<td>July 1, 2019</td>
<td>Revision to Standards 2-8 and 3-1</td>
<td>Implementation</td>
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<td>Standards 2-24d and 2-25</td>
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STANDARD 3—FACULTY AND STAFF

3-1 The number, distribution and qualifications of faculty and staff must be sufficient to meet the dental school’s stated purpose/mission, goals and objectives, at all sites where required educational activity occurs. The faculty member responsible for the specific discipline must be qualified through appropriate knowledge and experience in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.

**Intent:** Faculty should have knowledge and experience at an appropriate level for the curriculum areas for which they are responsible. The collective faculty of the dental school should have competence in all areas of dentistry covered in the program.

**A. Description:**

1. Describe the distribution and balance of academic titles, qualifications and experience within each department of the dental school, and at all sites where required educational activity occurs.

2. List and describe the criteria used to assign job responsibilities and workload, including at all sites where required educational activity occurs.

3. Define the dental school’s faculty credentialing criteria. Describe how the dental school applies its faculty credentialing process. Explain how the school assures that the faculty member responsible for a specific discipline is qualified through appropriate knowledge and experience in the discipline as deterred by the credentialing of the faculty.

4. Specify the number of full-time equivalent faculty positions allocated to the dental program, including all sites where required educational activity occurs. Comment on the percentage of full-time equivalent positions assigned to the school and all sites where required educational activity occurs that are filled by part-time faculty.

5. List all vacant full-time faculty positions along with current disposition of the vacant positions.

6. In the context of the dental school’s stated purpose/mission, goals and objectives, describe how the number and distribution of the full-time faculty ensures time for:
   a. course preparation and teaching,
b. mentoring of fellow faculty,
c. student advising and counseling,
d. research/scholarly activities,
e. faculty development, including calibration instruction for sites where required educational activity occurs,
f. participation in faculty clinical practice,
g. participation in dental school and university committees,
h. professional presentations (continuing education), and
i. contributions to professional organizations.

7. Describe how the current faculty/student instructional ratios during laboratory, preclinical and clinical sessions are adequate to provide individualized instruction, guidance, and evaluative supervision, including sites where required educational activity occurs,

8. In the context of the dental school’s stated purpose/mission, goals and objectives describe the adequacy of staff resources, including at sites where required educational activity occurs,
   a. administrative assistants,
   b. secretaries,
   c. student services personnel,
   d. teaching assistants,
   e. dental laboratory technicians,
   f. dental assistants, and
   g. information technology personnel.

9. Indicate those individuals who have additional teaching and/or administrative responsibilities within the institution, and at sites where educational activity occurs, and describe the extent of these responsibilities.

B. Supportive Documentation:

1. Departmental Listing of Faculty (Table 7, Appendix A)

2. Alphabetical Listing of Faculty (Tables 8-10, Appendix A)

3. Summary of Faculty (Tables 11-13, Appendix A)

4. Summary of Committee Membership (Table 15, Appendix A)
5. Provide the dental school’s credentialing policies and procedures. Include sample forms used for faculty credentialing.

6. List the secretarial and clerical support provided for the dental program, including at sites where required educational activity occurs. List the number and provide a brief description of full-time positions that are designated solely for the school. List the number and provide a brief description of any support, provided by a centralized clerical/duplicating service.

7. List the support services, e.g., custodial, maintenance, learning resources, instructional, audiovisual, provided by the institution to the dental program, including at sites where required educational activity occurs.

8. List current faculty/student instructional ratios during all laboratory, preclinical and clinical sessions.

9. Policy document for faculty activities such as administrative duties, research, advising and counseling students, supervision of clinical experiences (including clinical experiences at sites where educational activity occurs) and committee assignments.

10. Faculty recruitment and retention policies and procedures

11. Policies and procedures for faculty use of any centralized administrative service.

3-2 The dental program must show evidence of an ongoing faculty development process.

**Intent:**
_ONGOING FACULTY DEVELOPMENT IS A REQUIREMENT TO IMPROVE TEACHING AND LEARNING, TO FOSTER CURRICULAR CHANGE, TO ENHANCE RETENTION AND JOB SATISFACTION OF FACULTY, AND TO MAINTAIN THE VITALITY OF ACADEMIC DENTISTRY AS THE WELLSPRING OF A LEARNED PROFESSION._

**Examples of evidence to demonstrate compliance may include:**
- Participation in development activities related to teaching and learning
- 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
- Documented understanding of relevant aspects of teaching methodology
• Curriculum design and development
• Curriculum evaluation
• Student/Resident assessment
• Cultural Competency
• Ability to work with students of varying ages and backgrounds
• Use of technology in didactic and clinical components of the curriculum
• Records of Calibration of Faculty

A. Description:

1. Describe the faculty development program sponsored by the dental school, including any procedures faculty must follow to participate. In particular, give a brief description of the policy, procedures and criteria used to select faculty development programs.

2. In what ways are members of the faculty encouraged to attend meetings of professional organizations?

3. Describe the availability of continuing education courses for faculty in the community. Give examples of the types of courses available.

4. How does faculty maintain and improve their clinical skills? What does the institution do to encourage clinical skills improvement and calibration, including at sites where required educational activity occurs? If faculty members are located at distance sites, explain how faculty members are provided the same opportunities as faculty at the primary program location.

B. Supportive Documentation:

1. List of meetings/seminars/courses which dental faculty attended during the last calendar year

2. List of dental school sponsored in-service programs/meetings/seminars/courses that have been presented to full- and part-time dental faculty during the past five years. including, but not limited to, the following categories:
   a. pedagogy (the art and science of teaching) and learning
   b. curriculum design and innovation
   c. mentored experiences
   d. scholarly productivity
   e. clinical skills development
f. other education-related

g. records of calibration of faculty

3. Include a list of faculty who participated in each program, including faculty at sites where required educational activity occurs, in #2 above. Provide information by program site.

4. List all financial resources used to support the faculty development program

3-3 Faculty must be ensured a form of governance that allows participation in the school’s decision-making processes.

A. Description:

1. Describe how faculty governance process allows for effective faculty input in organizational decision-making.

2. Describe and assess the roles of faculty, department chairs, and administrators in the decision-making process.

B. Supportive Documentation:

1. Minutes of faculty meetings for the last 3 years

2. Administrative and faculty chart

3. School Standing Committee Membership (Table 15, Appendix A)

4. Diagram outlining the dental school's decision-making process

3-4 A defined process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

A. Description:

1. Describe the criteria used in evaluating full-time and part-time faculty. Who determines the criteria? What input does faculty have in the process?
2. How often and by whom are faculty evaluated and how are the evaluative data used? Does the evaluation include clinical as well as didactic teaching evaluation criteria?

3. If the criteria used to evaluate administrators is different than that used to evaluate faculty members, please explain.

4. How often and by whom are administrators evaluated? How is the evaluation used?

5. How are results of the evaluations communicated to the faculty members?

**B. Supportive Documentation:**

1. Evaluation Forms used for:
   a. Full-time faculty
   b. Part-time faculty, if different from above
   c. Administrators

3-5 The dental school **must** have a stated process for promotion and/or tenure (where tenure exists), that is clearly communicated to the faculty.

**A. Description:**

1. Describe the schools' tenure and/or promotion policy and process and how it is communicated to the faculty.

2. Provide non-tenure and tenure track promotion policies, guidelines and norms.

**B. Supportive Documentation:**

1. Anonymous listing of faculty presented for tenure and/or promotion, by department, for the past 5 years and the results of the tenure and/or promotion evaluation.
Table 7: DEPARTMENT CHAIRS

List the departments or divisions within the purview of the dental school/college. Include the name of the department chair of each and the length of time the individual has served as chair. Indicate areas or sub-areas of instruction included in each department or division.

<table>
<thead>
<tr>
<th>Department/Division</th>
<th>Chair/Director</th>
<th>Areas Included in Department/Division</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
INSTRUCTIONS FOR COMPLETING FACULTY TABLES 8, 9 AND 10

**Note:** In completing the Tables on full- and part-time faculty holding an academic rank, do not include allied dental personnel unless they hold an academic rank.

**Instructions:** For faculty, who also have completed an educational program in an advanced area of dental practice, indicate whether the faculty member is educationally qualified, board eligible or board certified by the appropriate nationally accepted certifying board.

**DEFINITIONS**

**Educationally Qualified**—Faculty member has successfully completed an accredited advanced dental education program in a discipline-specific area and possesses a certificate from the institution.

**Board Eligible**—Faculty member has successfully completed an accredited advanced dental education program in a discipline-specific area, possesses a certificate from the institution, has made application to the nationally accepted certifying board to take the board examination and has been notified by the certifying board that the application has been approved.

**Board Certified**—Faculty member is a Diplomate of one or more of the discipline-specific areas of dental practice.

**Percentage of Time Spent in School Assignments (FTE)**—Teaching time includes classroom preparation time and should include time devoted to all teaching programs, i.e., predoctoral, advanced and allied education programs. Determine percentage of time in each activity and full-time equivalent (FTE) using the following table:

<table>
<thead>
<tr>
<th>Percentage of Time</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>½ day per week</td>
<td>0.1 FTE</td>
</tr>
<tr>
<td>1 ½ days per week</td>
<td>0.3 FTE</td>
</tr>
<tr>
<td>2 ½ days per week</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>3 ½ days per week</td>
<td>0.7 FTE</td>
</tr>
<tr>
<td>4 ½ days per week</td>
<td>0.9 FTE</td>
</tr>
<tr>
<td>1 day per week</td>
<td>0.2 FTE</td>
</tr>
<tr>
<td>2 days per week</td>
<td>0.4 FTE</td>
</tr>
<tr>
<td>3 days per week</td>
<td>0.6 FTE</td>
</tr>
<tr>
<td>4 days per week</td>
<td>0.8 FTE</td>
</tr>
<tr>
<td>5 days per week</td>
<td>1.0 FTE</td>
</tr>
</tbody>
</table>
### Table 8: ALPHABETICAL LISTING OF FULL-TIME FACULTY

<table>
<thead>
<tr>
<th>Name of Faculty Member</th>
<th>Degree(s), Cert(s), Dates and Institution(s)</th>
<th>Acad Rank</th>
<th>Dept</th>
<th>Dental Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example:</strong> 1) Adams, W.T. *</td>
<td>B.A., 80 Yale D.D.S., 84 Mich Cert., 86 Mich</td>
<td>Assoc Prof</td>
<td>Perio</td>
<td>✓</td>
</tr>
</tbody>
</table>

* List all faculty, but place an * to indicate faculty budgeted exclusively by dental school

Underline names of department chairs
## Table 9: ALPHABETICAL LISTING OF PART-TIME FACULTY

<table>
<thead>
<tr>
<th>Name of Faculty Member</th>
<th>F T E+</th>
<th>Degree(s), Cert(s), Dates and Institution(s)</th>
<th>Acad Rank</th>
<th>Dept</th>
<th>Dental Specialty</th>
</tr>
</thead>
</table>
| **Example:**  1) Adams, W.T. * | 0.5 | B.A., 80 Yale  
D.D.S., 84 Mich  
Cert., 86 Mich | Assoc Prof | Perio | ✓ |

* List all faculty, but place an * to indicate faculty budgeted exclusively by dental school

+ Determine FTE using formula on page 57

Underline names of department chairs
Table 10: ALPHABETICAL LISTING OF ALL FACULTY BY DEPARTMENT

Department:

<table>
<thead>
<tr>
<th>Name of Faculty Member</th>
<th>Rank</th>
<th>Teaching</th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Predoc prog</td>
<td>Forgn Grads</td>
<td>Advn Prog</td>
<td>Adm</td>
<td>Res</td>
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<tr>
<td>Example:</td>
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<td></td>
</tr>
<tr>
<td>1) Adams, W.T. *</td>
<td>Assoc Prof</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
</tr>
</tbody>
</table>

* List all faculty, but place an * to indicate faculty budgeted exclusively by dental school

List department chairperson first

(none) Indicates faculty position budgeted but unfilled
Table 11: SUMMARY OF BASIC SCIENCES FACULTY

<table>
<thead>
<tr>
<th>Rank</th>
<th>Current Faculty</th>
<th>Vacant, Budgeted</th>
<th>Additional Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Half-Time</td>
<td>Less Than Half-Time</td>
</tr>
<tr>
<td>Professor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate Professor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Professor</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Instructor</td>
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<td></td>
<td></td>
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<tr>
<td>Clinical Professor</td>
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<tr>
<td>Clinical Associate Professor</td>
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<td></td>
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<tr>
<td>Clinical Assistant Professor</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical Instructor</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Table 12: SUMMARY OF CLINICAL SCIENCES FACULTY

<table>
<thead>
<tr>
<th>Rank</th>
<th>Current Faculty</th>
<th>Vacant, Budgeted</th>
<th>Additional Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Half-Time</td>
<td>Full-Time</td>
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<td>Half-Time</td>
<td>Less Than Half-Time</td>
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<td></td>
<td>Less Than Half-Time</td>
<td>Less Than Half-Time</td>
<td>Less Than Half-Time</td>
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<tr>
<td>Professor</td>
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<tr>
<td>Associate Professor</td>
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<tr>
<td>Assistant Professor</td>
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<tr>
<td>Instructor</td>
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<tr>
<td>Clinical Professor</td>
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<tr>
<td>Clinical Associate Professor</td>
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<td></td>
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<tr>
<td>Clinical Assistant Professor</td>
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<tr>
<td>Clinical Instructor</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Table 13: SUMMARY OF BEHAVIORAL SCIENCES FACULTY

<table>
<thead>
<tr>
<th>Rank</th>
<th>Current Faculty</th>
<th>Vacant, Budgeted</th>
<th>Additional Needs</th>
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<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Half-Time</td>
<td>Less Than Half-Time</td>
</tr>
<tr>
<td>Professor</td>
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<tr>
<td>Associate Professor</td>
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<tr>
<td>Assistant Professor</td>
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<td>Instructor</td>
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<td>Clinical Professor</td>
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<td>Clinical Associate Professor</td>
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<tr>
<td>Clinical Assistant Professor</td>
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<tr>
<td>Clinical Instructor</td>
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<td>Other</td>
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</tbody>
</table>
# Commission on Dental Accreditation

## Table 14 BioSketch

*Do not attach Curriculum Vitae.*  
*Print or Type Only*

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
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<tbody>
<tr>
<td>Current Institution:</td>
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</tbody>
</table>

## EDUCATIONAL BACKGROUND (Begin with college level)

<table>
<thead>
<tr>
<th>Name of School, City and State</th>
<th>Yr of Grad.</th>
<th>Certificate or Degree</th>
<th>Area of Study</th>
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## LICENSURE

<table>
<thead>
<tr>
<th>License (Do not include license number)</th>
<th>From (Year)</th>
<th>To (Year)</th>
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## BOARD CERTIFICATION

<table>
<thead>
<tr>
<th>Certifying Organization</th>
<th>Specialty</th>
<th>Date certified</th>
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</table>

## CE COURSES TAKEN (last 5 years)

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Course Content and Provider</th>
<th>Month and Year</th>
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</tr>
</tbody>
</table>
TEACHING APPOINTMENTS (Begin with current)

<table>
<thead>
<tr>
<th>Name of Institution, City and State</th>
<th>Rank</th>
<th>Subjects/Content Areas Taught/ Administrative Responsibilities</th>
<th>From (Year)</th>
<th>To (Year)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

CURRENT TEACHING RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Name of Institution, City, State</th>
<th>Course Title</th>
<th>Discipline and Level of Students (Year)</th>
<th>Total Contact Hours Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Didactic Clinic/Laboratory</td>
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</tbody>
</table>

HOSPITAL APPOINTMENTS (Begin with current)

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>City</th>
<th>State</th>
<th>From (Year)</th>
<th>To (Year)</th>
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PRACTICE EXPERIENCE

<table>
<thead>
<tr>
<th>Location (City and State)</th>
<th>Type of Practice</th>
<th>From (Year)</th>
<th>To (Year)</th>
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</tbody>
</table>
### MEMBERSHIP, OFFICES OR APPOINTMENTS HELD IN LOCAL, STATE OR NATIONAL DENTAL OR ALLIED DENTAL ORGANIZATIONS, INCLUDING APPOINTMENTS TO STATE BOARDS OF DENTISTRY AND CODA

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Title</th>
<th>From (Year)</th>
<th>To (Year)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### PUBLISHED WORKS (For the most recent five years, list articles in which you were the principal author that appeared in refereed journals or text books, by author(s), title, publication, and date)

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Publication</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Table 15: COMMITTEE MEMBERSHIP

Using the sample format presented below, develop a chart showing membership of each dental school standing committee. Please indicate student members with an *.

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
<th>Members</th>
<th>Charge of the Committee</th>
<th>When they Meet</th>
</tr>
</thead>
</table>


REPORT OF THE STANDING COMMITTEE ON INTERNATIONAL ACCREDITATION

**Background:** The Standing Committee on International Accreditation has the following charge:

- Provide international consultation fee-based services to international predoctoral dental education programs, upon request.
- Develop and implement international consultation policies and procedures to support the international consultation program.
- Monitor and make recommendations to the Commission regarding changes that may affect its operations related to international issues.

**September 16, 2019 and December 9, 2019 Meetings:** The Standing Committee on International Accreditation met via conference call on Monday, September 16, 2019 and Monday, December 9, 2019.

The following members were present for the September 16, 2019 meeting: Dr. George Shepley, chair (ADA), Dr. Bryan Edgar (ADA), Dr. Marsha Pyle (CODA Commissioner), Dr. Perry Tuneberg (ADA), and Dr. Lawrence Wolinsky (CODA Commissioner). Dr. Stephen Young, consultant to the Standing Committee on International Accreditation was unable to attend. Dr. Sherin Tooks, director, CODA, Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, ADA and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA also attended.

The following members were present for the December 9, 2019 meeting: Dr. George Shepley, chair (ADA), Dr. Marsha Pyle (CODA Commissioner), Dr. Perry Tuneberg (ADA), Dr. Lawrence Wolinsky (CODA Commissioner) and Dr. Stephen Young, consultant to the Standing Committee on International Accreditation. Dr. Bryan Edgar (ADA) was unable to attend. Dr. Sherin Tooks, director, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA also attended.

The Standing Committee considered the following programs during their September 16, 2019 meeting:

- Yeditepe University, Istanbul, Turkey (PACV Site Visit Progress Report)
- University of Otago, Dunedin, New Zealand (PACV Self-Study)
- Hebrew University Hadassah, Jerusalem, Israel (Informational Update)
- University Autonoma de Nuevo Leon, Nuevo Leon, Mexico (PACV Site Visit Progress Report)
- Seoul National University, Seoul, South Korea (Intent to Proceed with PACV Self-Study)

The Standing Committee considered the following programs during their December 9, 2019 meeting:

- Saveetha Institute of Medical and Technical Sciences, Chennai, India (PACV Survey)
• University Autonoma de Nuevo Leon, Nuevo Leon, Mexico (PACV Site Visit Progress Report)
• Seoul National University, Seoul, South Korea (Informational Update on Intent to Proceed with PACV Self-Study)
• King Saud University, Riyadh, Kingdom of Saudi Arabia (Informational Update on PACV Process Inquiry)

**Standing Committee Actions**: The Standing Committee on International Accreditation directed that formal letters be sent to the programs reviewed at each meeting, as applicable, in accordance with the actions taken by the Committee.

**Commission Action**: This report is informational in nature and no action is required.

Prepared by: Dr. Sherin Tooks