Winter 2021 CODA Meeting

Agenda Book 2: Reports Requiring Action

Book 2 Contains:
- CODA Open Session Agenda with Bookmarks
- All Review Committee Meeting Minutes and New Business Items (if applicable)
- All Commission-only Reports (p. 1600 items)
- Consent Agenda Items
Call to Order: Friday, February 12, 2021
10:00 a.m., Open Session

Dr. Jeffery L. Hicks, presiding

I. Roll Call: Dr. John Agar, Dr. Victor Badner, Dr. Keith Beasley, Dr. Joel Berg, Dr. Linda Casser, Dr. Scott DeVito, Dr. Maxine Feinberg, Mr. Marco Gargano, Dr. Christopher Hasty, Dr. Kevin Haubrick, Dr. John Hellstein, Dr. Jeffery Hicks (chair), Dr. Amid Ismail, Dr. Adolphus Jackson, Dr. Susan Kass, Dr. James Katancik, Dr. Barbara Krieg-Menning, Dr. Brent Larson, Dr. Sanjay Mallya, Ms. Martha McCaslin, Mr. Charles McClemens, Dr. Carol Anne Murdoch-Kinch, Dr. Garry Myers, Dr. William Nelson, Dr. Bruce Rotter (vice chair), Dr. Timmothy Schwartz, Dr. Marybeth Shaffer, Dr. Alan Stein, Dr. Marshall Titus, and Dr. Lawrence Wolinsky.

Commission Staff: Dr. Sherin Tooks, ex-officio (director), Ms. Dawn Herman, Mr. Gregg Marquardt, Ms. Kirsten Nadler, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner. Ms. Cathryn Albrecht, senior associate general counsel, CODA.

Trustee Liaison: Dr. Linda Edgar, Eleventh District Trustee, Board of Trustees Liaison to CODA, American Dental Association (ADA).

Guests: Dr. Amarjit Rihal, chair, Ms. Lee Callan, manager, Commission on Dental Accreditation of Canada (CDAC).

II. Adoption of the Agenda

III. Conflict of Interest Statement, Fiduciary Reminder, and Reminder of Professional Conduct Policy and Prohibition Against Harassment

IV. Approve Minutes from Summer 2020 and October 2020 Meetings

V. Mail Ballots Approved Since Last Commission Meeting

   • Nomination Committee Ballot Closed, 11/3/2020
   • Nomination Committee Ballot Closed, 12/22/2020

VI. Consent Agenda

VII. Report of the Review Committee on Predoctoral Dental Education: Dr. Bruce Rotter, Chair, Dr. William Akey, Dr. Abby Brodie, Mr. Drew Christianson, Dr. Marcia Ditmyer, Dr. Chester Evans, Dr. Susan Long, Dr. Ana Karina Mascarenhas, and Dr. John Valenza.

   A. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Dental Education Programs (p. 100)
   B. Consideration of Proposed Revisions to the Dental Education Programs Annual Survey Curriculum Section (p. 101)
VIII. Report of the Review Committee on Dental Assisting Education: Ms. Martha McCaslin, Chair, Ms. Kimberly Bland, Ms. Margaret Bowman-Pensel, Ms. Dorothea Cavallucci, Ms. Nichole Finnegan, Ms. Carol Little, Ms. Kori Preble-Boeckler, Ms. Christy Ross, Dr. Preeti Sahasi, and Dr. Debra Schneider.

A. Report on Dental Assisting Programs Annual Survey Curriculum Section (p.300)

IX. Report of the Review Committee on Dental Hygiene Education: Dr. Susan Kass, Chair, Ms. Tami Grzesikowski, Ms. Carrie Hobbs, Dr. Lorie Holt, Dr. Tariq Javed, Ms. Betty Kabel, Dr. Barbara Krieg-Menning, Dr. Richard Leyba, Ms. Laura Scully and Dr. Sheila Vandenbush.

A. Report on Dental Hygiene Programs Annual Survey Curriculum Section (p.400)
B. Consideration of Proposed Revisions to the Accreditation Standards for Dental Hygiene Education Programs (p.401)

X. Report of the Review Committee on Dental Laboratory Technology Education: Mr. Charles McClemens, Chair, Ms. Arax Cohen, Mr. Gary Gann, Dr. Arpana Verma, and Dr. Alice Warner-Mehlhorn.

A. Report on Dental Laboratory Technology Programs Annual Survey Curriculum Section (p.500)
B. Consideration of Proposed Revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs (p.501)

XI. Report of the Review Committee on Endodontics Education: Dr. Garry Myers, Chair, Dr. Linda Casser, Dr. Gerald Glickman, Dr. Scott McClanahan, Dr. Ankur Patel, and Dr. Roberta Pileggi.

A. Informational Report on Endodontics Programs Annual Survey Curriculum Data (p. 700)
B. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics (p. 701)
XII. **Report of the Review Committee on Oral and Maxillofacial Surgery Education:** Dr. William Nelson, Chair, Dr. George Kushner, Dr. Pushkar Mehra, Dr. Faisal Quereshy, Dr. Phillip Rinaudo, and Ms. Cindy Stergar.

A. Report on Oral and Maxillofacial Surgery Programs (Residency and Fellowship) Annual Survey Curriculum Sections (p. 1000)
C. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (p. 1002)

**Policy Report**

**Review Committee Minutes**

XIII. **Report of the Review Committee on Orthodontics and Dentofacial Orthopedics:** Dr. Brent Larson, Chair, Mr. David Cushing, Dr. Patrick Foley, Dr. Sarandeep Huja, Dr. Howard Lieb, and Dr. Steven Lindauer.

A. Informational Report on Orthodontics and Dentofacial Orthopedics Programs (Residency and Fellowship) Annual Survey Curriculum Data (p. 1100)
B. Progress Report on the 2019 Validity and Reliability Studies of the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics and the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (p. 1101)
C. Consideration of the Use of the Term “Should” Within the Accreditation Standards (p. 1102)
D. Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p. 1103)

**Policy Report**

**Review Committee Minutes**

XIV. **Report of the Review Committee on Periodontics Education:** Dr. James Katancik, Chair, Dr. Linda Hatzenbuehler, Dr. Georgia Johnson, Dr. Paul Luepke, Dr. Angela Palaiologou-Gallis, and Dr. Jaqueline Sobota.

A. Informational Report on Periodontics Programs Annual Survey Curriculum Data (p. 1300)
B. Progress Report on the 2019 Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Periodontics (p. 1301)
C. Consideration of the Use of the Term “Should” Within the Accreditation Standards (p. 1302)

**Policy Report**

**Review Committee Minutes**
XV. Miscellaneous Affairs – Consideration of Matters Relating to More than One Review Committee

A. Informational Report on Review Committee and Commission Meeting Dates
   (p.1500) (All Review Committees) Dr. Ismail
   Policy Report
   Review Committee Minutes

B. Reminder of Professional Conduct Policy and Prohibition Against Harassment
   (p.1501) (All Review Committees) Dr. Shaffer
   Policy Report
   Review Committee Minutes

C. Consideration of Resolutions Adopted by the ADA House of Delegates and the ADA
   Board of Trustees Related to the Commission on Dental Accreditation and Dental Education
   (p.1502) (All Review Committees) Dr. Hasty
   Policy Report
   Review Committee Minutes

XVI. Miscellaneous Affairs – Matters for the Commission as a Whole

A. Report of the Standing Committee on Finance (p. 1600) Dr. Rotter
   Commission Report

B. Report of the Standing Committee on Quality Assurance and Strategic Planning (p. 1601)
   Commission Report Dr. Hicks

   Commission Report Dr. DeVitto

D. Report of the Ad Hoc Committee on Review Committee and Commission
   Structure and Function (p. 1603) Dr. Casser
   Commission Report

E. Report of the Ad Hoc Committee on Educational Activity Sites (p. 1604)
   Commission Report Dr. Schwartz
F. Report of the Ad Hoc Committee on Alternative Site Visit Methods (p. 1605)

Commission Report  
Dr. Haubrick

G. Consideration of a Request from the Commission on Dental Accreditation of Canada for Review of Oral Medicine Standards for Potential Inclusion in the Reciprocal Agreement Between the Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada (p. 1606)

Commission Report  
Dr. Wolinsky

H. Report of the Standing Committee on Nomination (p. 1607)

Commission Report  
Dr. Katancik

I. Update on USDE and Higher Education Accreditation Issues  
Dr. Tooks

J. Survey of Meeting (verbal)  
Dr. Tooks

XVII. New Business

XVIII. Adjourn
CONSENT AGENDA

I. Report of the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education: Dr. Jeffery Hicks, Chair, Dr. Douglas Barnes, Dr. Michael Brennan, Dr. Tracy Dellinger, Dr. Gary Fischer, Dr. Joseph Giovannitti, Dr. Gary Heir, Dr. Neal Henning, Dr. Yasser Khaled, Dr. Miriam Robbins, Dr. Eric Sung, and Mr. Glenn Unser.

A. Report on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Programs Annual Survey Curriculum Data (p. 200)

B. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 201)

Policy Report

Review Committee Minutes

II. Report of the Review Committee on Dental Public Health Education: Dr. Victor Badner, Chair, Dr. Bruce Dye, Dr. Maya Popova, Dr. Shannon Smith-Stephens, and Dr. Robert Weyant.

A. Report on Dental Public Health Programs Annual Survey Curriculum Data (p. 600)

Policy Report

Review Committee Minutes

III. Report of the Review Committee on Oral and Maxillofacial Pathology Education: Dr. John Hellstein, Chair, Dr. Ashley Clark, Mr. James Hinds, Dr. Kathryn Korff, and Dr. Vikki Noonan.

A. Report on Oral and Maxillofacial Pathology Programs Annual Survey Curriculum Data (p. 800)

B. Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology (p. 801)

Policy Report

Review Committee Minutes

IV. Report of the Review Committee on Oral and Maxillofacial Radiology Education: Dr. Sanjay Mallya, Chair, Dr. Boris Bacanurschi, Dr. Gene Kelber and Dr. Sindhura Anamali Reddy.

A. Report on Oral and Maxillofacial Radiology Programs Annual Survey Curriculum Data (p. 900)

Policy Report

Review Committee Minutes
CONSENT AGENDA

V. Report of the Review Committee on Pediatric Dentistry Education: Dr. Joel Berg, Chair, Dr. James Boynton, Dr. Kevin Haubrick, Dr. Cynthia Hipp, Dr. Joseph Morales, and Dr. Anupama Rao Tate.

A. Report on Pediatric Dentistry Programs Annual Survey Curriculum Data (p. 1200)

Policy Report

Review Committee Minutes

VI. Report of the Review Committee on Prosthodontics Education: Dr. John Agar, Chair, Dr. Scott DeVito, Dr. David Felton, Dr. Joseph Hagenbruch, Dr. Kent Knoernschild and Dr. Sang Lee.

A. Report on Prosthodontics Programs Annual Survey Curriculum Data (p. 1400)

Policy Report

Review Committee Minutes
REPORT OF THE REVIEW COMMITTEE ON PREDOCTORAL DENTAL EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Bruce Rotter. Committee Members: Dr. William Akey, Dr. Abby Brodie, Mr. Drew Christianson, Dr. Marcia Ditmyer, Dr. Chester Evans, Dr. Susan Long, Dr. Ana Karina Mascarenhas, and Dr. John Valenza. Commissioner: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation (CODA), ex officio, attended a portion of the meeting. Guests (Open Session Only): Ms. Ann Lynch, director, Advocacy and Education, American Dental Hygienists’ Association and Dr. Anthony Palatta, chief learning officer, American Dental Education Association attended the policy portion of the meeting. Staff Members: Dr. Sherin Tooks, director, Ms. Dawn Herman, manager, Predoctoral Dental Education, and Mr. Eric Wiig, senior project assistant, CODA. Ms. Peggy Soeldner, manager, Advanced Dental Education, CODA, attended a portion of the meeting. The meeting of the Review Committee on Predoctoral Dental Education (PREDOC RC) was held on Monday, January 11, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO PREDOCTORAL DENTAL EDUCATION AND DENTAL THERAPY EDUCATION

Informational Report on the Conduct of a Validity and Reliability Study for the Accreditation Standards for Dental Education Programs (p. 100): 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, Policy Report p. 100), 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 applying to programs four years in length will be assessed seven years after implementation.

Accordingly, the validity and reliability study for predoctoral dental education was due to be initiated in Spring 2020. However, due to the COVID-19 pandemic, the Commission, at its Summer 2020 meeting, directed the study be postponed until Spring 2021. Survey results will be
considered at the Summer 2021 meetings of the Predoctoral Dental Education Review Committee and the Commission on Dental Accreditation.

In cooperation with the ADA’s Health Policy Institute (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. A sample format of the survey is presented in Appendix 2, Policy Report p. 100. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2021. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2021 meeting.

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

**Consideration of Proposed Revisions to the Dental Education Programs Annual Survey Curriculum Section (p. 101):** The Review Committee on Predoctoral Dental Education (PREDOC RC) considered its Summer 2020 report to the Commission regarding its review of the Curriculum Section (Appendix 1, Policy Report p. 101) as well as the Curriculum Section of the Commission’s Annual Survey (Appendix 2, Policy Report p. 101), which was scheduled to be distributed in Fall 2020 but was delayed until Fall 2021 as directed by the Commission in Summer 2020. The Review Committee also reviewed aggregate data of the most recent Curriculum Section of the Annual Survey, conducted in Fall 2018 (Appendix 3, Policy Report p. 101). The Committee noted that the Curriculum Section is distributed every other year to dental education programs.

The Review Committee discussed several aspects of the Annual Survey as well as questions from the Health Policy Institute (HPI), which assists the Commission in the distribution and compilation of the Commission’s Annual Survey.

**Group II Survey - Student Information on Gender:** At this meeting, the PREDOC RC further considered the student information on gender, noting that the current gender options in the annual survey are “male,” “female,” and “other.” The Review Committee believed that using terms that correspond with the Integrated Postsecondary Education Data System (IPEDS) would ensure that dental education programs report the same information among required surveys. The IPEDS surveys require reporting based upon “male” and “female” categories. Following discussion, the PREDOC RC determined that the categories used within the Group II Survey regarding a student’s gender should be retained as written.

**Group IV Survey – Curriculum Section, Questions 80 to 83 on Use of Educational Activity Sites:** The PREDOC RC discussed several components of the Curriculum Section on the use of educational activity sites.

- Related to Types of Services, it was noted that there may be confusion between “Emergency Care (Emerg Care)” and “Episodic and Urgent Care (Ep/Urg Care)” since programs define and interpret these terms differently. Following discussion, the PREDOC RC believed that revising the term “Episodic and Urgent Care” to “Focused
Limited Care” would help programs distinguish between the requirements to classify emergency care different from focused limited care. The proposed revision is noted below.

(Underline indicates addition; Strikethrough indicates deletion)

For Questions 80 through 83, please select the most appropriate type(s) of services and type(s) of evaluations used at sites where educational activity occurs.

Types of Services:
- Preventive (Prev)
- Restorative Dentistry (Rest Dent)
- Emergency Care (Emerg Care)
- Extractions (Extract) Endodontics (Endo)
- Periodontal Therapy (Perio Ther)
- Prosthodontics (Protho)
- Orthodontics (Ortho)
- Comprehensive Care (Comp Care)
- Episodic and Urgent Care (Ep / Urg Care) Focused Limited Care

• The PREDOC RC also noted that it would be helpful to add a question asking each program to define the age range for its child, adult and geriatric populations, just prior to the question on use of educational activity sites, which asks for data on these categories of patients. Information on the program’s defined age range of each patient category would help in interpreting the responses within Questions 80 through 83. Therefore, the PREDOC RC proposed the following addition to Annual Survey Group IV Curriculum.

(Underline indicates addition; Strikethrough indicates deletion)

For Questions 80 through 83, please define the program’s age range for the following patient populations, and address the questions below within those defined ranges:

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geriatric</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Finally, related to the “number of days that a typical dental student(s) renders care,” the Review Committee noted the following alternative language should be adopted to clarify the intent of the Questions 80 through 83 (Underline indicates addition; Strikethrough indicates deletion), “the number of days that a typical dental student(s) is assigned to renders care.”
Following discussion, the PREDOC RC believed that revisions to the Annual Survey Curriculum Section should be implemented in the survey to be distributed in Fall 2021, which had been delayed from Fall 2020, as directed by the Commission due to the COVID-19 pandemic.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct that the proposed revisions to the Annual Survey Curriculum Section, as noted above, be adopted and implemented in the Annual Survey that will be distributed to all predoctoral dental education programs in Fall 2021.

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PREDOCTORAL DENTAL EDUCATION AND DENTAL THERAPY EDUCATION**

The Review Committee on Predoctoral Dental Education (PREDOC RC) considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Bruce Rotter
Chair, Review Committee on Predoctoral Dental Education
REPORT OF THE REVIEW COMMITTEE ON ADVANCED EDUCATION IN
GENERAL DENTISTRY, GENERAL PRACTICE RESIDENCY, DENTAL
ANESTHESIOLOGY, ORAL MEDICINE AND OROFACIAL PAIN EDUCATION
TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Jeffery Hicks. Commissioner: Dr. Bruce Rotter, vice chair, Commission on Dental Accreditation (CODA), ex officio, attended a portion of the meeting. Committee Members: Dr. Doug Barnes, Dr. Michael Brennan, Dr. Tracy Dellinger, Dr. Gary Fischer, Dr. Joseph Giovannitti, Dr. Gary Heir, Dr. Neal Henning, Dr. Yasser Khaled, Dr. Miriam Robbins, Dr. Eric Sung, and Mr. Glenn Unser. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, CODA. Dr. Sherin Tooks, director and Ms. Bridget Blackwood, senior project assistant, CODA, attended a portion of the meeting. The meeting of the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education (AGDOO RC) was held January 14-15, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED ADVANCED EDUCATION IN
GENERAL DENTISTRY, GENERAL PRACTICE RESIDENCY, DENTAL
ANESTHESIOLOGY, ORAL MEDICINE AND OROFACIAL PAIN EDUCATION

Informational Report on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Programs Annual Survey Curriculum Data (p. 200): As directed at the Winter 2015 meeting, the AGDOO RC reviewed the aggregate data from the Curriculum Section for advanced dental education programs in advanced education in general dentistry, general practice residency, dental anesthesiology, oral medicine, and orofacial pain conducted in August/September 2020.

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

Informational Report on Conduct of Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 201): The Accreditation Standards for Advanced Education Programs in Dental Anesthesiology were adopted by the Commission on Dental Accreditation at its January 25, 2007 meeting for immediate implementation.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1, Policy Report p. 201), 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 applying to programs four years in length will be assessed seven years after implementation.

Significant revisions were made to the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology in 2012 and 2015. Therefore, the validity and reliability study for Advanced Dental Education Programs in Dental Anesthesiology will be initiated in the Spring of 2021.

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. A sample format of the survey is presented in **Appendix 2, Policy Report p. 201**. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2021. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2021 meeting.

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

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREAS OF ADVANCED EDUCATION IN GENERAL DENTISTRY, GENERAL PRACTICE RESIDENCY, DENTAL ANESTHESIOLOGY, ORAL MEDICINE AND OROFACIAL PAIN EDUCATION**

The Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education (AGDOO) considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,
Chair, Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education
REPORT OF THE REVIEW COMMITTEE ON DENTAL ASSISTING EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Ms. Martha McCaslin. Committee Members: Ms. Kimberly Bland, Ms. Margaret Bowman-Pensel, Ms. Dorothea Cavallucci, Ms. Nichole Finnegan, Ms. Carol Little, Ms. Kori Preble-Boeckler, Ms. Christy Ross, and Dr. Debra Schneider. Dr. Preeti Sahasi attended a portion of the meeting. Commissioner: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation (CODA), ex officio, attended a portion of the meeting. Guests (Open Session Only): Ms. Rebecca Stolberg, senior director, Allied Dental Education and Faculty Development, American Dental Education Association attended the policy portion of the meeting. Commission Staff: Ms. Michelle Smith, manager, Allied Dental Education and Mr. Daniel Sloyan, senior project assistant, Allied Dental Education, CODA. Dr. Sherin Took, director, CODA, attended a portion of the meeting. The meeting of the Review Committee on Dental Assisting Education (DA RC) was held on January 14, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL ASSISTING EDUCATION

Report on Dental Assisting Programs Annual Survey Curriculum Section (p. 300): The Dental Assisting Review Committee (DA RC) noted that the Annual Survey Curriculum Section for dental assisting education is reviewed during the Winter Review Committee meeting in the year the survey will be distributed; which will next occur in 2021. The DA RC considered its discipline-specific Annual Survey Curriculum Section (Appendix 1, Policy Report p. 300). Following discussion, the DA RC determined that the questions on the Dental Assisting Annual Survey Curriculum Section were straightforward and appropriate in relation to the Accreditation Standards for Dental Assisting Education Programs. The DA RC recommended revision to question 56 requiring renumbering of the Standards mentioned due to revisions to the Accreditation Standards for Dental Assisting Education Programs since the last Annual Survey Curriculum Section review.

Recommendation: It is recommended that the Commission on Dental Accreditation direct revision of the Dental Assisting Annual Survey Curriculum Section (Appendix 1), with implementation in Fall 2021.

NEW BUSINESS

Consideration of the Proposed Revision to Dental Assisting Standards 3-3 and 3-7: The Dental Assisting Review Committee (DA RC) reviewed Standards 3-3 and 3-7 with regard to the Dental Assisting National Board “Certified Dental Assistant Credential” and noted that dental assistants may earn an “honorary emeritus status” issued by the Dental Assisting National Board (DANB) if they retire from dental assisting with 35 years of continuous DANB certification. The DA RC noted an increased frequency of inquiries related to whether the honorary emeritus status
is considered “current” DANB certification for part-time faculty appointments. The Review Committee also noted that the honorary emeritus status does not require continuing education for maintaining this status with DANB, thereby not meeting the spirit of the Accreditation Standards. Therefore, the DA RC determined that revising the intent statements to Standards 3-3 and 3-7, with immediate implementation, to further clarify these standards, was warranted (addition is underlined).

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

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

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

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

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the intent statements of Dental Assisting Standards 3-3 and 3-7 of the Accreditation Standards for Dental Assisting Education Programs, with immediate implementation.

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.
CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL ASSISTING EDUCATION

The Review Committee on Dental Assisting Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Ms. Martha McCaslin
Chair, Review Committee on Dental Assisting Education
### 2020-21 Assisting

(Underline indicates addition; Strikethrough indicates Deletion)

Start of Block: Curriculum Information (Q51-54)

Curriculum Information

This section is confidential. Any report produced from this section will not identify individual programs. However, some data will be included in the program profile for the site visit materials used by the Commission on Dental Accreditation.

51. What are the number of hours each student typically spends in the following over the course of the full program?

<table>
<thead>
<tr>
<th></th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Formal clinical practice seminar</td>
<td></td>
</tr>
<tr>
<td>b. Clinical practice experience</td>
<td></td>
</tr>
</tbody>
</table>
52. What types of settings are utilized for students' clinical practice experience?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. On-campus comprehensive dental clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Private dental office, general</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Private Dental office, specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Dental school clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Public health / non-profit clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Other, please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53. What are the minimum and maximum number of sites to which each student is assigned?

<table>
<thead>
<tr>
<th>Number of sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Minimum</td>
</tr>
<tr>
<td>b. Maximum</td>
</tr>
</tbody>
</table>
54. During the off-campus clinical practice experience, do any of the following individuals plan, supervise and/or evaluate the dental assisting students?

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Supervise</th>
<th>Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>a. Dental assisting</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>faculty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Dentists/dental</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>office personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Other, please</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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________________________________________________________________

End of Block: Curriculum Information (Q51-54)
Curriculum Information (continued)

The curriculum section of the survey is designed to describe the required program in each school/institution in terms of clock hours of instruction by major teaching areas. The methodology for this study was adapted from the “Dental Education in the United States 1976” study. This study relied on clock hours as the best indicator of the scope of curricula and found that the data on instructional hours made possible general comparisons of overall program length, the breadth of curriculum content, and the degree(s) of emphasis.

Since no single reporting format could satisfy all of the reporting requirements of all programs, the validity of the information reported in this survey will have to rely on careful judgments made at individual institutions. Curricula that contain significant amounts of self-paced instruction, optional summer sessions and early graduation options are difficult to report in terms of clock hours. Nevertheless, report a typical or common number of hours rather than a range.

Clock hour of instruction:
Please quantify the amount of instruction provided in each content area for the accredited program. A clock hour is considered one hour of formal instruction devoted to a subject area. It must be clearly distinguished from a semester or quarter hour. For example, if a semester is 15 weeks long, one semester hour would equal 15 clock hours.

When one subject or topic is covered in more than one course, report the total instructional time. If multiple content areas are included in a single course, divide the hours for the course into appropriate allocations for each topic area.

Retain a copy of this form for your files. The next time this information is collected (2021-22), focus on any changes in the curriculum and update the information relating to your program.

Didactic instruction:
Lectures, demonstrations or other instruction without psychomotor participation by students.

Laboratory or pre-clinical instruction:
Indicates that students receive supervised experience in performing functions in the laboratory setting using study models, mannequins, etc., and their performance is evaluated by faculty according to predetermined criteria.

Clinical instruction:
Indicates that students receive supervised experience in performing functions in the clinical
setting on patients and clinical performance of the functions is evaluated by faculty according to predetermined criteria. Clinical hours should not be reported twice; any hours reported in line v. Clinical Externships should not be reported in any earlier lines for a specific content area.

Faculty/student ratios:
Should be reported based on the average number of students taught by one faculty member at a time. The total number of students taught are to be divided by the total number of teaching faculty members. For example, 45 students taught by three instructors are reported as a faculty/student ratio of 1:15 for that class. If there are multiple clinical or laboratory sections for a particular class, the ratio is based on the number of students and faculty assigned to the sections. For different ratios in sections of the same subject area, report the average ratio among all sections or classes. Faculty/student ratios of 1:0 are not acceptable.

Faculty/student ratios must be provided for all areas of instruction for which clock hours are listed.

N/A:
Not applicable.

55. Please complete the following chart for all content areas required in the accredited dental assisting program.
Do not include elective courses, prerequisite courses, or physical education courses. Indicate the clock hours of instruction and the corresponding faculty/student ratio for each content area listed below. If none, enter 0.

NOTE: Laboratory faculty/student ratios must be provided for all areas of instruction for which laboratory clock hours are listed. Round all ratios to the nearest whole number.
If there are no laboratory clock hours in an area, delete "1:" and enter "NA" in the faculty/student ratio column.
<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Interpersonal communications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Psychology of patient management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Anatomy and physiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Microbiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Oral anatomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Oral histology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Oral embryology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
h. Legal and ethical aspects of dental assisting

55 (continued). Please complete the following chart for all content areas required in the accredited dental assisting program.

Do not include elective courses, prerequisite courses, or physical education courses. Indicate the clock hours of instruction and the corresponding faculty/student ratio for each content area listed below. If none, enter 0.

NOTE: Laboratory and/or clinical faculty/student ratios must be provided for all areas of instruction for which laboratory and/or clinical clock hours are listed. Round all ratios to the nearest whole number.

If there are no laboratory clock hours in an area, delete "1:" and enter "NA" in the laboratory faculty/student ratio column.
If there are no clinical clock hours in an area, delete "1:" and enter "NA" in the clinical faculty/student ratio column.
<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Clinical instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
<th>Clinical faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Dental materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Dental radiography</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Oral and maxillofacial pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. General dentistry procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Specialty procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Practice management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Preventive dentistry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Dental emergencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Medical emergencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s. Bloodborne pathogens &amp; hazard communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t. Pharmacology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>u. Advanced/expanded dental assistant functions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
55 (continued). Please complete the following chart for all other content areas required in the accredited dental assisting program.

<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Clinical instruction clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>v. Clinical externships</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
55 (continued). Please complete the following chart for all other content areas required in the accredited dental assisting program.

<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Clinical instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
<th>Clinical faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>w.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>x.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>y.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>z.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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End of Block: Curriculum Information (Q55)
### Curriculum Information (continued)

56. Are any of the following functions, not required with the Dental Assisting Standards, taught in the dental assisting program? If so, please indicate the level of instruction provided in that function.

NOTE: The function is taught to clinical competence if all students receive supervised experience in performing the service on patients (including student partners) in a clinical setting and their performance is evaluated by faculty according to predetermined criteria. If a function is not permitted in the program’s state, select "No" in the first column.

<table>
<thead>
<tr>
<th>Are students taught to perform the function?</th>
<th>Level taught</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Laboratory/ Pre-clinical</td>
<td>Clinical competence</td>
</tr>
<tr>
<td></td>
<td>a. Placing periodontal and other surgical dressings</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>b. Removing periodontal and other surgical dressings</td>
</tr>
<tr>
<td></td>
<td>c. Removing sutures</td>
</tr>
<tr>
<td></td>
<td>d. Inspecting the oral cavity</td>
</tr>
<tr>
<td></td>
<td>e. Polishing coronal surfaces of teeth</td>
</tr>
<tr>
<td></td>
<td>f. Scaling coronal surfaces of teeth</td>
</tr>
<tr>
<td></td>
<td>g. Placing matrices</td>
</tr>
<tr>
<td></td>
<td>h. Removing matrices</td>
</tr>
<tr>
<td></td>
<td>i. Placing temporary restorations</td>
</tr>
<tr>
<td></td>
<td>j. Removing temporary restorations</td>
</tr>
<tr>
<td></td>
<td>k. Placing amalgam restorations</td>
</tr>
<tr>
<td></td>
<td>l. Carving amalgam restorations</td>
</tr>
<tr>
<td></td>
<td>m. Polishing restorations</td>
</tr>
<tr>
<td>n. Placing and finishing composite restorations</td>
<td>o</td>
</tr>
<tr>
<td>o. Removing excess cement from coronal surfaces of teeth</td>
<td>o</td>
</tr>
<tr>
<td>p. Applying pit and fissure sealants</td>
<td>o</td>
</tr>
<tr>
<td>q. Applying cavity liners and bases</td>
<td>o</td>
</tr>
<tr>
<td>r. Monitoring nitrous oxide analgesia</td>
<td>o</td>
</tr>
<tr>
<td>s. Other 1, not specified in Standards 2-7 2-9 and 2-8 2-10</td>
<td>o</td>
</tr>
<tr>
<td>t. Other 2, not specified in Standards 2-7 2-9 and 2-8 2-10</td>
<td>o</td>
</tr>
</tbody>
</table>

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

_________________________________________________________________
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_________________________________________________________________
_________________________________________________________________
REPORT OF THE REVIEW COMMITTEE ON DENTAL HYGIENE EDUCATION TO
THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Susan Kass. Committee Members: Ms. Tami Grzesikowski, Ms. Carrie Hobbs, Dr. Lorie Holt, Ms. Betty Kabel, Dr. Richard Leyba, Dr. Barbara Krieg-Menning, Ms. Laura Scully, Dr. Suzanne Thomas, and Dr. Sheila Vandenbush. Dr. Tariq Javed attended a portion of the meeting. Commissioner: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation (CODA), ex officio, attended a portion of the meeting. Guests (Open Session Only): Ms. Ann Lynch, director, Education and Advocacy, American Dental Hygienists’ Association and Ms. Rebecca Stolberg, senior director, Allied Dental Education and Faculty Development, American Dental Education Association attended the policy portion of the meeting. Commission Staff: Ms. Michelle Smith, manager, Allied Dental Education and Mr. Daniel Sloyan, senior project assistant, Allied Dental Education, CODA. Dr. Sherin Tookes, director, CODA, attended a portion of the meeting. The meeting of the Review Committee on Dental Hygiene Education (DH RC) was held on January 12-13, 2021 via virtual conference meetings.

CONSIDERATION OF MATTERS RELATED TO DENTAL HYGIENE EDUCATION

Report on Dental Hygiene Programs Annual Survey Curriculum Section (p. 400): The Dental Hygiene Review Committee (DH RC) noted that the Annual Survey Curriculum Section for dental hygiene education is reviewed during the Winter Review Committee meeting in the year the survey will be distributed; which will next occur in 2021. The DH RC considered its discipline-specific Annual Survey Curriculum Section (Appendix 1, Policy Report p. 400).

Following discussion, the DH RC determined that the questions on the Dental Hygiene Annual Survey Curriculum Section were straightforward and appropriate in relation to the Accreditation Standards for Dental Hygiene Education Programs. The DH RC recommended one (1) revision to question 53 related to the removal of pre-requisite courses or physical education courses from the wording in the question for clarity. The DH RC noted that if programs include pre-requisite courses in the dental hygiene curriculum, these hours will be noted; however, this is not the case for the majority of programs and will not be reported in the curriculum survey. Additionally, the Review Committee noted that physical education courses should be removed from the wording as this is not applicable to dental hygiene education.

Recommendation: It is recommended that the Commission on Dental Accreditation direct revision of the Dental Hygiene Annual Survey Curriculum Section (Appendix 1), with implementation in Fall 2021.

Consideration of Proposed Revisions to the Accreditation Standards for Dental Hygiene Education Programs (p. 401): The Accreditation Standards for Dental Hygiene Education Programs were adopted by the Commission on Dental Accreditation at its February 3, 2012 meeting for implementation January 1, 2013.
According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” In accordance with this policy, the Validity and Reliability Study for Accreditation Standards for Dental Hygiene Education Programs was conducted in 2019, with results considered at the Commission’s Summer 2019 meeting.

In Summer 2019, the Dental Hygiene Review Committee (DH RC) conducted an initial review of the validity and reliability study report. The Review Committee concluded that further study of the survey data was warranted. The DH RC believed that a small workgroup should be formed to further study the report and identify Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of a workgroup composed of five (5) Dental Hygiene Review Committee members, to further study the findings of the Dental Hygiene Validity and Reliability Study and identify Accreditation Standards, if any, which warrant revision, with a report to the DH RC and Commission in Winter 2020.

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

At the Winter 2020 meeting, the DH RC considered the proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs submitted by the workgroup. Following lengthy discussion, the DH RC further revised Standards 2-7 (examples of evidence), 2-8a and 2-8b (intent statements), 2-10, 2-12 (examples of evidence), 2-15, 2-18, 3-3 and 3-6 to enhance clarity of the requirements and to provide a “grandfather” clause for currently employed program administrators and faculty members in regard to proposed changes on faculty credentials. The DH RC recommended the proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs be circulated to the communities of interest for review and comment for one (1) year with hearings conducted at the 2020 American Dental Education Association (ADEA) Annual Session, the 2020 American Dental Hygienists’ Association (ADHA) Annual Meeting, the 2020 ADEA Allied Program Directors’ Conference, and the 2020 American Dental Association (ADA) Annual Meeting. Comments would be reviewed at the Commission’s Winter 2021 meeting. The DH RC noted there would be a financial implication to the Commission related to the hearings at the ADHA and ADEA Allied Program Directors’ meetings. However, the DH RC believed that hearings among dental hygiene educators and practitioners are important, given the extensive revisions in the proposed Accreditation Standards document. The Commission concurred.

As directed by the Commission, at this meeting the DH RC considered the proposed revisions (Appendix 1, Policy Report p. 401) and all of the comments received prior to the December 1, 2020 deadline, (Appendices 2, 3, 4, and 5 Policy Report p. 401). The DH RC noted that due to the COVID-19 pandemic, the 2020 Annual Meeting of the American Dental Education
Association (ADEA) and the 2020 ADEA Allied Program Directors’ Conference were canceled and the 2020 American Dental Hygienists’ Association (ADHA) Annual Meeting was postponed and conducted virtually. Therefore, the Commission’s hearings on accreditation standards were held virtually on May 18, 2020 and October 20, 2020, respectively, to address all hearings directed by the Commission. Five (5) comments were received at the May 18, 2020 virtual hearing to replace the ADEA March and June hearings (Appendix 2, Policy Report p. 401); 28 comments were received at the May 18, 2020 virtual hearing to replace the ADHA hearing (Appendix 3, Policy Report p. 401); and five (5) comments were received at the October 20, 2020 virtual hearing to replace the ADA hearing (Appendix 4, Policy Report p. 401). The Commission office received 26 written comments prior to the December 1, 2020 deadline (Appendix 5, Policy Report p. 401). Additionally, the Commission received one (1) written comment on January 6, 2021, after the December 1, 2020 deadline and following circulation of the Commission’s Policy Report p. 401 to the DH RC (Appendix 2). The DH RC determined that the post-deadline comment should be considered in its deliberations.

The Review Committee carefully reviewed the written comments and the corresponding proposed Standards revisions. The DH RC noted that the written comments generally focused on the following areas: keeping “research” in Standard 1-1, concern over the number of hours of clinical practice per week and minimum weekly total hours, delegable duties for dental hygiene graduates, program administrator primary responsibility and what constitutes a majority of hours, faculty requirements, and infectious diseases.

The DH RC noted that several comments indicated opposition to the removal of “research” in Standard 1-1. The Review Committee discussed the comments and concluded that “research” should be retained in Standard 1-1.

Comments about the proposed revisions to the minimum number of hours of preclinical and clinical experience per week and minimum total hours of clinical experience were discussed by the Review Committee. Following careful consideration and lengthy discussion, the DH RC determined that the Standard should focus on competency-based education rather than on meeting hourly requirements.

The Review Committee discussed whether there should be definitions for the child, adolescent, adult and geriatric patient populations in Standard 2-12 based on comments received. The DH RC noted that a definition currently exists for patients with special needs in the Definition of Terms, and that programs should define these remaining patient population categories.

The comments received related to Standard 2-18 warranted a lengthy discussion about State Practice Acts, delegable duties, and the need for the revision to this Standard. The DH RC noted that this Standard has been an area of confusion for program directors and site visitors. Additionally, in some states, Dental Practice Acts are written such that a dental hygienist may perform all duties that a dental assistant may perform and it may cause confusion if a program is to teach all of the dental assisting duties to competence in addition to the dental hygiene curriculum. The Review Committee determined that the proposed revisions to Standard 2-18 were warranted and should be retained.
The DH RC noted comments pertaining to Standard 3-2 and the primary responsibility for the operation, supervision, evaluation and revision of the program. The Review Committee discussed that “primary responsibility” or “majority of hours” may be ambiguous and may require further clarification. After discussion, the DH RC noted that the program administrator’s teaching contact hours vary by program and the clarification noted in the intent statement represents a clear expectation that the program administrator’s teaching contact hours should not exceed the number of administrative hours; therefore, the Review Committee determined the proposed revisions to the intent statement were warranted and should be retained.

Comments were received related to faculty requirements and concern that these requirements may be restrictive to programs in rural areas. The DH RC noted the concerns; however, the revisions permit part-time clinical and dental science laboratory faculty appointed prior to the date of implementation of the Standards be exempt from the academic degree requirement. The Review Committee determined that the revisions to the Standard were warranted and should be retained.

The Review Committee discussed comments suggesting that respiratory diseases be added to Standard 5-1 under “Bloodborne and infectious diseases.” The DH RC understood that this comment was likely made due to the COVID-19 pandemic; however, the Review Committee felt that respiratory diseases are considered infectious diseases and that the revisions to the Standard should be retained as written.

Upon conclusion of the discussion and review of all written comments received, the Review Committee determined the proposed revisions found in Appendix 3 should be adopted for implementation on July 1, 2022.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs found in Appendix 3, with implementation July 1, 2022.

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL HYGIENE EDUCATION**

The Review Committee on Dental Hygiene Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**
Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Susan Kass
Chair, Review Committee on Dental Hygiene Education
2020-21 Hygiene

(Underline indicates addition; Strikethrough indicates Deletion)

Start of Block: Curriculum Information (Q53a-n)

Curriculum Information

This section is confidential. Any report produced from this section will not identify individual programs. However, some data will be included in the program profile for the site visit materials used by the Commission on Dental Accreditation.

The curriculum survey is designed to describe the required program in each school/institution in terms of clock hours of instruction by major teaching areas. The methodology for this study was adapted from the “Dental Education in the United States 1976” study. This study relied on clock hours as the best indicator of the scope of curricula and found that the data on instructional hours made possible general comparisons of overall program length, the breadth of curriculum content, and the degree(s) of emphasis.

Since no single reporting format could satisfy all of the reporting requirements of all programs, the validity of the information reported in this survey will have to rely on careful judgments made at individual institutions. Curricula that contain significant amounts of self-paced instruction, optional summer sessions and early graduation options are difficult to report in terms of clock hours. Nevertheless, report a typical or common number of hours rather than a range.

Clock hour of instruction:
Please quantify the amount of instruction provided in each content area for the accredited program. A clock hour is considered one hour of formal instruction devoted to a subject area. It must be clearly distinguished from a semester or quarter hour. For example, if a semester is 15 weeks long, one semester hour would equal 15 clock hours.

When one subject or topic is covered in more than one course, report the total instructional time. If multiple content areas are included in a single course, divide the hours for the course into appropriate allocations for each topic area.

Retain a copy of this form for your files. The next time this information is collected (2021-22), focus on any changes in the curriculum and update the information relating to your program.

Didactic instruction:
Lectures, demonstrations or other instruction without psychomotor participation by students.

**Laboratory or pre-clinical instruction:**
Indicates that students receive supervised experience in performing functions in the laboratory setting using study models, mannequins, etc., and their performance is evaluated by faculty according to predetermined criteria.

**Clinical instruction:**
Indicates that students receive supervised experience in performing functions in the clinical setting on patients and clinical performance of the functions is evaluated by faculty according to predetermined criteria. Clinical hours should not be reported twice; if clinical hours are reported for a specific content area, they must not be duplicated on the clinical practice line.

**Faculty/student ratios:**
Should be reported based on the average number of students taught by one faculty member at a time. The total number of students taught are to be divided by the total number of teaching faculty members. For example, 45 students taught by three instructors are reported as a faculty/student ratio of 1:15 for that class. If there are multiple clinical or laboratory sections for a particular class, the ratio is based on the number of students and faculty assigned to the sections. For different ratios in sections of the same subject area, report the average ratio among all sections or classes. Faculty/student ratios of 1:0 are not acceptable.

Faculty/student ratios must be provided for all areas of instruction for which clock hours are listed.

**N/A:**
Not applicable.
53. Please complete the following chart for all content areas required in the accredited dental hygiene program. Do not include elective courses, prerequisite courses, or physical education courses. Indicate the clock hours of instruction and the corresponding faculty/student ratio for each content area listed below. If none, enter 0.

**NOTE:** Laboratory faculty/student ratios must be provided for all areas of instruction for which laboratory clock hours are listed. Round all ratios to the nearest whole number.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Clock Hours</th>
<th>Faculty/Student Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
If there are no laboratory clock hours in an area, delete "1:" and enter "NA" in the faculty/student ratio column.
If there are no laboratory clock hours in an area, delete "1:" and enter "NA" in the faculty/student ratio column.

<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Written communications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Oral communications</td>
<td></td>
<td></td>
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<tr>
<td>c. Psychology</td>
<td></td>
<td></td>
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<tr>
<td>d. Sociology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Anatomy</td>
<td></td>
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<tr>
<td>f. Physiology</td>
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<tr>
<td>g. Chemistry</td>
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<td>--------------------------------------------------</td>
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<td></td>
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<tr>
<td>h. Biochemistry</td>
<td></td>
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<tr>
<td>i. Microbiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Immunology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. General and/or pathophysiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Head, neck and oral anatomy</td>
<td></td>
<td></td>
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<tr>
<td>m. Oral embryology and histology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Legal and ethical aspects of dental hygiene</td>
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</tbody>
</table>
Use this space to enter comments or clarifications for your answers on this page.

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End of Block: Curriculum Information (Q53a-n)

Start of Block: Curriculum Information (Q53o-54)

Curriculum Information (continued)

53 (continued). Please complete the following chart for all content areas required in the accredited dental hygiene program.

Do not include elective courses, prerequisite courses, or physical education courses. Indicate the clock hours of instruction and the corresponding faculty/student ratio for each content area listed below. If none, enter 0.

NOTE: Laboratory and/or clinical faculty/student ratios must be provided for all areas of instruction for which laboratory and/or clinical clock hours are listed. Round all ratios to the nearest whole number.

If there are no laboratory clock hours in an area, delete "1:" and enter "NA" in the laboratory faculty/student ratio column.
If there are no clinical clock hours in an area, delete "1:" and enter "NA" in the clinical faculty/student ratio column.
<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Clinical instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
<th>Clinical faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>o. Nutrition</td>
<td></td>
<td></td>
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<tr>
<td>p. Pharmacology</td>
<td></td>
<td></td>
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<tr>
<td>q. Tooth morphology</td>
<td></td>
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<tr>
<td>r. Oral and maxillofacial pathology</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>s. Radiography</td>
<td></td>
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<tr>
<td>t. Periodontology</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>u. Pain management</td>
<td></td>
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<tr>
<td>v. Dental materials</td>
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<tr>
<td>w. Oral health education and preventive counseling</td>
<td></td>
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</tr>
<tr>
<td>x. Patient management</td>
<td></td>
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</tr>
<tr>
<td>y. Clinical Dental Hygiene</td>
<td></td>
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</tr>
<tr>
<td>z. Provision of services for and management of patients with special needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>aa. Community dental/oral health</td>
<td></td>
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<tr>
<td>----------------------------------</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>bb. Medical emergencies (including basic life support)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>cc. Infection and hazard control management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dd. Provision of oral health services to patients with bloodborne infectious diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
53 (continued). Please complete the following chart for all other content areas required in the accredited dental hygiene program.

<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Clinical instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
<th>Clinical faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>ee.</td>
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<tr>
<td>ff.</td>
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<tr>
<td>gg.</td>
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<tr>
<td>hh.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ii.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>jj.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
54. Of the students enrolled in the dental hygiene science portion of the curriculum, how many clock hours per term per year are they scheduled for pre-clinical and clinical practice? Note that the word 'term' is used here as a generic reference for type of session: semester, quarter, etc.

<table>
<thead>
<tr>
<th></th>
<th>Term 1</th>
<th>Term 2</th>
<th>Term 3 (if applicable)</th>
<th>Term 4 (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st year: pre-clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. 1st year: clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 2nd year: clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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End of Block: Curriculum Information (Q53o-54)
55. Please indicate which of the following services students are taught to perform, and if so, indicate if they are taught to clinical competence.

NOTE: The service is taught to clinical competence if all students receive supervised experience in performing the service on patients (including student partners) in a clinical setting and their performance is evaluated by faculty according to predetermined criteria. If a function is not permitted in the program’s state, select “No” in the first column.

<table>
<thead>
<tr>
<th>Are students taught to perform the service?</th>
<th>If yes, are students taught to clinical competence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>a.</td>
<td>Clinical infection control procedures</td>
</tr>
<tr>
<td>b.</td>
<td>Medical and dental histories</td>
</tr>
<tr>
<td>c.</td>
<td>Vital signs</td>
</tr>
<tr>
<td>d.</td>
<td>Intraoral inspection (including charting carious lesions, periodontal diseases, existing and missing teeth)</td>
</tr>
<tr>
<td>e.</td>
<td>Extraoral inspection</td>
</tr>
<tr>
<td>f.</td>
<td>Dental hygiene assessment/dental hygiene treatment planning</td>
</tr>
<tr>
<td>g.</td>
<td>Evaluation of dental hygiene services</td>
</tr>
<tr>
<td>h.</td>
<td>Radiographs</td>
</tr>
<tr>
<td>i.</td>
<td>Indices</td>
</tr>
<tr>
<td>j.</td>
<td>Risk management (i.e., tobacco, systemic, caries)</td>
</tr>
<tr>
<td>k.</td>
<td>Impressions for study casts</td>
</tr>
<tr>
<td>l.</td>
<td>Occlusal registration for mounting study casts</td>
</tr>
<tr>
<td>Pulp vitality testing</td>
<td>n. Oral health education including health promotion, disease prevention and behavior modification</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>o. Clean removable appliances and prostheses</td>
<td></td>
</tr>
<tr>
<td>p. Nutritional counseling</td>
<td></td>
</tr>
<tr>
<td>q. Supragingival scaling</td>
<td></td>
</tr>
<tr>
<td>r. Subgingival scaling</td>
<td></td>
</tr>
<tr>
<td>s. Root planing</td>
<td></td>
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<tr>
<td>t. Coronal polishing</td>
<td></td>
</tr>
<tr>
<td>u. Application of chemotherapeutic agents</td>
<td></td>
</tr>
<tr>
<td>v. Application of anticariogenic agents</td>
<td></td>
</tr>
<tr>
<td>w. Polish restorations</td>
<td></td>
</tr>
<tr>
<td>x. Pit and fissure sealants</td>
<td></td>
</tr>
<tr>
<td>y. Application of topical anesthetic agents</td>
<td></td>
</tr>
<tr>
<td>z. Administration of local anesthetic: infiltration</td>
<td></td>
</tr>
<tr>
<td>aa. Administration of local anesthetic: block</td>
<td></td>
</tr>
<tr>
<td>bb. Administration of nitrous oxide/analgesia</td>
<td></td>
</tr>
<tr>
<td>cc. Monitoring of nitrous oxide/analgesia</td>
<td></td>
</tr>
<tr>
<td>dd. Periodontal and surgical dressing: place</td>
<td></td>
</tr>
<tr>
<td>ee. Periodontal and surgical dressing: remove</td>
<td></td>
</tr>
<tr>
<td>ff. Suture: place</td>
<td></td>
</tr>
<tr>
<td>gg. Suture: remove</td>
<td></td>
</tr>
<tr>
<td>hh. Closed soft tissue curettage</td>
<td></td>
</tr>
<tr>
<td>ii. Rubber dams: place</td>
<td></td>
</tr>
<tr>
<td>jj. Rubber dams: remove</td>
<td></td>
</tr>
<tr>
<td>kk. Matrices: place</td>
<td></td>
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<tr>
<td>II. Matrices:</td>
<td></td>
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<td>-------------</td>
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<tr>
<td>remove</td>
<td></td>
</tr>
<tr>
<td>mm. Temporary restorations: place</td>
<td></td>
</tr>
<tr>
<td>nn. Temporary restorations: remove</td>
<td></td>
</tr>
<tr>
<td>oo. Amalgam restorations: place</td>
<td></td>
</tr>
<tr>
<td>pp. Amalgam restorations: carve</td>
<td></td>
</tr>
<tr>
<td>qq. Amalgam restorations: finish</td>
<td></td>
</tr>
<tr>
<td>rr. Composite resin restorations: place</td>
<td></td>
</tr>
<tr>
<td>ss. Composite resin restorations: finish</td>
<td></td>
</tr>
<tr>
<td>tt. Application of cavity liners and bases</td>
<td></td>
</tr>
<tr>
<td>uu. Removal of excess restorative materials</td>
<td></td>
</tr>
</tbody>
</table>

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

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Page 19 of 20
End of Block: Curriculum Information (Q55)
Ms. Lynch,

The Commission’s deadline for receipt of comments was December 1, 2020, and the policy report for this item has been written and distributed to the Dental Hygiene Review Committee and Commission. We are unable to add the two written comments to the policy report, which has already been distributed. Having said that, CODA staff will forward these two comments to the Dental Hygiene Review Committee and CODA as comments that were received after the December 1 deadline. The Review Committee and Commission may, at their discretion, choose whether to consider these comments during their deliberations on the policy report. The Review Committee’s decision on this matter and recommendation to CODA will be forwarded to CODA after the Review Committee meeting.

If you have any questions, please contact me.

Sherin Tooks, Ed.D., M.S. tookss@ada.org
Director
Commission on Dental Accreditation (CODA)
312-440-2940 office

Dr. Tooks,

ADHA President Lisa Moravec provided oral testimony at the hearing on Oct. 20, 2020. Upon review of the meeting materials for the DHRC Meeting I have realized that the more comprehensive written comments that were indicated would be submitted were not received by CODA. I am very sorry for this unfortunate oversight on my part. I would request that the comprehensive written comments from ADHA be added to the record of comments. Given the extent of the proposed revisions it is important that ADHA’s comments be provided to the Commission. Thank you in advance for consideration of this request. Much appreciated!

Ann
The health and wellness of the dental hygiene community and the patients you serve is our top priority. We are closely monitoring developments surrounding COVID-19 and will continue to keep you informed. For more information from ADHA, visit https://www.adha.org/covid19. Visit www.adha.org for membership information, continuing education, professional resources and more.
October 20, 2020

Jeffery Hicks, DDS, Chair
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611
Delivered electronically to: snowj@ada.org

Dear Dr. Hicks and Members of the Commission:

Thank you for the opportunity to comment on the Proposed Revisions to Accreditation Standards for Dental Hygiene Education Programs. On behalf of the American Dental Hygienists’ Association (ADHA), the largest national organization representing the professional interests of more than 185,000 dental hygienists across the country, we value CODA’s responsibility to accredit dental and dental related education programs in the United States. The standards adopted by CODA establish a minimum set of national standards that promote and assure quality in educational institutions and programs and serves as a mechanism to protect the public.

By way of background, I am Lisa Moravec and I am from Scottsbluff, Nebraska. I am the current President of ADHA and I am also an Associate Professor and Site Coordinator at the University of Nebraska Medical Center College of Dentistry’s West Division Dental Hygiene Program.

ADHA works to ensure access to quality oral health care and promote the highest standards of dental hygiene education, licensure, practice and research. On behalf of ADHA, I would like to focus my comments on specific proposed revisions where ADHA has existing policy. I would like to note that given the breadth and content of the proposed revisions, ADHA will not be recommending adoption of the proposed revisions in their entirety.

**Page 14, Lines 10-11**
ADHA recommends CODA adopt the proposed revisions to the Definitions of Terms Used in Dental Hygiene Accreditation Standards on page 15, lines 10 through 11 that would bring needed clarity to the use of the terms must and should. The clarifying language for the term should of “highly desirable, but not mandatory” will make it clear to everyone involved in the accreditation process what is mandatory and not.

**Page 15, Lines 35-37**
We are pleased to see the definition of interprofessional education added to Definitions of Terms Used in Dental Hygiene Accreditation Standards on page 15, lines 35 through 37. This revision will bring clarity to
the use of the term in the standards and is in line with ADHA policy which supports the integration of interprofessional education into the dental hygiene curriculum.

**Page 17, Lines 9-24**
ADHA is concerned about the proposed changes to Standard 1-1 on page 17, lines 9 through 24 because the proposed text would remove the word research from the standard. Research is an integral aspect of advancing the dental hygiene profession and ADHA’s policy advocates the role of dental hygienists in research, including their contributions to interdisciplinary studies and practice. ADHA recommends CODA reject this proposed revision to ensure research remains in the standard. Dental hygiene research should be included in the planning and assessment of every level of dental hygiene education. Research literacy and scholarship are critical to improving oral and overall health and advancing evidence-based treatment.

**Page 18, Lines 6-22**
ADHA appreciates the new addition of Standard 1-2 on page 18, lines 6 through 22 regarding a humanistic culture and learning environment. When dental hygienists graduate and go on to practice they need to be prepared to work in a culturally diverse work environment and serve patients from all walks of life. This standard sets the groundwork and will help ensure programs are instilling the values that make dental hygienists such exceptional primary care providers through professionalism, ethical behavior, and appreciation of diversity.

**Page 20, Lines 25-32**
ADHA supports the proposed revisions to Standard 1-7 on page 20, lines 25-32 regarding formalized written agreements with co-sponsoring or affiliated institutions. The proposed change adds an intent section to the standard and an additional example of evidence to meet the standard. The addition of the intent to the standard clarifies the relationships between institutions and programs. If an institution or program where to venture into crisis territory, it is important that the relationships between these entities is clearly articulated in order to protect students, faculty, and the program.

**Page 26, Lines 25-32 and Page 27, Lines 2-8**
ADHA supports the proposed changes to Standard 2-7 on page 26, lines 25 through 32 and page 27, lines 2 through 8. The proposed changes will reformat the standard and provide examples for meeting the standard. The proposed revision will assist programs by creating more clarity for the requirements of course syllabi.

**Page 27, Lines 14-15**
We recommend that CODA adopt the proposed revisions to Standard 2-7 on page 27, lines 14 through 15. This proposed change removes the requirement that a curriculum document be submitted for each course. We believe this proposed change will streamline the documentation process for accreditation and provide some relief for program administrators because not all courses are fully within the jurisdiction of the program.

**Page 33, Line 3**
As a dental hygiene educator, I am pleased to see the proposed change to Standard 2-14 on page 33, line 3. The proposed change adds “program criteria for classification of periodontal disease” as an example of evidence to meet the standard. This proposal is very relevant and timely with the release of the 2018 Classification of Periodontal and Peri-Implant Diseases and Conditions. Dental hygiene programs are preparing students to be frontline oral health professionals and they should be knowledgeable of the new
classification system. This new language providing another example of meeting the standard will encourage programs to incorporate this information into their education program.

**Page 39, Lines 4-5 and Lines 7-9**

ADHA supports the proposed changes to Standard 3-3 on page 39, lines 4 through 5. This proposed revision would require the program administrator to hold a master’s degree or higher and be a graduate of a CODA accredited program. We recommend rejecting the new text on page 39, lines 7 through 9 that provide an exemption for a dentist who did not graduate from a CODA accredited program. We believe any program administrator should be a graduate of a CODA accredited program regardless of whether they are a dentist or dental hygienist.

**Page 41, Lines 9-16 and Lines 24-25**

In standard 3-6, ADHA supports the changes on page 41, lines 9 through 16 that requires both full-time and part-time faculty possess a baccalaureate or higher degree and be a graduate of a CODA accredited program. ADHA supports all aspects of formal dental hygiene education which includes certificate, associate, baccalaureate, masters and doctoral degree programs. Further, ADHA has declared its intent to establish the baccalaureate degree as the minimum entry level for dental hygiene practice and to further develop the theoretical base for dental hygiene practice. This change supports ADHA policy. Like the proposed revision to standard 3-3, ADHA recommends rejecting the changes on page 41, lines 24 through 25 which would provide an exemption for current faculty members who are dentists and did not graduate from a CODA accredited program. ADHA believes all faculty should be graduates of a CODA accredited program.

**Page 49, Lines 15-30**

We recommend CODA adopt the proposed changes to Standard 4-6 on page 49, lines 15 through 30. The proposed revisions will provide flexibility and clarity to the standard related to office space. As a dental hygiene educator, I know first-hand how important it is to have space available to have confidential discussions with students, faculty and others. Office space at educational institutions can be at a premium and it may not be possible to provide every faculty member with a private office. This proposed change brings clarity to the standard and provides a balanced solution to make sure faculty have access to privacy space for confidential matters.

**Page 52, Lines 33-43**

We recommend CODA adopt the proposed changes to Standard 5-3 on page 52, lines 33 through 43. The changes made here tie emergency management and life support together and require faculty, staff, and students to be prepared to assist in an emergency.

**Page 53, Lines 1-22**

ADHA recommends CODA adopt the proposed revisions to Page 53, lines 1 through 22. The proposed revision to the Emergency Management and Life Support Certification standard is in support of ADHA’s policy advocating for current basic life support health care provider course completion for all dental hygienists. I agree with the proposed intent of the standard: “All individuals involved with patient care or have contact with patients should be trained in the recognition and management of medical emergencies and basic life support procedures.”

I would like to thank you again for providing an opportunity for comments on the Proposed Revisions to Accreditation Standards for Dental Hygiene Education Programs. We appreciate the Commission’s
consideration of our comments to ensure the standards will best prepare dental hygienists for the evolving profession of dental hygiene.

Sincerely,

Lisa Moravec, RDH, MS
ADHA President
Introduction
Thank you, CODA Commissioners, for holding today’s hearing. My name is Lisa Moravec and I am from Scottsbluff, Nebraska. I am the current President of ADHA and I am also an Associate Professor and Site Coordinator at the University of Nebraska Medical Center College of Dentistry’s West Division Dental Hygiene Program.

ADHA works to ensure access to quality oral health care and promote the highest standards of dental hygiene education, licensure, practice and research. Our association values the work of CODA as the sole agency to accredit dental hygiene education programs and we support accreditation standards that prepare entry-level dental hygienists to assume all the professional roles of a dental hygienist. In my role as an educator, I have seen how standards are implemented and how they improve and effect the educational environment for dental hygiene students. As a national dental hygiene leader, I understand the evolving practice of dental hygiene and applaud CODA’s efforts to ensure that accreditation standards are relevant, contemporary and reflective of what is needed to prepare today’s dental hygienist.

Page 17, Lines 9-24
I recommend CODA reject the proposed changes to Standard 1-1 on page 17, lines 9 through 24. As a dental hygiene educator, I am deeply troubled that the word research is proposed to be removed from Standard 1-1. The word research is used in Standards 1-4, 2-3, 2-19, 3-7, 3-8 and 4-7. If Standard 1-1 is intended to require programs assess, plan, implement and evaluate dental hygiene programs to maximize the academic success of students, then standard 1-1 must include research because it is a critical aspect of other standards.

As an educator, it is essential for me to teach students the importance of research in order to practice evidence-based care. Students need to use the current best evidence in making decisions about patient care.

ADHA has several policy statements and definitions to support RESEARCH by dental hygienists and students within our policy manual. In general, practicing dental hygienists provide evidence-based oral health management strategies for the prevention of oral and systemic disease. To make this practical, dental hygiene education programs should be providing a foundational understanding of research. Additionally, in order to continuously build our knowledge and advance oral health, dental hygiene education should be preparing the next generation of researchers. I do not think this is possible if research is removed from the planning and assessment standard of dental hygiene programs.

Page 33, Line 3
As a dental hygiene educator, I am pleased to see the proposed change to Standard 2-14 on page 33, line 3. The proposed change adds “program criteria for classification of periodontal disease” as an example of evidence to meet the standard. This proposal is very relevant and timely with the release of the 2018 Classification of Periodontal and Peri-Implant Diseases and Conditions. Dental hygiene programs are preparing students to be frontline oral health professionals and they should be knowledgeable of the new
classification system. This new language providing another example of meeting the standard will encourage programs to incorporate this information into their education program.

**Conclusion**

I would like to thank you again for providing an opportunity for comments on the Proposed Revisions to Accreditation Standards for Dental Hygiene Education Programs. We appreciate the Commission’s consideration of our comments to ensure the standards will best prepare dental hygienists for the evolving profession of dental hygiene. I will be submitting more comprehensive written comments for the Commission’s consideration.

Thank you.

Lisa Moravec, RDH, MSDH
ADHA President
At its Winter 2020 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2020, for review at the Winter 2021 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from January 31, 2020 to December 1, 2020.

This document will be considered by the Commission in Winter 2021.

Additions are Underlined
Strikethroughs indicate Deletions

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

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

Effective January 1, 2013 TBD

Last Revised: August 2019

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Accreditation Standards for 
Dental Hygiene Education Programs 

Document Revision History 

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 26, 2007</td>
<td>Accreditation Standards for Dental Hygiene</td>
<td>Approved</td>
</tr>
<tr>
<td></td>
<td>Education Programs</td>
<td></td>
</tr>
<tr>
<td>July 26, 2007</td>
<td>Standards to Ensure Program Integrity</td>
<td>Approved and Implemented</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

1. Programs That Are Fully Operational:
   Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

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

   Circumstances under which an extension for good cause would be granted include, but are not limited to:
   - sudden changes in institutional commitment;
   - natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
   - changes in institutional accreditation;
   - interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

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

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

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

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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

The Accreditation Standards for Dental Hygiene Education Programs represent a revision of Requirements and Guidelines for Accredited Dental Hygiene Education Programs. These standards have been developed for the following reasons: (1) to protect the public welfare, (2) to serve as a guide for dental hygiene program development, (3) to serve as a stimulus for the improvement of established programs, and (4) to provide criteria for the evaluation of new and established programs. To be accredited by the Commission on Dental Accreditation, a dental hygiene program must meet the standards set forth in this document. These standards are national in scope and represent the minimum requirements for accreditation. The importance of academic freedom is recognized by the Commission; therefore, the standards are stated in terms which allow institution flexibility in the development of an educational program. It is expected that institutions which voluntarily seek accreditation will recognize the ethical obligation of complying with the spirit as well as the letter of these standards.

The Commission on Dental Accreditation

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

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

Specialized Accreditation

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

- Periodontics
- Prosthodontics
- Public Health Dentistry
- Endodontics
- Pediatric Dentistry
- Orthodontics
- Preventive Dentistry
- General Dentistry
- Oral Surgery
- Maxillofacial Surgery
- Dental Public Health
- Dental Hygiene
- Dental Laboratory Technology
- Dental Office Administration
- Dental Laboratory Science
- Dental Hygiene Science
- Dental Hygiene Technology
recognized by the United States Department of Education to accredit programs which provide basic preparation for licensure or certification in dentistry and the related disciplines.

**Dental Hygiene Accreditation**

The first dental hygiene accreditation standards were developed by three groups: the American Dental Hygienists’ Association, the National Association of Dental Examiners and the American Dental Association’s Council on Dental Education. The standards were submitted to and approved by the American Dental Association House of Delegates in 1947, five years prior to the launching of the dental hygiene accreditation program in 1952. The first list of accredited dental hygiene programs was published in 1953, with 21 programs. Since then the standards for accreditation have been revised five eight times -- in 1969, 1973, 1979, 1991, 1998, and 2005, 2007, and TBD.

In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation utilized the following procedures:

- conducting surveys of communities of interest, holding open hearings and distributing widely a draft of the proposed revision of the standards for review and comment. Prior to approving the revised standards in July 2007 TBD, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in January 2009 TBD.
Statement of General Policy

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

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

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

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

4. Provides consultation in initial and ongoing program development.

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

The importance of institutional academic freedom is recognized by the Commission, and the Accreditation Standards allow institutions considerable flexibility in structuring their educational programs. The Commission encourages the achievement of excellence through curricular innovation and development of institutional individuality. Dependent upon its objectives, resources, and state practice act provisions, the institution may elect to extend the scope of the curriculum to include content and instruction in additional areas.

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

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

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

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

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

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

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

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

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

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

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

**Basic Clinical Education:** The patient care experiences required for all students in order to attain clinical competence and complete the dental hygiene program. This education is provided in the program's clinical facilities (on campus or extended campus facilities) as defined in the Accreditation Standards and is supervised and evaluated by program faculty according to predetermined criteria.

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

**Enriching Clinical Experiences:** Clinical experiences that exceed the basic clinical education requirements of the program and that are provided to enhance the basic clinical education. Enriching experiences may be provided on campus and/or in extramural clinical facilities and may be supervised by non-program personnel according to predetermined learning objectives and evaluation criteria.

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

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

**Post-Degree Certificate:** A certificate awarded to students who have previously earned a minimum of an associate’s degree and complete all requirements of the accredited educational program in dental hygiene.

**Standard of Care:** Level of clinical performance expected for the safe, effective and ethical practice of dental hygiene.

**Dental Hygiene Diagnosis:** Identification of an existing or potential oral health problem that a dental hygienist is qualified and licensed to treat.

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

**Sponsoring Institution:** The post-secondary entity that directly sponsors the dental hygiene program and provides immediate administration and local leadership. The sponsoring institution has the overall administrative control and responsibility for the conduct of the program.
Interprofessional Education*: When students and/or professionals from two or more professions learn about, from and with each other to enable effective collaboration to improve health outcomes.


The Commission’s accreditation standards have been stated, purposefully, in terms which allow flexibility, innovation and experimentation. Regardless of the method(s) used to provide instruction, the Commission expects that each accredited program will comply with the spirit as well as the letter of the accreditation standards.
STANDARD 1 - INSTITUTIONAL EFFECTIVENESS

Planning and Assessment

The program must demonstrate its effectiveness using a formal and ongoing planning and assessment process that is systematically documented by:

- developing a plan addressing teaching, patient care, research and service which are consistent with the goals of the sponsoring institution and appropriate to dental hygiene education;
- implementing the plan;
- assessing the outcomes, including measures of student achievement;
- using the results for program improvement.

Intent:
Assessment, planning, implementation and evaluation of the educational quality of a dental hygiene education program (inclusive of distance education modalities/programs), that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students in an accountable and cost effective manner. The Commission on Dental Accreditation expects each program to define its own goals for preparing individuals in the discipline and that one of the program goals is to comprehensively prepare competent individuals in the discipline.

Examples of evidence to demonstrate compliance may include:
- program completion rates related to outcomes
- employment rates related to outcomes
- success of graduates on state licensing examinations
- success of graduates on national boards
- surveys of alumni, students, employers, and clinical sites
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Dental Hygiene RC
CODA Winter 2021

• other benchmarks or measures of learning used to demonstrate effectiveness
• examples of program effectiveness in meeting its goals
• examples of how the program has been improved as a result of assessment
• ongoing documentation of change implementation
• mission, goals and strategic plan document
• assessment plan and timeline

1-2 The program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

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

Examples of evidence to demonstrate compliance may include:
• Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available
• Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities
• Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment

Financial Support

1-21 The institution must have a strategic plan which identifies stable financial resources sufficient to support the program's stated mission, goals and objectives. A financial statement document must be submitted providing revenue and expense data for the dental hygiene program.

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

Examples of evidence to demonstrate compliance may include:
- program’s mission, goals, objectives and strategic plan
- institutional strategic plan
- revenue and expense statements for the program for the past three years
- revenue and expense projections for the program for the next three years

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

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

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

Institutional Accreditation

Programs must be sponsored by institutions of higher education that are accredited by an institutional accrediting agency (i.e., a regional or appropriate* national accrediting agency) recognized by the United States Department of Education for offering college-level programs.

* Agencies whose mission includes the accreditation of institutions offering allied health education programs.

Intent:
Dental schools, four-year colleges and universities, community colleges, technical institutes, vocational schools, and private schools, which offer appropriate fiscal, facility, faculty and curriculum resources are considered appropriate settings for the program. The institution should offer appropriate fiscal, facility, faculty and curriculum resources to sponsor the dental hygiene educational program.
Examples of evidence to demonstrate compliance may include:

- Accreditation (or candidate status) from a recognized institutional (regional or national) accrediting agency, for example:
  Commission on Higher Education, Middle States Association of Colleges and Schools; Commission on Institutions of Higher Education, New England Association of Schools and Colleges; Commission on Technical and Career Institutions, New England Association of Schools and Colleges; Commission on Institutions of Higher Education, North Central Association of Colleges and Schools; Commission on Colleges, Northwest Association of Schools and Colleges; Commission on Colleges, Southern Association of Colleges and Schools; Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges; Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges; Accrediting Bureau of Health Education Schools; Accrediting Commission of Career Schools and Colleges of Technology; Accrediting Commission of the Distance Education and Training Council; The Council on Occupational Education; Accrediting Council for Independent Colleges and Schools

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

Intent:

The purpose of a formalized written agreement is to protect the dental hygiene program, faculty, and students regarding the roles and responsibilities of the institution(s) that sponsor the dental hygiene program.

Examples of evidence to demonstrate compliance may include:

- affiliation agreement(s)
- flowchart delineating roles and responsibilities of sponsoring institution(s)

Community Resources

There must be an active liaison mechanism between the program and the dental and allied dental professions in the community. The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest with the educational institution.
Intent:
The purpose of an active liaison mechanism is to provide a mutual exchange of information for improving the program, recruiting qualified students and meeting employment needs of the community. The responsibilities of the advisory body should be defined in writing and the program director, faculty, and appropriate institution personnel should participate in the meetings as non-voting members to receive advice and assistance.

Examples of evidence to demonstrate compliance may include:
• policies and procedures regarding the liaison mechanism outlining responsibilities, appointments, terms and meetings
• membership list with equitable representation if the group represents more than one discipline
• criteria for the selection of advisory committee members
• an ongoing record of committee or group minutes, deliberations and activities
STANDARD 2 - EDUCATIONAL PROGRAM

Instruction

2-1 The curriculum must include at least two academic years of full-time instruction or its equivalent at the postsecondary college-level. The scope and depth of the curriculum must reflect the objectives and philosophy of higher education. The college catalog must list the degree awarded and course titles and descriptions.

In a two-year college setting, the graduates of the program must be awarded an associate degree. In a four-year college or university, graduates of the program must be awarded an associate or comparable degree, post-degree certificate, or baccalaureate degree.

Intent:
The dental hygiene curriculum is comprehensive in scope and depth and requires a minimum of two years of academic preparation. The curriculum should include additional coursework and experiences, as appropriate, to develop competent oral health care providers who can deliver optimal patient care within a variety of practice settings and meet the needs of the evolving healthcare environment.

In a four-year college setting that awards a certificate, admissions criteria should require a minimum of an associate degree. Institutions should provide students with opportunities to continue their formal education through affiliations with institutions of higher education that allow for transfer of course work. Affiliations should include safeguards to maximize credit transfer with minimal loss of time and/or duplication of learning experiences.

General education, social science and biomedical science courses included in associate degree dental hygiene curricula should parallel those offered in four-year colleges and universities. In baccalaureate degree curricula, attention is given to requirements for admission to graduate programs to establish a balance between professional and nonprofessional credit allocations.

Examples of evidence to demonstrate compliance may include:
- copies of articulation agreements
- curriculum documents
- course evaluation forms and summaries
- records of competency examinations
- college catalog
A process must be established to assure students meet the academic, professional and/or clinical criteria as published and distributed. Academic standards and institutional due process policies must be followed for remediation or dismissal. A college document must include institutional due process policies and procedures.

**Intent:**
If a student does not meet evaluation criteria, provision should be made for remediation or dismissal. On the basis of designated criteria, both students and faculty can periodically assess progress in relation to the stated goals and objectives of the program.

Examples of evidence to demonstrate compliance may include:
- written remediation policy and procedures
- records of attrition/retention rates related to academic performance
- institutional due process policies and procedures

**Admissions**

Admission of students must be based on specific written criteria, procedures and policies. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability must be utilized as criteria in selecting students who have the potential for successfully completing the program. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental hygienists.

**Intent:**
The dental hygiene education curriculum is a postsecondary scientifically-oriented program which is rigorous and intensive. Because enrollment is limited by facility capacity, special program admissions criteria and procedures are necessary to ensure that students are selected who have the potential for successfully completing the program. The program administrator and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures which are non-discriminatory and ensure the quality of the program.

Examples of evidence to demonstrate compliance may include:
- admissions management policies and procedures
• copies of catalogs, program brochures or other written materials
• established ranking procedures or criteria for selection
• minutes from admissions committee
• periodic analysis supporting the validity of established admission criteria and procedures
• results from institutional research used in interpreting admissions data and criteria and/or correlating data with student performance
• graduation rates
• analysis of attrition
• employment rates

2-4 Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program. Students with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by students regularly enrolled in the program.

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

Examples of evidence to demonstrate compliance may include:
• policies and procedures on advanced standing
• results of appropriate qualifying examinations
• course equivalency or other measures to demonstrate equal scope and level of knowledge
The number of students enrolled in the program must be proportionate to the resources available.

Intent:
In determining the number of dental hygiene students enrolled in a program (inclusive of distance sites), careful consideration should be given to ensure that the number of students does not exceed the program’s resources, including patient supply, financial support, scheduling options, facilities, equipment, technology and faculty.

Examples of evidence to demonstrate compliance may include:
• sufficient number of clinical and laboratory stations based on enrollment
• clinical schedules demonstrating equitable and sufficient clinical unit assignments
• clinical schedules demonstrating equitable and sufficient radiology unit assignments
• faculty full-time equivalent (FTE) positions relative to enrollment
• budget resources and strategic plan
• equipment maintenance and replacement plan
• patient pool availability analysis
• course schedules for all terms

Curriculum

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

The dental hygiene program must:

1) define and list the overall graduation competencies that describe the levels of knowledge, skills and values expected of graduates.
2) employ student evaluation methods that measure all defined graduation competencies.
3) document and communicate these competencies and evaluation methods to the enrolled students.
Intent:
The educational competencies for the dental hygiene education program should include the preparation of graduates who possess the knowledge, skills and values to begin the practice of dental hygiene. The evaluation methods used in the dental hygiene program should include process and end-product assessments of student performance, as well as a variety of objective testing measures. These mechanisms will provide student performance data related to measuring defined program competencies throughout the program for the students, faculty and college administration.

Examples of evidence to demonstrate compliance may include:
- a singular document that includes graduation competencies aligned with curriculum
- competencies documentation demonstrating relationship between graduation competencies, course competencies, and evaluation methods and program competencies
- process and product evaluation forms

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

2-7 Course syllabi for dental hygiene courses must be available at the initiation of each course and include:

1) written course descriptions
2) content and topic outlines
3) specific instructional objectives
4) learning experiences
5) evaluation methods

Intent:
The program should identify the dental hygiene fundamental knowledge and competencies that will be included in the curriculum based on the program goals, resources, current dental hygiene practice responsibilities and other influencing factors. Individual course documentation needs to be periodically reviewed and revised to accurately reflect instruction being provided as well as new concepts and techniques taught in the program.
Examples of evidence to demonstrate compliance may include:

- individual syllabi for each dental hygiene course, excluding general education and basic science courses
- weekly topical outlines and associated instructional objectives
- learning experiences for each class session to include identified didactic, laboratory, pre-clinical and clinical sessions
- the overall evaluation procedures used to determine a final course grade

The curriculum must include content in the following four areas: general education, biomedical sciences, dental sciences and dental hygiene science. This content must be integrated and of sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies. A curriculum document must be submitted for each course included in the dental hygiene program for all four content areas.

**Intent:**

Foundational knowledge should be established early in the dental hygiene program and of appropriate scope and depth to prepare the student to achieve competence in all components of dental hygiene practice. Content identified in each subject may not necessarily constitute a separate course, but the subject areas are included within the curriculum.

Curriculum content and learning experiences should provide the foundation for continued formal education and professional growth with a minimal loss of time and duplication of learning experiences. General education, social science, and biomedical science courses included in the curriculum should be equivalent to those offered in four-year colleges and universities.

General education content must include oral and written communications, psychology, and sociology.

**Intent:**

These subjects provide prerequisite background foundational knowledge for components of the curriculum, which prepare the students to communicate effectively, assume responsibility for individual oral health counseling, and participate in community health programs.
Biomedical science content must include content in anatomy, physiology, chemistry, biochemistry, microbiology, immunology, general and maxillofacial pathology and/or pathophysiology, nutrition and pharmacology.

Intent:
These subjects provide foundational knowledge for dental and dental hygiene sciences. The subjects are to be of the scope and depth comparable to college transferable liberal arts course work. The program should ensure that biomedical science instruction serves as a foundation for student analysis and synthesis of the interrelationships of the body systems when making decisions regarding oral health services within the context of total body health.

Biological science instruction in dental hygiene education ensures an understanding of basic biological principles consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems. The biomedical knowledge base emphasizes the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

Dental hygienists need to understand abnormal conditions to recognize the parameters of comprehensive dental hygiene care. The program should ensure that graduates have the level of understanding that assures that the health status of the patient will not be compromised by the dental hygiene interventions.

Dental sciences content must include tooth morphology, head, neck and oral anatomy, oral embryology and histology, oral pathology, radiography, periodontology, pain management, and dental materials.

Intent:
These subjects provide the student with knowledge of oral health and disease as a basis for assuming responsibility for assessing, planning and implementing preventive and therapeutic services. Teaching methodologies should be utilized to assure that the student can assume responsibility for the assimilation of knowledge requiring judgment, decision making skills and critical analysis.
2-8d Dental hygiene science content must include oral health education and preventive counseling, health promotion, patient management, clinical dental hygiene, provision of services for and management of patients with special needs, community dental/oral health, medical and dental emergencies, legal and ethical aspects of dental hygiene practice, infection and hazard control management, and the provision of oral health care services to patients with bloodborne infectious diseases.

Intent:
Dental hygiene sciences provide the knowledge base for dental hygiene and prepares the student to assess, plan, implement and evaluate dental hygiene services as an integral member of the health team. Content in provision of oral health care services to patients with bloodborne infectious diseases prepares the student to assess patients’ needs and plan, implement and evaluate appropriate treatment.

2-9 The basic clinical education aspect of the curriculum must include a formal course sequence in scientific principles of dental hygiene practice, which extends throughout the curriculum and is coordinated and integrated with clinical experience in providing dental hygiene services.

Intent:
Learning experiences and practice time in clinical procedures is necessary to assure sufficient opportunity to develop competence in all clinical procedures included in the curriculum. Didactic material on clinical dental hygiene should be presented throughout the curriculum.

2-10 Clinical experiences must be distributed throughout the curriculum. The number of hours of preclinical practice and direct patient care clinical practice scheduled must ensure that students attain clinical competence and develop appropriate judgment. Clinical practice must be distributed throughout the curriculum.

Intent:
Sufficient practice time and learning experiences should be provided during preclinical and clinical courses to ensure that students attain clinical competence. The number of hours devoted to clinical practice time should increase as the students progress toward the attainment of clinical competence.

The preclinical course should have at least six hours of clinical practice per week. As the first-year students begin providing dental hygiene services for patients,
each student should be scheduled for at least eight to twelve hours of \textit{clinical practice time-direct patient care} per week. In the final prelicensure year of the curriculum, each second-year student should be scheduled for at least twelve to sixteen hours of \textit{practice with patients-direct patient care} per week in the dental hygiene clinic.

Examples of evidence to demonstrate compliance may include:

- program clinical experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation system policy and procedures demonstrating student competencies
- clinic schedules for each term

\textbf{Patient Care Competencies}

2-11 The dental hygiene program must have established mechanisms to ensure a sufficient number of patient experiences that afford all students the opportunity to achieve stated competencies.

\textbf{Intent:} A system should be developed and implemented to categorize patients according to difficulty level and oral health/disease status. This system should be used to monitor students’ patient care experiences to ensure equal opportunities for each enrolled student. Patient assignments should include maintenance appointments to monitor and evaluate the outcome of dental hygiene care. A system should be in place to monitor student patient care experiences at all program sites.

Examples of evidence to demonstrate compliance may include:

- program clinical and radiographic experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation system policy and procedures demonstrating student \textit{patient care} competencies

\textbf{Patient Care Competencies}
2-12 Proposed Revisions to Dental Hygiene Standards

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

2-12 Graduates must be competent in providing dental hygiene care for all patient populations including:

1) child
2) adolescent
3) adult
4) geriatric
5) special needs

Intent:
An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, developmental, intellectual or social conditions may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student.

Clinical instruction and experiences should include the dental hygiene process of care compatible with each of these patient populations.

Examples of evidence to demonstrate compliance may include:

- program definition for each patient population category
- program clinical and radiographic experiences, direct and non-direct patient contact assignments, and off-site enrichments experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- student clinical evaluation mechanism demonstrating student competence in clinical skills, communication and practice management.

2-13 Graduates must be competent in providing the dental hygiene process of care which includes:

a) comprehensive collection of patient data to identify the physical and oral health status;
b) analysis of assessment findings and use of critical thinking in order to address the patient’s dental hygiene treatment needs;
c) establishment of a dental hygiene care plan that reflects the realistic goals and treatment strategies to facilitate optimal oral health;
d) provision of comprehensive patient-centered treatment and evidence-based care in a manner minimizing risk and optimizing oral health;

e) measurement of the extent to which goals identified in the dental hygiene care plan are achieved;

f) complete and accurate recording of all documentation relevant to patient care.

Intent:
The dental hygienist functions as a member of the dental team and plays a significant role in the delivery of comprehensive patient health care. The dental hygiene process of care is an integral component of total patient care and preventive strategies. The dental hygiene process of care is recognized as part of the overall treatment plan developed by the dentist for complete dental care.

Examples of evidence to demonstrate compliance may include:
- Program clinical and radiographic experiences
- Patient tracking data for enrolled and past students
- Policies regarding selection of patients and assignment of procedures
- Monitoring or tracking system protocols
- Clinical evaluation system policy and procedures demonstrating student competencies
- Assessment instruments
- Evidence-based treatment strategies
- Appropriate documentation
- Use of risk assessment systems and/or forms to develop a dental hygiene care plan

2-14 Graduates must be competent in providing dental hygiene care for all types of classifications of periodontal diseases including patients who exhibit moderate to severe periodontal disease.

Intent:
The total number and type of patients for whom each student provides dental hygiene care should be sufficient to ensure competency in all components of dental hygiene practice. A patient pool should be available to provide patient experiences in all classifications of periodontal patients, including both maintenance and those newly diagnosed. These experiences should be monitored to ensure equal opportunity for each enrolled student.
Examples of evidence to demonstrate compliance may include:

- program criteria for classification of periodontal disease
- program clinical and radiographic experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation mechanism demonstrating student competence

2-15 Graduates must be competent in communicating and collaborating interprofessional communication, collaboration and interaction with other members of the health care team to support comprehensive patient care.

Intent:
Students should understand the roles of members of the health-care team and have interprofessional educational experiences that involve working with other health-care professional students and practitioners. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental Hygienists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs). Students should understand the roles of members of the health-care team and have educational experiences that involve working with other health-care professional students and practitioners.

Examples of evidence to demonstrate compliance may include:

- student experiences demonstrating the ability to communicate and collaborate effectively with a variety of individuals, groups and health care providers.
- examples of individual and community-based oral health projects implemented by students during the previous academic year
- evaluation mechanisms designed to assess knowledge and performance of interdisciplinary communication and collaboration

2-16 Graduates must demonstrate competence in:

a) assessing the oral health needs of community-based programs
b) planning an oral health program to include health promotion and disease prevention activities
c) implementing the planned program, and,
d) evaluating the effectiveness of the implemented program.
Intent:
Population based activities will allow students to apply community dental health principles to prevent disease and promote health.

Examples of evidence to demonstrate compliance may include:
- student projects demonstrating assessing, planning, implementing and evaluating community-based oral health programs
- examples of community-based oral health programs implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance

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

Intent:
Dental hygienists should be able to provide appropriate support for medical or dental emergencies basic life support as providers of direct patient care.

Examples of evidence to demonstrate compliance may include:
- evaluation methods/grading criteria such as classroom or clinic examination, station examination, and performance on emergency simulations, basic life support certification/recognition

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

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

Ethics and Professionalism

2-19 Graduates must be competent in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management.

Intent:
Dental hygienists should understand and practice ethical behavior consistent with the professional code of ethics throughout their educational experiences.

Examples of evidence to demonstrate compliance may include:
- documents which articulate expected behavior of students such as policy manuals, college catalog, etc.
- evaluation of student experiences which promotes ethics, ethical reasoning and professionalism
- evaluation strategies to monitor knowledge and performance of ethical behavior

2-20 Graduates must be competent in applying legal and regulatory concepts to the provision and/or support of oral health care services.

Intent:
Dental hygienists should understand the laws which govern the practice of the dental profession. Graduates should know how to access licensure requirements, rules and regulations, and state practice acts for guidance in judgment and action.

Examples of evidence to demonstrate compliance may include:
- evaluation mechanisms designed to monitor knowledge and performance concerning legal and regulatory concepts
- outcomes assessment mechanisms
Critical Thinking

2-21 Graduates must be competent in the application of self-assessment skills to prepare them for life-long learning.

Intent:
Dental hygienists should possess self-assessment skills as a foundation for maintaining competency and quality assurance.

Examples of evidence to demonstrate compliance may include:
• written course documentation of content in self-assessment skills
• evaluation mechanisms designed to monitor knowledge and performance
• outcomes assessment mechanisms

2-22 Graduates must be competent in the evaluation of current scientific literature.

Intent:
Dental hygienists should be able to evaluate scientific literature as a basis for life-long learning, evidenced-based practice and as a foundation for adapting to changes in healthcare.

Examples of evidence to demonstrate compliance may include:
• written course documentation of content in the evaluation of current and classic scientific literature
• evaluation mechanisms designed to monitor knowledge and performance
• outcomes assessment mechanisms

2-23 Graduates must be competent in problem solving strategies related to comprehensive patient care and management of patients.

Intent:
Critical thinking and decision making skills are necessary to provide effective and efficient dental hygiene services. Throughout the curriculum, the educational program should use teaching and learning methods that support the development of critical thinking and problem solving skills.

Examples of evidence to demonstrate compliance may include:
• evaluation mechanisms designed to monitor knowledge and performance;
• outcomes assessment mechanisms demonstrating application of critical thinking skills;
• activities or projects that demonstrate student experiences with analysis of problems related to comprehensive patient care;
• demonstration of the use of active learning methods that promote critical appraisal of scientific evidence in combination with clinical application and patient factors.

Curriculum Management

2-24 The dental hygiene program must have a formal, written curriculum management plan, which includes:

a) an ongoing annual formal curriculum review and evaluation process with input from faculty, students, administration and other appropriate sources;
b) evaluation of the effectiveness of all courses as they support the program’s goals and competencies;
c) a defined mechanism for coordinating instruction among dental hygiene program faculty.
d) a defined mechanism to calibrate dental hygiene faculty for student clinical evaluation.

Intent:
To assure the incorporation of emerging information and achievement of appropriate sequencing, the elimination of unwarranted repetition, and the attainment of student competence, a formal curriculum review process should be conducted on at least an annual an ongoing and regular basis. Periodic workshops and in-service sessions should be held for the dissemination of curriculum information and modifications.

Examples of evidence to demonstrate compliance may include:
• competencies documentation demonstrating relationship of course content to defined competencies of the program
• documentation of ongoing curriculum review and evaluation
• minutes of curriculum management meetings documenting curriculum review and evaluation
• student evaluation of instruction
• curriculum management plan
• documentation of calibration exercises
STANDARD 3 - ADMINISTRATION, FACULTY AND STAFF

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

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

Examples of evidence to demonstrate compliance may include:
- institutional organizational flow chart
- short and long-range strategic planning documents
- examples of program and institution interaction to meet program goals
- dental hygiene representation on key college or university committees

Program Administrator

3-2 The dental hygiene program administrator must have a full-time appointment as defined by the institution, whose primary responsibility is for operation, supervision, evaluation and revision of the program.

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

Examples of evidence to demonstrate compliance may include:
- program administrator position description and/or contract
- faculty schedules including contact hours and supplemental responsibilities
- policies of the institution which define teaching load for full-time faculty and administrators
- copies of union regulations and/or collective bargaining agreements
The program administrator must be a dental hygienist or a dentist who is a graduate of a program accredited by the Commission on Dental Accreditation and possesses a masters or higher degree, or is currently enrolled in a masters or higher degree program or a dentist who has background in education and the professional experience necessary to understand and fulfill the program goals. A dentist who was appointed as program administrator prior to July 1, 2022 is exempt from the graduation requirement.

Intent:
The program administrator’s background should include administrative experience, instructional experience, and professional experience in clinical practice either as a dental hygienist or working with a dental hygienist. The term of interim/acting program administrator should not exceed a two year period.

Examples of evidence to demonstrate compliance may include:
• curriculum vitae current allied biosketch of program administrator

The program administrator must have the authority and responsibility necessary to fulfill program goals including:

a) curriculum development, evaluation and revision;
b) faculty recruitment, assignments and supervision;
c) input into faculty evaluation;
d) initiation of program or department in-service and faculty development;
e) assessing, planning and operating program facilities;
f) input into budget preparation and fiscal administration;
g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.

Examples of evidence to demonstrate compliance may include:
• program administrator position description
3.5 The number and distribution of faculty and staff must be sufficient to meet the dental hygiene program’s stated purpose, goals and objectives.

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

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

### 3.6 3.5

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

1. In preclinical and clinical sessions, the ratio must not exceed one (1)
   faculty to five (5) students
2. In radiography laboratory sessions, the ratio must not exceed one (1)
   faculty to five (5) students
3. In other dental sciences laboratory sessions, the ratio must not exceed one (1) faculty to 10 students

**Intent:**
The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and clinical practice sessions rather than by the number of full-time equivalent positions for the program. The faculty to student ratios in clinical and radiographic practice should allow for individualized instruction and evaluation of the process as well as the end results. Faculty are responsible for both ensuring that the clinical and radiographic services delivered by students meet current standards for dental hygiene care and for the instruction and evaluation of students during their performance of those services.
Examples of evidence to demonstrate compliance may include:

- faculty teaching commitments—schedules including student contact loads and supplemental responsibilities
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-73-6 The full-time and part-time faculty of a dental hygiene program must possess a baccalaureate or higher degree. All part-time clinical and dental science laboratory faculty appointed prior to [date of implementation] are exempt from the degree requirement.

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

All dental hygiene program faculty members must have:

a) current knowledge of the specific subjects they are teaching.
b) documented background in current educational methodology concepts consistent with teaching assignments.
c) Faculty who are dental hygienists or dentists must be graduates of dental hygiene programs accredited by the Commission on Dental Accreditation. A dentist who was appointed as a faculty prior to July 1, 2022 is exempt from the graduation requirement.
d) evidence of faculty calibration for clinical evaluation.

Intent:
Faculty should have background in current education theory and practice, concepts relative to the specific subjects they are teaching, clinical practice experience and, if applicable, distance education techniques and delivery. These criteria apply to dentists and dental hygienists who supervise students’ clinical procedures should have qualifications which comply with the state dental or dental hygiene practice act. Individuals who teach and supervise dental hygiene students in clinical enrichment experiences should have qualifications comparable to faculty who teach in the dental hygiene clinic and are familiar with the program’s objectives, content, instructional methods and evaluation procedures.

Examples of evidence to demonstrate compliance may include:

- faculty curriculum vitae with recent professional development activities listed
• evidence of participation in workshops, in-service training, self-study courses, on-line and credited courses
• attendance at regional and national meetings that address education
• mentored experiences for new faculty
• scholarly productivity
• maintenance of existing and development of new and/or emerging clinical skills

3-83-7 Opportunities must be provided for the program administrator and full-time faculty to continue their professional development.

Intent:
To assure competency in the discipline and educational theory, opportunities to attend professional development activities should be provided regularly for the program administrator and full-time faculty. Workshops should be offered to new faculty to provide an orientation to program policies, goals, objectives and student evaluation. This can be demonstrated through activities such as professional association involvement, research, publishing and clinical/practice experience.

Examples of evidence to demonstrate compliance may include:
• curriculum vitae with recent professional development activities listed
• examples of the program’s or college’s faculty development offerings
• records of formal in-service programs
• demonstration of funded support for professional development

3-93-8 A defined faculty evaluation process must exist that ensures objective measurement of the performance of each faculty member.

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

Examples of evidence to demonstrate compliance may include:
• sample evaluation mechanisms addressing teaching, patient care, research, scholarship and service
• faculty evaluation policy, procedures and mechanisms
3-103-9 Opportunities for promotion, tenure, and development must be the same for dental hygiene faculty as for other institutional faculty.

**Intent:**
The dental hygiene program faculty should be granted privileges and responsibilities as afforded all other institutional faculty.

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

**Support Staff**

3-113-10 Qualified institutional support personnel must be assigned to the program to support both the instructional program and the clinical facilities providing a safe environment for the provision of instruction and patient care.

**Intent:**
Maintenance and custodial staff should be sufficient to meet the unique needs of the academic and clinical program facilities. Faculty should have access to instructional specialists, such as those in the areas of curriculum, testing, counseling, computer usage, instructional resources and educational psychology. Secretarial and clerical staff should be assigned to assist the administrator and faculty in preparing course materials, correspondence, maintaining student records, and providing supportive services for student recruitment and admissions activities. Support staff should be assigned to assist with the operation of the clinic facility including the management of appointments, records, billing, insurance, inventory, hazardous waste, and infection control.

**Examples of evidence to demonstrate compliance may include:**
- description of current program support/personnel staffing
- program staffing schedules
- staff job descriptions
- examples of how support staff are used to support students
3-123-11 Student assignments to clerical and dental assisting responsibilities during clinic sessions must be minimal and must not be used to compensate for limitations of the clinical capacity or to replace clerical or clinical staff.

Intent:
Secretarial and clerical staff should be assigned to assist the administrator and faculty in preparing course materials, correspondence, maintaining student records, and providing supportive services for student recruitment and admissions activities. Support staff should be assigned to assist with the operation of the clinic facility including the management of appointments, records, billing, insurance, inventory, hazardous waste, and infection control.

Examples of evidence to demonstrate compliance may include:
- description of current program support/personnel staffing
- program staffing schedules
- staff job descriptions
- examples of how support staff are used to support students
STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Facilities

4-1 The program must provide sufficient and appropriately maintained facilities to support the academic and clinical purposes of the program that conform to applicable local, state and federal regulations.

Clinical Facilities

The dental hygiene facilities must include the following:

a) sufficient clinical facility with clinical stations for students including conveniently located hand-washing sinks areas for hand hygiene; equipment allowing display of radiographic images during dental hygiene treatment; and view boxes and/or computer monitors; a working space for the patient's record adjacent to units; functional equipment, modern equipment; an area that accommodates a full range of operator movement and opportunity for proper instructor supervision;

b) a number of clinical stations based on the number of students admitted to a class (If the number of stations is less than the number of students in the class, one clinical station is available for every student scheduled for each clinical session.);

c) a capacity of the clinic that accommodates individual student practice on a regularly scheduled basis throughout all phases of preclinical technique and clinical instruction;

d) a sterilizing area that includes sufficient space for preparing, sterilizing and storing instruments;

e) sterilizing equipment and personal protective equipment/supplies that follow current infection and hazard control protocol;

f) facilities and materials for students, faculty and staff that provide compliance with accepted infection and hazard control protocols;

g) space and furnishings for patient reception and waiting provided adjacent to the clinic;

h) patient records kept in an area assuring safety and confidentiality.

Intent:
The facilities should permit the attainment of program goals and objectives. To ensure health and safety for patients, students, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or...
laboratory schedule. This Standard applies to all sites where students receive clinical instruction.

Radiography Facilities

4-2 Radiography facilities must be sufficient for student practice and the development of clinical competence.

The radiography facilities must contain the following:

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

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

c) an area for mounting and viewing radiographs; equipment allowing display of radiographic images;

d) documentation of compliance with applicable local, state and federal regulations.

Regardless of the number of machines provided, it must be demonstrated that time is available for all students to obtain required experience with faculty supervision and that acceptable faculty teaching loads are maintained.

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

Examples of evidence to demonstrate compliance may include:

- Institutional, local, state and federal agencies related to radiation safety report(s)

- Institutional local, state and federal quality assurance compliance report(s)
Laboratory Facilities

4-3 A multipurpose laboratory facility must be provided for effective instruction and allow for required laboratory activities. If the laboratory capacity requires that two or more sections be scheduled, time for all students to obtain required laboratory experience must be provided.

Laboratory facilities must conform to applicable local, state and federal regulations and contain the following:

a) placement and location of equipment that is conducive to efficient and safe utilization with ventilation and lighting appropriate to the procedures;

b) student stations work areas that are designed and equipped for students to work while seated including sufficient ventilation and lighting, with necessary utilities, and storage space, and an adjustable chair;

c) documentation of compliance with applicable local, state and federal regulations.

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

Examples of evidence to demonstrate compliance may include:

- Institutional local, state and federal quality assurance compliance report(s)
- Air quality report(s)
- Floor plans
Extended Campus Facilities

The educational institution must provide physical facilities and equipment which are sufficient to permit achievement of program objectives. If the institution finds it necessary to contract for use of an existing facility for basic clinical education and/or distance education, When the institution uses an additional facility for clinical education that includes program requirements then the following conditions must be met in addition to all existing Standards:

a) a formal contract between the educational institution and the facility;
b) a two-year notice for termination of the contract stipulated to ensure that instruction will not be interrupted or;
c) b) a contingency plan developed by the institution should the contract be terminated;
d) c) a location and time available for use of the facility compatible with the instructional needs of the dental hygiene program;
e) d) the dental hygiene program administrator retains authority and responsibility for instruction and scheduling of student assignments;
f) e) clinical instruction is provided and evaluated by calibrated dental hygiene program faculty;
g) f) all dental hygiene students receive comparable instruction in the facility;
h) g) the policies and procedures of the facility are compatible with the goals of the educational program.

Intent:
The purpose of extended campus agreements is to ensure that sites that are used to provide clinical education will offer an appropriate educational experience. This standard does not apply to program sites used for enrichment experiences.

Examples of evidence to demonstrate compliance may include:
- contract with extended campus facility
- formal written contingency plan
- course and faculty schedules for clinical programs
- affiliation agreements and policies/objectives for all off-campus sites
- documentation of calibration activites
Classroom Space

4-5 Classroom space which is designed and equipped for effective instruction must be provided for and readily accessible to the program.

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

Office Space

4-6 Office space which allows for privacy must be provided for the program administrator and all faculty to enable the fulfillment of faculty assignments and ensure privacy for confidential matters. Student and program records must be stored to ensure confidentiality and safety.

Intent:
Office space for full- and part-time faculty should be allocated to allow for class preparation, student counseling and supportive academic activities. Faculty that share offices should have access to available privacy space for confidential matters.

Examples of evidence to demonstrate compliance may include:
- Floor plan showing room allocation
- Office space which provides privacy for the program administrator
- Office space for faculty with duties that involve administrative or didactic teaching responsibilities

Learning Resources

4-7 Instructional aids and equipment must be provided for student learning. Institutional library holdings must include or provide access to a diversified collection of current dental, dental hygiene and multidisciplinary literature and references necessary to support teaching, student learning needs, service, research and development. There must be a mechanism for program faculty to periodically review, acquire and select current titles and instructional aids.
Intent:
The acquisition of knowledge, skill and values for dental hygiene students requires the use of current instructional methods and materials to support learning needs and development. All students, including those receiving education at distance sites, will be assured access to learning resources.

Examples of evidence to demonstrate compliance may include:
- a list of references on education, medicine, dentistry, dental hygiene and the biomedical sciences
- policies and procedures related to learning resource access
- timely electronic access to a wide variety of professional scientific literature
- skeletal and anatomic models and replicas, sequential samples of laboratory procedures, slides, films, video, and other media which depict current techniques
- a wide range of printed materials and instructional aids and equipment available for utilization by students and faculty
- current and back issues of major scientific and professional journals related to dentistry and dental hygiene

Student Services

4-8 There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

Intent:
All policies and procedures should protect the students as consumers and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect work accomplished and are maintained in a secure manner.

Examples of evidence to demonstrate compliance may include:
- student rights policies and procedures
- student handbook or campus catalog
- ethical standards and policies to protect students as consumers
- student records
STANDARD 5 - HEALTH AND SAFETY PROVISIONS

Infectious Disease/Radiation Management

5-1 The program must document its compliance with institutional policy and applicable regulations of local, state and federal agencies including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all students, faculty, and appropriate support staff, and continuously monitored for compliance. Policies on bloodborne and infectious diseases must be made available to applicants for admission and patients.

A. Policies must include, but not be limited to:
   1. Radiation hygiene and protection,
   2. Use of ionizing radiation,
   3. Hazardous materials, and

B. Policies must be provided to all students, faculty, and appropriate support staff, and continuously monitored for compliance.

C. Policies on bloodborne and infectious diseases must be made available to applicants for admission and patients.

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

Policies and procedures on the use of ionizing radiation should include criteria for patient selection, frequency of exposing and retaking radiographs on patients, consistent with current, accepted dental practice. All radiographic exposures should be integrated with clinical patient care procedures.
Policies and procedures should be in place to provide for a safe environment for students, patients, faculty and staff. The confidentiality of information pertaining to the health status of each individual should be strictly maintained.

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

Examples of evidence to demonstrate compliance may include:
- protocols on preclinical/clinical/laboratory asepsis and infection control
- protocols on biohazard control and disposal of hazardous waste
- program policy manuals
- compliance records with applicable state and/or federal regulations
- policies and procedures on the use of ionizing radiation
- policies and procedures regarding individuals with bloodborne infectious diseases
- established post-exposure guidelines as defined by the Centers for Disease Control and Prevention

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

Intent:
All individuals who provide patient care or have contact with patients should follow all standards of risk management thus ensuring a safe and healthy environment.

Examples of evidence to demonstrate compliance may include:
- policies and procedures regarding infectious disease immunizations
- immunization compliance records
- declinations forms

Emergency Management and Life Support Certification

5-3 The program must establish, enforce, and instruct students in preclinical/clinical/laboratory protocols and mechanisms to ensure the management of common medical emergencies in the dental setting. These program protocols must be provided to all students, faculty and appropriate staff. Faculty, staff...
Faculty, staff and students must be prepared to assist with the management of emergencies. All students, clinical faculty and clinical support staff must be continuously recognized/certified in basic life support procedures, including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED).

**Intent:**

All individuals involved with patient care or have contact with patients should be trained in the recognition and management of medical emergencies and basic life support procedures.

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

- accessible and functional emergency equipment, including oxygen
- instructional materials
- documentation of simulation drills
- written protocol and procedures for management of medical emergencies
- emergency kit(s)
- installed and functional safety devices and equipment
- first aid kit accessible for use in managing clinic and/or laboratory accidents
- continuous recognition records of students, faculty and support staff involved in the direct provision of patient care
- exemption documentation for anyone who is medically or physically unable to perform such services
STANDARD 6 - PATIENT CARE SERVICES

6-1 The program must have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs. Patients accepted for dental hygiene care must be advised of the scope of dental hygiene care available at the dental hygiene facilities.

Intent:
All dental hygiene patients should receive appropriate care that assures their right as a patient is protected. Patients should be advised of their treatment needs and the scope of care available at the training facility and appropriately referred for procedures that cannot be provided by the program. This Standard applies to all program sites where clinical education is provided.

Examples of evidence to demonstrate compliance may include:
- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided
- quality assurance policy and procedures
- patient bill of rights

6-2 The program must have a formal written patient care quality assurance plan that allows for a continuous systematic review of patient care standards. The quality assurance plan must be applied at least annually and includes:

a) standards of care that are patient-centered, focused on comprehensive care, and written in a format that facilitates assessment with measurable criteria;
b) an ongoing audit review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
c) mechanisms to determine the cause of treatment deficiencies;
d) patient review policies, procedure, outcomes and corrective measures.

Intent:
The program should have a system in place for continuous review of established standards of patient care. Findings should be used to modify outcomes and assessed in an on-going manner. This Standard applies to all program sites where clinical education is provided.
Examples of evidence to demonstrate compliance may include:

- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided evidence of chart audits

- quality assurance policy and procedures

- patient bill of rights

- documentation of policies on scope of care provided, recalls and referrals

- description of the quality assurance process for the patient care program

- samples of outcomes assessment measures that assess patients’ perceptions of quality of care, i.e., patient satisfaction surveys and results

- results of patient records review and documentation of corrective measures

6-3 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive dental hygiene patient care.

Intent:
The need for students to satisfactorily complete specific clinical requirements prior to advancement and graduation should not adversely affect the health and care of patients.

Examples of evidence to demonstrate compliance may include:

- patient bill of rights

- documentation that patients are informed of their rights

- continuing care (recall) referral policies and procedures

6-4 The program must develop and distribute a written statement of patients’ rights to all patients, appropriate students, faculty, and staff.

Intent:
The primacy of care for the patient should be well established in the management of the program and clinical facility assuring that the rights of the patient are protected. A written statement of patient rights should include:

a) considerate, respectful and confidential treatment;
b) continuity and completion of treatment;
c) access to complete and current information about his/her condition;
d) advance knowledge of the cost of treatment;
e) informed consent;
f) explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;
g) treatment that meets the standard of care in the profession.

6-5 All students, faculty and support staff involved with the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED).

Intent:
The need for students to be able to provide basic life support procedures is essential in the delivery of health care.

Examples of evidence to demonstrate compliance may include:
• continuous recognition records of students, faculty and support staff involved in the direct provision of patient care
• exemption documentation for anyone who is medically or physically unable to perform such services

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

Intent:
The program should have a system in place to ensure patient confidentiality. The use of student employees as secretarial staff does not preclude the essential need for All individuals who have access to patient information will ensure patient confidentiality.

Examples of evidence to demonstrate compliance may include:
• evidence of confidentiality training
• student, faculty and staff attestation to ensure patient confidentiality
• evidence of HIPAA training
REPORT OF THE REVIEW COMMITTEE ON DENTAL LABORATORY TECHNOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Mr. Charles McClemens. Committee Members: Ms. Arax Cohen, Mr. Gary Gann, Dr. Alice Mehlhorn, and Dr. Arpana Verma. Guests (Open Session Only): Mr. Bennett Napier, chief staff executive, National Association of Dental Laboratories and Ms. Rebecca Stolberg, senior director, Allied Dental Education and Faculty Development, American Dental Education Association attended the policy portion of the meeting. Staff Members: Ms. Michelle Smith, manager, Allied Dental Education, Ms. Peggy Soeldner, manager, Advanced Dental Education, and Mr. Daniel Sloyan, senior project assistant, Allied Dental Education, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Dental Laboratory Technology Education (DLT RC) was held on January 11, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL LABORATORY TECHNOLOGY EDUCATION

Report on Dental Laboratory Technology Annual Survey Curriculum Section (p. 500):
The Dental Laboratory Technology Review Committee (DLT RC) noted that the Annual Survey Curriculum Section for dental laboratory technology education is reviewed during the Winter Review Committee meeting in the year the survey will be distributed; which will next occur in 2021.

At this meeting, the DLT RC reviewed the Annual Survey Curriculum Section for dental laboratory technology education (Appendix 1, Policy Report p. 500) and concluded that these Curriculum sections do not warrant further revision at this time and should be implemented in their current format in the 2021 Annual Survey. The Review Committee discussed that the Annual Survey Curriculum Section will be reviewed in 2023 and will likely require revisions as noted below in the report related to the proposed revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs.

Recommendation: It is recommended that the Commission direct the Annual Survey Curriculum Section for dental laboratory technology education programs (Appendix 1, Policy Report p. 500) be implemented in its current format in the Fall 2021 Annual Survey.

Consideration of Proposed Revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs (p. 501): The Accreditation Standards for Dental Laboratory Technology Education Programs were adopted by the Commission on Dental Accreditation at its August 8, 2013 meeting for implementation January 1, 2014.

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

In Summer 2019, the Dental Laboratory Technology Review Committee (DLT RC) conducted an initial review of the validity and reliability study report. The Review Committee concluded that further study of the survey data was warranted. The DLT RC believed that a small workgroup should be formed to further study the report and identify Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of a workgroup composed of three (3) Dental Laboratory Technology Review Committee members and two (2) additional members representing the National Association of Dental Laboratories (NADL), to further study the findings of the Dental Laboratory Technology Validity and Reliability Study and identify Accreditation Standards, if any, which warrant revision, with a report to the DLT RC and Commission in Winter 2020.

The workgroup members included Mr. Charles McClemens (DLT RC and workgroup chair), Ms. Arax Cohen (DLT RC), Mr. Gary Gann (DLT RC), Ms. Renata Budny (NADL), and Mr. Bob Lathrop (NADL). The workgroup conducted three (3), two-hour meetings on September 20, November 5, and November 22, 2019.

At the Winter 2020 meeting, the DLT RC considered the proposed revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs submitted by the workgroup. The DLT RC discussed the definition of special needs and determined that the term “normal” should be removed from the definition. Additionally, the Review Committee discussed Standard 2-4 related to the degree awarded in a two-year or four-year college setting. The DLT RC felt the proposed revisions to Standard 2-4 would not adversely affect any programs; therefore, the Review Committee did not modify the proposed revisions to this standard. The DLT RC also discussed Standard 3-8 related to faculty qualifications at length, and considered the addition of a “grandfather” clause for currently employed faculty members; however, the DLT RC determined that the proposed revisions to the standard adequately reflects the Review Committee’s recommendation to elevate the requirements of faculty education. Following discussion, the DLT RC recommended the proposed revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs be circulated to the communities of interest, without further edits by the DLT RC, for review and comment for one (1) year with hearings conducted at the 2020 American Dental Education Association (ADEA) Annual Session and the 2020 American Dental Association (ADA) Annual Meeting. Comments would be reviewed at the Commission’s Winter 2021 meetings.

At this meeting, the DLT RC considered the proposed revisions (Appendix 1, Policy Report p. 501) and all of the comments received prior to the December 1, 2020 deadline (Appendix 2, Policy Report p. 501). The DLT RC noted that due to the COVID-19 pandemic, the 2020 Annual Meeting of the American Dental Education Association (ADEA) was canceled and the ADA Annual Meeting was conducted virtually. Therefore, the Commission’s hearings on accreditation standards were held virtually on May 18, 2020 and October 20, 2020, respectively. No (0) comments were received at the May 18, 2020 virtual hearing to replace the ADEA
hearing; and no (0) comments were received at the October 20, 2020 virtual hearing to replace the ADA hearing. The Commission office received three (3) written comments prior to the December 1, 2020 deadline (Appendix 2, Policy Report p. 501).

The Review Committee carefully reviewed the written comments and the corresponding proposed Standards revisions. After reviewing the comments received the Review Committee determined that the comments warranted one (1) minor revision to the proposed Accreditation Standards for Dental Laboratory Technology Education Programs, which was to keep “Fabricating surgical templates” under Complete Dentures, within the duties listed under Standard 2-15 (Appendix 1).

Upon conclusion of the discussion and review of all written comments received, the Review Committee determined that the proposed revisions found in Appendix 1 should be adopted by the Commission with an implementation date of January 1, 2022.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs found in Appendix 1, with implementation January 1, 2022.

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL LABORATORY TECHNOLOGY EDUCATION**

The Review Committee on Dental Laboratory Technology Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Mr. Charles McClemens
Chair, Review Committee on Dental Laboratory Technology Education
At its Winter 2020 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Dental Laboratory Technology Education Programs be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2020, for review at the Winter 2021 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from January 31, 2020 to December 1, 2020.

This document will be considered by the Commission in Winter 2021.

Additions are Underlined
Strikethroughs indicate Deletions
Accreditation Standards for Dental Laboratory Technology Education Programs

Commission on Dental Accreditation
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Chicago, Illinois 60611
312/440-4653
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Accreditation Standards for Dental Laboratory Technology Education Programs

Document Revision History

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<tr>
<td>August 9, 2013</td>
<td>Accreditation Standards for Dental Laboratory Technology Education Programs</td>
<td>Adopted</td>
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<tr>
<td>February 6, 2015</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

1. Programs That Are Fully Operational:

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

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

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

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

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

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

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

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based upon one or more site evaluation visit(s).

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

**Other Accreditation Actions:**

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

**Withdraw:** An action taken by the Commission when a program has been unable to demonstrate compliance with the accreditation standards or policies within the time period specified. A final action to withdraw accreditation is communicated to the program and announced to the communities of interest. A statement summarizing the reasons for the Commission’s decision and comments, if any, that the affected program has made with regard to this decision, is available upon request from the Commission office. Upon withdrawal of accreditation by the Commission, the program is no longer recognized by the United States Department of Education. In the event the Commission withdraws accreditation from a program, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program, will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission accredited program. Such graduates may be ineligible for certification/licensure examinations.
Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9

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

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

The Accreditation Standards for Dental Laboratory Technology Education Programs have been developed for the following reasons: (1) to protect the public welfare, (2) to serve as a guide for dental laboratory technology education program development, (3) to serve as a stimulus for the improvement of established programs, and (4) to provide criteria for the evaluation of new and established programs. To be accredited by the Commission on Dental Accreditation a dental laboratory technology program must meet the standards set forth in this document. These standards are national in scope and represent the minimum requirements for accreditation.

The importance of academic freedom is recognized by the Commission. Therefore, the standards are stated in terms which allow an institution flexibility in the development of an educational program. The Commission encourages curricular experimentation, development of institutional individuality and achievement of excellence in all accredited programs.

Programs and their sponsoring institutions are encouraged to provide for the educational mobility of students through articulation arrangements and career laddering. Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying and proficiency examinations. It is expected that institutions which voluntarily seek accreditation will recognize the ethical obligation of complying with the spirit as well as the letter of these standards.

The Commission on Dental Accreditation

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

The Commission is comprised of 30 members. The National Association of Dental Laboratories’ representative serves with other disciplines accredited by the Commission as well as public and student representatives.

Specialized Accreditation

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

**Dental Laboratory Technology Accreditation**

The first educational standards for the education of dental laboratory technicians were adopted by the American Dental Association House of Delegates in 1946. These standards were rescinded and revised requirements were approved in 1957. Since then the accreditation standards have been revised six seven times—in 1967, 1973, 1979, 1991, 1998, and 2008, and TBD to reflect the dental profession and laboratory industry’s profession’s changing needs and educational trends.

In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation utilized the following procedures: appointing an ad hoc committee representing broad communities of interest; holding open hearings at annual meetings of the National Association of Dental Laboratories and the American Association of Dental Schools; and widely distributing a draft of the proposed revision of the standards for review and comment. Prior to approving the revised standards in January, 2008 TBD, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in July 2009 TBD.
Statement of General Policy

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

1. Evaluates dental laboratory technology 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 laboratory technology 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 laboratory technology program. In evaluating the curriculum in institutions that are accredited by a recognized regional accrediting agency, the Commission will concentrate on those courses which have been developed specifically for the dental laboratory technology program and core courses developed for related disciplines. When an institution has been granted an accreditation status or candidate for accreditation status by a regional agency, the Commission will accept that status as evidence that the general studies courses included in the dental laboratory technology curriculum meet accepted standards, provided the level and content of such courses are appropriate 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.

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

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

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

**Intent:** Intent statements are presented to provide clarification to the allied education programs in dental laboratory technology educational programs in the application of and in connection with compliance with the Accreditation Standards for Dental Laboratory Technology 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.

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

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

**TYPES OF INSTRUCTION**

**Didactic Instruction:** Refers to lectures, demonstrations or other non-laboratory instruction.

**Laboratory Instruction:** Indicates instruction in which students receive demonstrations, supervised experience enabling performing techniques and procedures in the laboratory setting using study models, typodonts, etc., and established clear protocols with predetermined criteria for student performance evaluation, their performance is evaluated by faculty according to predetermined criteria.

**Practical Experience:** Indicates instruction in which students received supervised experience in performing techniques and procedures in the laboratory setting by fabricating prostheses for patients currently under treatment, or from actual casts or impressions, and occlusal records from previously fabricated prostheses. Performance of the procedures is evaluated by faculty or laboratory supervisors according to predetermined criteria that emphasize quality, productivity and the ability to complete a clinically acceptable appliance in a reasonable amount of time.

**LEVELS OF KNOWLEDGE**

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

**LEVELS OF SKILL**

**Exposure:** The level of skill attained by observation of or participation in a particular activity.

**Competence:** The achievement of a predetermined level of special skill derived from education, experience and task completion obtained in the dental laboratory setting through continuous participation and attendance.

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

**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 as well as modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and vulnerable older adults.
STANDARD 1 - INSTITUTIONAL EFFECTIVENESS

Program Planning and Assessment

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

a) A plan with program goals Program goals that include, but are not limited to a purpose, mission statement, and student learning outcomes that are consistent with the goals of the sponsoring institution and appropriate to dental technology education

b) An implementation plan

c) An assessment process which includes with methods of assessment and data collection, including measures of student achievement

d) Use of results for program improvement

Intent:
Planning for, evaluation of and improvement of the educational quality of the program is broad-based, systematic, continuous and designed to promote achievement of program goals.

Examples of evidence to demonstrate compliance may include:

a. A Plan with Program Goals:

• The program has a clearly stated purpose and goals which are consistent with the goals of the sponsoring institution.

• The program’s A clearly stated program purpose and mission statement is reflective of the sponsoring institution’s mission and vision and appropriate to dental laboratory technology education; the purpose addresses teaching, and as appropriate, patient care and service.

• List of the program’s goals which are consistent with the goals of the sponsoring institution.

• The Commission on Dental Accreditation expects each program to regularly examine and re-define define its own goals, and objectives, and program and student learning outcomes as necessary, based on the current needs of the program, for preparing individuals in the discipline, and that one program goal is to comprehensively prepare competent individuals in the discipline.

b. An Implementation Plan

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c. An Assessment Process with Methods of Assessment and Data Collection
The assessment methods are related to the program goals and may include, but are not limited to:

**Longitudinal Program Outcomes Measures such as:**
- Consideration of course completion
- Job placement rates
- Success of graduates on state licensing and/or certification examinations
- Other measures of learning used to demonstrate effectiveness, such as tests and National Board scores, as appropriate
- Surveys of alumni, students, employers and clinical sites
- Degree/certificate completions

Financial Resources Management Mechanisms such as:
- Budget provisions ensure the currency of learning

Faculty Coordination and Curriculum Review Mechanisms such as:
- Faculty meetings are held to coordinate curriculum content.
- Formal curriculum review is conducted and assessed to implement curriculum improvements as necessary.
- Periodic workshops and in-service sessions are conducted.

Admissions Management Mechanisms such as:
- The program administrator and faculty, in cooperation with appropriate institutional personnel, establish admissions procedures which contribute to the quality of the program.
- Periodic analyses support the validity of established admission criteria and procedures; adjustments are made where indicated.
- The expertise of institutional research personnel is utilized in interpreting data, correlating data with student performance, and evaluating various criteria.

d. Use of Results for Program Improvement
- Results of the assessment process are used to evaluate the program’s effectiveness in meeting its goals and fostering enhanced student achievement.
- Examples of how the program has been improved

**Financial Support**

1-2 The program must have a strategic plan which identifies stable institutional financial resources sufficient to support the program’s stated mission, goals and objectives.
Intent:
The institution has the financial resources required to develop and sustain the program on a continuing basis. The ability to employ an adequate number of full-time faculty, replace and add equipment, procure supplies, reference material, and teaching aids is reflected in annual budget appropriations for the program. Financial allocations ensure that the program will be in a competitive position to recruit and retain qualified faculty. Annual appropriations provide for innovations and changes necessary to reflect current concepts of education in the discipline. The Commission assesses the adequacy of financial support on the basis of current appropriations. The financial resources identify stable sources of funding for the program and the degree of dependence upon a given funding source is based upon the stability of that source.

Examples of evidence to demonstrate compliance may include:
- Program’s mission, goals and objectives; current and previous year revenue and expenses; revenue and expense projections for the program for the next three to five years

1-3 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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

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

Institutional Accreditation

1-5 Programs must be sponsored by educational institutions that are responsible for postsecondary education and accredited by an agency recognized by the United States Department of Education or an officially recognized state accrediting agency.

Intent:
Dental schools, four-year colleges and universities, community colleges, technical institutes, vocational schools, private schools, and recognized federal service training centers which offer appropriate fiscal, facility, faculty and curriculum resources are considered appropriate sponsors for the program.
Examples of evidence to demonstrate compliance may include:

- Accreditation (or candidate status) from a recognized institutional (state, regional or national) accrediting agency.
- Examples of regional institutional accrediting agencies are: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, and Western Association of Schools and Colleges.
- Examples of national institutional accrediting agencies are: Accrediting Bureau of Health Education Schools and Accrediting Commission for Career Schools and Colleges of Technology.

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

Examples of evidence to demonstrate compliance may include:

- Written co-sponsoring/affiliation agreement(s) with termination clause

Community Resources

1-7 There must be an active liaison mechanism between the program and the dental and allied dental professionals in the community.

Intent:
The purpose of the active liaison mechanism is to provide a mutual exchange of information for improving the program and meeting employment needs of the community. Meetings, either in-person or virtual, should be held at least once per year.

Examples of evidence to demonstrate compliance may include:

- An advisory committee is one example of a liaison mechanism.

Responsibilities

- The responsibilities of the liaison mechanism or advisory committee are clearly defined in writing, recognizing that the institution has final responsibility and authority in curriculum development and approval, student selection, faculty selection and administrative matters.
- Documentation of community manpower needs is ongoing.
Membership

- The program has established criteria for the selection of liaison or advisory committee members.
- Consideration is given to appointing a student, recent graduate and public representative.
- If the liaison mechanism or advisory committee represents more than one discipline, representation is equitable.
- The program administrator, faculty, and appropriate institution personnel participate in the meetings as non-voting members to receive the advice and assistance of the committee.
- In appointing the advisory committee, the institution seeks recommendations from local or state dental and dental laboratory organizations.
- There is equitable representation of dentists, employed technicians, laboratory owners, as well as a student representative.
- The liaison or advisory committee membership includes dental laboratory technicians, laboratory owners and dentists who are able to provide information on the needs of the dental practitioners and dental laboratories.
- Membership list

Appointments

- Appointment terms are staggered to provide new input as well as continuity.

Meetings

- Policies regarding the liaison mechanism which outline responsibilities, appointments and meetings.
- The program administrator, faculty and appropriate institutional personnel participate in the meetings as non-voting members to receive the advice and assistance of the committee.
- The liaison or advisory committee meets at regular and frequent intervals as the program is being developed and continues to meet at regular and frequent intervals, at least once per year after the program has been implemented.
- A record of committee deliberations and activities is maintained and provided to liaison or advisory committee members.
STANDARD 2 – EDUCATIONAL PROGRAM

Admissions

2-1 Admission of students must be based on specific written criteria, procedures and policies. Minimum admissions requirements must include high school diploma or its equivalent. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability, and employment opportunities for dental laboratory technicians.

Intent:
Because the curriculum is science and technology-oriented and relatively difficult and enrollment is limited by facility capacity, special program admissions criteria and procedures may be necessary. The program administrator and faculty, in cooperation with appropriate institutional personnel establish admissions procedures which are non-discriminatory, contribute to the quality of the program, and allow selection of students with potential for successfully completing the program.

Examples of evidence to demonstrate compliance may include:

Recruitment
- Student recruitment activities provide an adequate number of qualified applicants to ensure that standards of instruction and achievement can be maintained.
- Applicants are informed of the criteria and procedures for selection, goals of the program, curricular content, the functions of a dental laboratory technician and employment opportunities.

Criteria and Selection Process
- There is an established admissions committee which includes program representation.
- A high school diploma, or its equivalent, is required for admission to the program.
- Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability are utilized for criteria in selecting students.
- High school class rank
- Cumulative grade point averages in previous education with particular attention given to grades in science and technology subjects, where appropriate.
- Pre-matriculation health standards, where appropriate, are identified to ensure that prospective students are qualified to undertake allied dental studies.
Academic Strengthening

- If academic strengthening is needed to meet basic admission criteria or to proceed satisfactorily through the curriculum, the institution and program have the resources required to assist students.
- Academic strengthening occurs prior, or concurrently while matriculating, to entry into program courses.

Transfer Credits

- Provisions are made to accept credits earned in another institution when a course is equivalent to, or exceeds, instruction in a course required in the curriculum.

Documentation

- Copies of policies, procedures and forms used
- Copies of catalogs and program brochures used

Admission of students with advanced standing must be based on the same standards of achievement required by students regularly enrolled in the program. Students with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by students regularly enrolled in the program. Criteria required of all applicants admitted to the program. If a program considers students for advanced standing, credit must be awarded based on equivalent didactic, laboratory content and student achievement.

Intent:

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

Examples of evidence to demonstrate compliance may include:

- Policies and procedures on advanced standing
- Results of appropriate qualifying examinations
• Course equivalency or other measures to demonstrate equal scope and level of knowledge

2-3 The number of students enrolled in the program must be proportionate to the resources available.

Intent:
In determining the number of students enrolled in a program, including off-campus sites, hybrid, or online courses, careful consideration is given that to ensure that the number of students does not exceed the program’s resources, including, as appropriate, financial support, scheduling options, facilities, equipment, supplies, including distance education and faculty.

Examples of evidence to demonstrate compliance may include:
• Number of laboratories and seats
• Full-time equivalent (FTE)
• Budget
• Equipment inventory list
• Scheduling
• Faculty/student ratio

Curriculum Management

2-4 The curriculum must be structured on the basis of include at least two academic years of full-time study instruction or its equivalent at the postsecondary level. The scope and depth of the curriculum must reflect the objectives and philosophy of higher education. The college catalog must list the degree awarded and course titles and descriptions. In a two-year college setting, the graduates of the program must be awarded an associate degree or certificate of completion. In a four-year college or university, graduates of the program must be awarded an associate degree, post-degree certificate, or baccalaureate degree.

Intent:
Minimum of at least two academic years or equivalent of full-time study are required to provide both didactic and laboratory experiences sufficient to ensure that students will acquire appropriate knowledge and skill. The curriculum may be structured to allow individual students to meet performance standards specified for graduation in less than the required length as well as to provide the opportunity for students who require more time to extend the length of their instructional program. The curriculum design provides maximum opportunity for students to continue their formal education with minimum duplication of learning experiences.
Examples of evidence to demonstrate compliance may include:

- Degree/certificates awarded
- Curriculum mapping
- Institutional catalog with program requirements
- Articulation agreements
- Grade transcripts
- Competency examinations
- State and national examinations

2-5 The curriculum must be designed to reflect the interrelationship of general studies, physical sciences, dental sciences and dental laboratory techniques to promote maximum application of basic concepts in the performance of dental laboratory techniques.

Intent:
Although there is not a prescribed sequence of instruction, the order of content presentation and learning experience is based on a reasonable relationship between the basic and applied aspects of the curriculum.

Examples of evidence to demonstrate compliance may include:

- Course outlines/syllabi
- Course sequencing plan within curriculum

Instruction

2-6 Written documentation of for each course in the curriculum must be provided to students and include:

a) The course name title and number and description
b) Course description
c) Primary faculty and instructor(s) of record and contact information
d) Course content outline including topics to be presented
e) Specific instructional objectives, student learning outcomes and assessment mechanisms
f) Learning experiences course schedule including time allocated for didactic and laboratory learning experiences
g) Specific criteria and evaluation procedures for course grade calculation
Intent:
Curriculum documentation is current, reviewed periodically and revised, and should include:
  a) Topics related to course content
  b) Instructional objectives and learning experiences are related to topics
  c) Evaluation procedures measure instructional objectives
  d) Course or weekly schedule

Examples of evidence to demonstrate compliance may include:

- Course syllabi
- Criteria for grade calculation
- Rubrics for student learning outcomes
- Institutional and program grading policies
- Course knowledge and/or skill assessments
- Course schedules to include laboratory activities and evaluations

Curriculum Content

2-7 The basic curriculum must include content in the subject areas: general studies; physical sciences; dental sciences; legal, ethical and historical aspects of dentistry and dental laboratory technology; infectious disease and hazard control management; and, basic laboratory techniques.

Intent:
To ensure that foundational knowledge is established early in the program and that subsequent information is provided which is comprehensive and prepares the student to achieve competence in all components of dental laboratory practice. Content identified in each subject need not constitute a separate course, but the subject areas are included within the curriculum.

Examples of evidence to demonstrate compliance may include:
The following examples of evidence apply, as appropriate, to demonstrate compliance with Standards 2-7 through 2-24.

- Course syllabi which address content in each of the listed areas (see general studies)
- An outline of the curriculum sequence including prerequisite course work
- A listing of courses which provide the major instruction in each required content area
- Course requirements
- Course length
- Laboratory hours
• Time allocated for the didactic and clinical/laboratory experiences
• Student participation in events organized by the program (invited speakers, lectures, workshops, field trips, etc.)
• Student participation in professional events (conferences, symposia, workshops, meetings, webinars, tradeshows, etc.)

General Studies

2-8 The curriculum must include content at the in-depth level in communication skills, mathematics and business principles relative to dental laboratory technology.

Intent:
Content in general studies prepares the student to work and communicate effectively with dental professionals and patients, and provides a foundation of knowledge for professional success

Examples of evidence to demonstrate compliance may include:
Topics in:
 a) Written Communications (written, interpersonal, verbal and non-verbal)
b) Interpersonal communication
c) Verbal and non-verbal communication
d) b) Weights and measures, percentages and metric system
e) c) Budgeting
f) d) Case scheduling, time management
g) c) Human resource management
h) f) Marketing
i) g) Compliance with applicable local, state, and federal regulations

Physical Sciences

2-9 The curriculum must include content at the in-depth level in chemistry and physics relative to dental laboratory technology.

Intent:
Content in physical sciences should prepare the student with an understanding of physical and chemical characteristics related to dental materials and processes, and utilized in proper fabrication of dental restorations, prostheses and appliances.

Examples of evidence to demonstrate compliance may include:

• State of matter
• Chemical bonding
• Acid-base theory
• Gases
• Solutions
• Heat and Temperature
• Light
• Lever System
• Force Principles

Dental Sciences

2-10 The curriculum must include content in dental materials, tooth morphology, oral anatomy and occlusion.

Intent:
Dental science content should provide the student with an understanding of physical properties, uses and manipulation of dental materials; tooth form and function; and structures of the oral cavity as related to proper application for use in fabricating dental restorations. Content should include principles of occlusion, determinants of occlusal morphology and physiology of mandibular movements.

Examples of evidence to demonstrate compliance may include:

- Dental science content which provides the student with an understanding of physical properties, uses and manipulation of dental materials; tooth form and function; and structures of the oral cavity.
- Principles of occlusion, determinants of occlusal morphology and physiology of mandibular movements as they relate to fabrication of dental restorations, prostheses and appliances.

Legal, Ethical and Historical Aspects

2-11 The curriculum must include content in the legal, ethical and historical aspects of dentistry and dental laboratory technology to include:

a) Organizations that advance certification and continuing education for dental technicians and certification of laboratories.
b) Work authorization/prescription of the dentist in accordance with the state dental practice act, consistent with current procedures in dental laboratory technology in the geographic area served by the program.
c) Federal and state laws and regulations related to operating a dental laboratory and/or working as a dental laboratory technician.
d) HIPAA laws related to health care professionals
e) Ethics for health care professionals

Intent:
The dental laboratory technology curriculum prepares students to assume a professional
and ethical standard to understand the basic foundation in which the fundamentals of dental laboratory technology were established, role in the dental health delivery system, and perform laboratory techniques and procedures in dental laboratories or dental offices.

Infectious Disease and Hazard Control Management

2-12 The program must present appropriate, ethical, legal and regulatory content related to bloodborne infectious diseases throughout the didactic and preclinical/clinical/laboratory components of the curriculum. Content in bloodborne infectious diseases must be presented at least once during each academic term. Each program must present a curriculum that prepares its students to provide and/or support the provision of oral health care services to patients with bloodborne infectious diseases.

2-13 Appropriate content related to bloodborne infectious diseases must be integrated throughout the didactic and preclinical/clinical/laboratory components of the curriculum.

2-14 Each student must understand the ethical, legal and regulatory considerations related to bloodborne diseases.

General Laboratory Techniques

2-15 The curriculum must include didactic as well as laboratory instruction in the following areas: general laboratory techniques, complete dentures, removable partial dentures, crown and bridge, dental ceramics, fixed prosthodontics, and orthodontics.

Intent:
Dental technology curriculum content includes theoretical aspects as well as practical application of the subjects. The theoretical aspect of the curriculum provides content necessary for the student to make appropriate judgments regarding the procedures an entry-level technician is expected to perform and access available resources. Time devoted to, and learning experience in, laboratory techniques ensures that each student has adequate opportunity to develop competency in performing all laboratory procedures and techniques in the curriculum. Students perform routine procedures that lead to the completion of clinically acceptable dental prostheses.

2-16 Students must demonstrate competence in general laboratory techniques, including:
a) Evaluating impressions

b) Preparing and evaluating casts

c) Fabricating custom impression trays

d) Articulating casts, using non-adjustable and semi-adjustable articulators

e) Developing functional occlusion on articulated casts

f) Recognizing variables that affect materials

g) Utilizing various manufacturing methods of fabrication (i.e., analog and/or digital)

h) Demonstrating safe handling of equipment and materials

i) Digital workflow (i.e., didactic and/or laboratory procedures)

Intent:
Dental technology curriculum content includes various manufacturing methods of fabrication; students should be exposed to new technologies and processes.

Complete Dentures

2-17 2-15 Students must demonstrate competence in the knowledge and skill required to fabricate complete denture prostheses, including:

a) Identifying various fabricating methods of fabrication

b) Constructing base plates and occlusion rims

c) Arranging a balanced denture set-up using anatomical teeth

d) Contouring denture wax-ups trial dentures prior to try-in and processing

e) Flaking, processing and recovery

f) Remounting

g) e) Equilibrating occlusal discrepancies

h) f) Finishing and polishing

i) g) Using a semi-adjustable articulator during fabrication

j) h) Relining and denture repairs

k) i) Fabricating surgical templates

Intent:
Dental laboratory technology curriculum content includes various methods of fabrication; students should be exposed to new technologies and processes.

Removable Partial Dentures

2-18 2-16 Students must demonstrate competence in the knowledge and skill required to fabricate removable partial dentures prostheses, including:

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a) Identification of the components of a removable partial denture, including various clasp designs
b) Principles of surveying and design
c) Performing blockout procedures
d) Duplicating master casts
e) Transferring the design
f) d) Fabricating wax patterns
c) Processing frameworks
g) Spruing and investing patterns
h) Burnout and casting frameworks utilizing recognized alloys
i) f) Finishing and polishing frameworks
j) g) Evaluating the fit of the framework to the master cast
k) h) Arranging teeth on the frameworks
l) i) Waxing, processing, recovering and finishing removable partial denture bases
m) j) Various repair procedures

Intent:
Dental laboratory technology curriculum content includes various methods of fabrication; students should be exposed to new technologies and processes.

Crown and Bridge

Students must demonstrate competence in the knowledge and skill required to fabricate fixed prostheses, including inlays, onlays, full crowns and bridgework, including:

a) Preparing and evaluating casts with removable dies
b) Recognizing variables that affect materials
c) Identifying various fabricating methods
d) Trimming dies and marking margins utilizing magnification
e) Identifying various margin and preparation designs and their applications
f) Developing wax patterns
g) Spruing and investing patterns
h) Burnout and casting restorations
i) Seating castings to dies utilizing magnification
j) Adjusting occlusal and interproximal contacts
k) Finishing and polishing restorations
l) Fabricating multi-unit restorations
m) Fabricating restorations on various types of articulators
n) Developing functional occlusion on full-arch articulated casts
o) Soldering as a fabrication/repair procedure
Intent:
Dental technology curriculum content includes various manufacturing methods, students need to be exposed to as many new technologies and processes as possible. Including but not limited to: pressing fabrication process, digital scanning and digital designing, and implants.

Dental Ceramics - Fixed Prosthodontics

2-20 2-17 Students must demonstrate competence in the knowledge and skill required to fabricate ceramic fixed prostheses, including inlays, onlays, full crowns and fixed partial dentures:

a) Preparing and evaluating casts with removable dies
b) Recognizing variables that affect materials
c) Identifying various methods of fabrication
   d) Trimming dies and marking Preparing margins utilizing magnification
e) Identifying various margin and preparation designs and their applications
   f) Designing and fabricating full contour restorations
   g) Designing and developing fabricating substructures patterns
   h) Seating ceramic fixed restoration utilizing magnification
i) Preparing substructure to receive porcelain
j) Applying and firing processing porcelain to substructure(s)
k) Contouring fired porcelain ceramic materials
l) Developing functional occlusion on full arch articulated casts
m) Adjusting occlusal and interproximal contacts
n) Performing optical external characterization
 o) Finishing and polishing restorations
p) Fabricating single and multi-unit restorations
m) Designing and fabricating porcelain margins

a) q) Demonstrating safe handling of all equipment associated with ceramic restorations

Intent:
Dental technology curriculum content includes various methods of fabrication, the program should introduce students to new technologies and processes wherever possible, including but not limited to: pressing fabrication processes, digital scanning and digital designing, and implant technology.
Orthodontics

2-18 Students must demonstrate competence in the knowledge and skill necessary to fabricate orthodontic appliances, including:

a) Recognizing variables that affect materials  
b) Preparing and evaluating orthognathic study casts  
c) Identifying the components of orthodontic appliances  
d) Identifying and categorizing types of appliances  
e) Fabricating retainers, space maintainers and tooth moving appliances  
f) Contouring various types of arch wires, clasps and springs  
g) Fabricating, finishing and polishing autopolymerizing resin appliances  
h) Soldering and band placement  
i) Appliance repairs

Intent:  
Dental laboratory technology curriculum content includes various methods of fabrication; students should be exposed to new technologies and processes.

Specialty Discipline Specific Content

2-19 The specialty discipline specific portion of the curriculum must prepare students to competence in additional techniques in at least one or more of the following specialty discipline specific areas: complete dentures, removable partial dentures, fixed prosthodontics, crown and bridge, dental ceramics and orthodontics, and implants.

Intent:  
While it is desirable that instruction in all five specialties discipline specific areas be offered, students need the opportunity to select from at least two specialties discipline specific areas.

Curriculum content in the specialty discipline specific areas includes reinforcement of techniques and procedures which were taught in the basic curriculum. A balanced emphasis is placed on incorporating productivity, flow time and quality requirements into the educational program. Dependent upon its objectives, resources and community needs, the institution may elect to extend the scope of the dental laboratory technology curriculum to include content and instruction in additional discipline specific disciplines or specialized areas. Institutions with the resources are encouraged to provide instruction in more than one specialty discipline specific area, thus providing the

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opportunity for students to elect areas of specialization on the basis of their interests.

Techniques and procedures are consistent with current procedures used in dental laboratory technology and the geographic area served by the program.
Practical Experience

Practical experiences to support the development of competency in performing laboratory procedures must be provided either in the program facilities or off-site facilities.

Examples of evidence to demonstrate compliance may include:

- This experience is provided by fabricating prostheses for patients currently under treatment, or from actual casts or impressions and occlusal records from previously fabricated prostheses.
- Practical experiences are evaluated by the program administrator and faculty on a continuing basis to determine the degree to which curriculum objectives are being met.
- Off-campus or extramural laboratory experiences are not required and are not considered substitutes for basic instruction to develop minimum competency.
- The program administrator and faculty are responsible for selecting the laboratories or institutions and for coordinating extramural experiences.
- The program administrator identifies individuals who will instruct, supervise, and evaluate students in extramural experiences.
- Laboratory personnel are oriented to the objectives of the program and the extramural experience, the preparation that the student has had for the laboratory assignment, and the criteria to be used in evaluating students during their assignment.
- Students are oriented to the laboratory operation.
- Laboratory procedures, instruction and evaluation are consistent with the philosophy and objectives of the dental technology program and the parent institution.
- To enable the faculty to determine the diversity of students’ extramural experiences and make appropriate revisions in subsequent assignments to compensate for any deficiencies, a record of students’ activities in each laboratory is maintained.
- Seminars are held periodically with students to integrate didactic and laboratory instruction with extramural experiences and to provide opportunities for students to share experiences.
- The value of extramural experiences is determined with input from the program faculty, laboratory personnel and students.
- Procedures and criteria are defined for use in evaluating the experience.
- Students are encouraged to evaluate their extramural learning experiences.
- An appropriate evaluation mechanism is utilized to help them do so.
- Formal agreements which clearly outline the commitments of the institution and the extramural facility and the responsibilities of each are established between...
Student Evaluation

Student evaluation methods must include defined objective criteria that measure all defined course objectives and/or student learning outcomes.

Intent:
Specific criteria and procedures for measuring student progress toward attainment of course objectives and/or student learning outcomes are developed and utilized as feedback to the student.

Examples of evidence to demonstrate compliance may include:
- In establishing the level of competence required, the program faculty considers generally accepted industry profession standards.
- Specific criteria for measuring levels of competence are developed for each component of a given procedure.
- Students’ performance is measured against accepted program’s student learning outcomes standards.
- Standards for performance are increased as students’ progress through the curriculum.
STANDARD 3 - ADMINISTRATION, FACULTY AND STAFF

3-1 The administrative structure must ensure the attainment of program goals.

Intent:
The administration includes formal provisions for program planning, staffing, direction, coordination and evaluation.

Examples of evidence to demonstrate compliance may include:
• Program inclusion in short and long range strategic planning documents
• Instructional program review

3-2 The program must be a recognized entity within the institution’s administrative structure.

Intent:
The position of the program in the institution’s administrative structure permits direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program.

Examples of evidence to demonstrate compliance may include:
• Institutional organization flow chart
• Program representation on college or university committees

Program Administrator

3-3 A program administrator who is employed full-time (as defined by the institution) and who is responsible for the day-to-day implementation of the program and must be appointed and have the authority, responsibility and privileges necessary to manage the program.

Examples of evidence to demonstrate compliance may include:
• Job description

3-4 The program administrator must:

a) have the educational background and occupational experience necessary to understand and fulfill the program goals
b) have attained a higher level of education than that presented in the

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program or be enrolled in a program progressing toward that degree
c) current background in educational theory and methodology
d) have practical experience as a dental technician
e) be certified by the National Board for Certification in Dental Laboratory Technology

Examples of evidence to demonstrate compliance may include:

- Curriculum vitae Biosketch
  - Documentation of degree completion and/or instruction in educational methodology
  - Documentation of current Certified Dental Technician status

3-5 Duties: The program administrator must have authority and responsibility necessary to fulfill program goals.

Examples of evidence to demonstrate compliance may include:

- The program administrator’s responsibilities include participation in:
  a. Budget preparation
  b. Fiscal administration
  c. Curriculum development and coordination
  d. Selection and recommendation of individuals for faculty appointment and promotion
  e. Supervision and evaluation of faculty, where institutional policies permit
  f. Determining faculty teaching assignments
  g. Determining admissions criteria and procedures
  h. Planning and operating program facilities
  i. Selection of extramural facilities and coordination of instruction in the facilities.

- The program administrator assesses facilities and equipment periodically in relation to current concepts of dental laboratory technology and recommends appropriate modifications.

- The program administrator’s teaching contact hours and course responsibilities are less than that of a full-time instructor who does not have administrative responsibilities.

- The program administrator’s teaching contact hours and course responsibilities allow sufficient time to fulfill assigned administrative responsibilities.
Faculty

3-6 Dental laboratory technology faculty must have background in and current knowledge of dental laboratory technology and the specific subjects they are teaching.

Intent:
Dental laboratory technology faculty members have current knowledge at an appropriate level for the subject they teach.

3-7 Faculty providing instruction must have current educational theory and, e.g., curriculum development, educational psychology, test construction, measurement and evaluation. Faculty providing instruction via distance education technology must have instruction in distance education techniques and delivery.

3-8 Faculty providing didactic instruction must hold a degree equivalent to the degree to be granted to their students or show documented annual progress toward achieving that degree higher than the degree being granted to their students or an equivalent degree to the degree being granted to their students plus five years of documented experience in the dental laboratory technology discipline area they would be teaching.

3-9 A dental laboratory technician who is appointed after January 1, 2000 and who has not previously served as a dental laboratory technology program faculty member, must be certified by the National Board for Certification in Dental Laboratory Technology or achieve certification within two years of appointment to the program or be a licensed dentist.

Examples of evidence to demonstrate compliance for 3-7 to 3-109 may include:

• Curriculum vitae Biosketch
• Degree transcripts or transcripts documenting annual progress toward degree completion and/or instruction in educational methodology
• Documentation of current educational methodology
• Documentation of current Certified Dental Technician status or dental license
  • Faculty participation in events organized by the program (invited speakers’ lectures, workshops, field trips, etc.)
  • Faculty participation in professional events (conferences, symposia, workshops, meetings, webinars, tradeshows, etc.)

3-10 The number of faculty positions must be sufficient to implement the program’s goals and objectives. The faculty to student ratio, during laboratory instruction, must not exceed one instructor for every twelve
students.

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

Examples of evidence to demonstrate compliance may include:
- To ensure development of appropriate skills, the faculty-student ratio does not exceed one instructor to ten-fifteen students during laboratory sessions.
- A ratio of more than one to fifteen twelve is considered inadequate for laboratory technique instruction.
- These ratios are important to dental technology education to ensure development of correct skills.

3-11 Opportunities must be provided for program faculty to continue their professional development.

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

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

3-12 Faculty must be ensured a form of governance that allows participation in the program and institution’s decision-making processes.

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

3-13 A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member.

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

- Measurement mechanisms address teaching, scholarship and service.
- The evaluations are communicated to each faculty member.

Support Staff

3-14 Services of institutional support personnel must be adequate to facilitate program operation.

Examples of evidence to demonstrate compliance may include:
- Secretarial and clerical staff is assigned to assist the administrator and faculty in preparing course materials, typing correspondence, maintaining student records, and providing supportive services for student recruitment activities and admissions.
- The secretarial personnel are located in an area which is readily accessible to the faculty.
- There are support services to assist the faculty in ordering supplies and equipment, maintaining and distributing equipment and providing other instructional aid assistance.
- Services of maintenance and custodial staff ensure that the unique requirements of the program facilities are met.
- The program faculty and students have access to available institutional specialists such as those in the areas of curriculum, testing, computer usage, counseling, and instructional resources equal to that of other programs.
STANDARD 4 - EDUCATIONAL SUPPORT SERVICES

Facilities

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

Intent:
To ensure that The physical facilities and equipment effectively accommodate the clinic—
and/or laboratory scheduled, the number of students, faculty and staff, and include
appropriate safety provisions for safety for students, faculty, and staff. Also, to ensure
that iThe facilities permit the attainment of program goals.

Examples of evidence to demonstrate compliance may include:
• The number of laboratory work stations is based on the number of students admitted
  registered to a class. If the number of stations is less than the number of students in
  the class, one laboratory station is available for every student scheduled for each
  laboratory session.
• Compressed air is available and adequate in the laboratory where needed.
• Student work stations are designed and equipped for students to work while
  seated in OSHA compliant seats and include adequate ventilation, and lighting, air
  hose, necessary utilities utility outlets, and dust collection equipment.
• Environment controls are available with adequate heat and air management, and a
  ventilation exhaust system are provided in the all laboratory facilities.
• The location of equipment is conducive to efficient and safe utilization.
• Electrical power is adequate to support all laboratory equipment.
• Laboratory layout is American Disabilities Act (ADA) compliant.
• Floor plan with student work station and equipment placement.
• Blueprints to show electrical and utility services.

Laboratory Facilities

4-2 An adequate multipurpose laboratory facility must be provided for effective
instruction and include:

a) Sufficient and secure storage space for instructional equipment, supplies,
  instruments and materials, including hazardous materials.
b) Policies and procedure for safe operation and maintenance of laboratory
  equipment
c) An appropriate number of work stations with necessary dental equipment for
Examples of evidence to demonstrate compliance may include:

- Facility schedule to demonstrate laboratory capacity is sufficient to accommodate individual student practice throughout all phases of technique instruction.
- Equipment inventory
- Posted safety policies, protocols relative to operation and maintenance of equipment
- Floor plan or blueprints

**Off-Campus Facilities**

4-3 Although it is preferable and therefore recommended that the educational institution provide physical facilities and equipment which are adequate to permit achievement of program goals and objectives, if the institution may find it necessary to contract for use of an existing laboratory facility for laboratory instruction, then the following conditions must be met in addition to all existing standards stipulated by the Commission are met. If a clinic and/or laboratory in the community is used as a primary facility for laboratory instruction, the standards specified for program facilities and the following provisions must be met:

a) There is a formal agreement between the educational institution and agency or institution providing the facility.

b) The program administrator retains authority and responsibility for instruction and student assignments.

c) All students receive instruction and practical experience in the facility.

d) Policies and procedures for operation of the facility are consistent with the philosophy and goals of the educational program.

e) A two-year notification of termination of the contract is required to ensure that instruction will not be interrupted.

f) A contingency plan is developed by the institution should the contract terminate.

g) The location and time available for use of the facility are compatible with the instructional needs of the program.

h) Clinical or laboratory instruction is provided and evaluated by program faculty.

i) All students receive comparable instruction in the facility.

j) All faculty are calibrated.

k) Availability of the facility accommodates the scheduling needs of the program.

l) Notification for termination of the contract ensures that instruction will not be interrupted for currently enrolled students.
Intent:
This standard applies to sites off-campus used for dental laboratory technology education. All students assigned to a particular facility are expected to receive instruction in that facility. This standard does not apply to individual dental laboratory and dental office sites used for externship/practical experience.

Classroom Space

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

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

Office Space

4-5 Office space must be provided for the program administrator and full-time faculty.

Intent:
The program administrator often meets with students which requires privacy. Sensitive and confidential student and program records are also safely stored in locked cabinets and drawers. Full-time faculty are also required to hold regular office hours and require a designated office space in which they may consult students.

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

Learning Resources

4-6 The program must provide adequate and appropriately maintained learning resources to support the goals and objectives of the program.

Intent:
Instructional aids and equipment, and institutional learning resources are provided and Dental Laboratory Technology

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include or provide access to a diversified collection of current dental, dental laboratory
technology and multidisciplinary literature and references necessary to support teaching,
student learning needs, services, and research. All students, including those receiving
education at an off campus facility or through distance education, are provided access to
learning resources.

Examples of evidence to demonstrate compliance may include:

- Specialized reference materials are provided in the following areas: dental and oral
  anatomy, tooth morphology, dental materials, complete and partial removable
  prosthodontics, fixed prosthodontics, ceramics, orthodontics, occlusion,
  maxillofacial prostheses, attachments, digital technologies, and implants used in the
  fabrication of fixed and removable prostheses, ethics and jurisprudence, and history
  of dentistry, medical and dental dictionaries, and indices are available.

- References on educational methodology

- Skeletal and anatomic models and replicas, sequential samples of laboratory
  procedures, slides, films, video, and other media which depict current techniques, and
  projection equipment are available for instruction.

- Instructional or media technologies

- A wide range of printed materials and instructional aids and equipment are
  available for utilization by students and faculty including: current and back issues
  of major scientific and professional journals related to dentistry and dental
  laboratory technology/dental assisting/dental hygiene; and diversified collection of
  current references on dentistry and related subjects.

- There is a mechanism or procedure for program faculty to periodically review
  and select current titles and instructional aids for acquisition.

- Facilities, hours and policies are conducive to faculty and student use.

- Student access to a virtual library and electronic resources

Student Services

4-7 There must be specific written due process policies and procedures for adjudication
of academic and disciplinary complaints, which parallel those established by the
sponsoring institution.

Intent:
These policies and procedures protect the students as consumers; provide avenues for
appeal and due process; ensure that student records accurately reflect work
accomplished, and are maintained in a secure manner; ensure confidentiality of and
access to student records is followed; ensure student participation when appropriate.
The institution provides services to the allied dental students equal to those available to
other students.
Examples of evidence to demonstrate compliance may include:
- Personal, academic and career counseling of students
- Appropriate information about the availability of financial and health services
- Student advocacy
- Information about further educational opportunities
- Ethical standards and policies to protect the students as consumers and avenues for appeal and due process
- Student records accurately reflect work accomplished during the program and are maintained in a secure manner.
- Policies concerning confidentiality of and access to student records are followed.

**Distance Education**

4-8 Distance education programs must meet the parent program’s stated mission, goals, objectives, and standards.

**Intent:**
While some differences between the parent program and distance learning are inherent, the distance program is expected to comply with the spirit as well as the letter of accreditation standards.

Examples of evidence to demonstrate compliance may include:
- [Institutional distance education training](#)
STANDARD 5 - HEALTH AND SAFETY PROVISIONS

Infectious Disease Management

5-1 The program must document its compliance with institutional policy and applicable regulations of local, state and federal agencies, including, but not limited to: hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all students, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on bloodborne infectious diseases must be available to applicants for admission.

Intent:
These policies provide for a safe environment for patients, students, faculty and staff. The program should establish and enforce a mechanism to ensure laboratory asepsis, infection and biohazard control, and disposal of hazardous waste. Policies and procedures should be in place to provide for a safe environment for students, faculty and staff. The confidentiality of information pertaining to the health status of each individual is strictly maintained. This standard applies to all program sites where laboratory education is provided.

Examples of evidence to demonstrate compliance may include:
- Written protocols on pre-clinical laboratory asepsis, infection and biohazard control and disposal of hazardous waste
- Access to industry guidelines relative to Safety Data Sheets are currently and readily accessible to students, faculty and staff
- Written disinfection procedures
- Program policy manuals listing emergency protocols
- Compliance with applicable state and/or federal regulations
- Established post-exposure guidelines as defined by the Centers for Disease Control and Prevention
- Admissions criteria

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

Intent:
Students, faculty and/or staff may enter a live laboratory setting where they may be exposed to infectious pathogens during their practical experience course, field trips, and community service.
Examples of evidence to demonstrate compliance may include:

- Documentation
- Immunization records
- Declinations forms

Emergency Management

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

Examples of evidence to demonstrate compliance may include:

- Instructional materials
- Written protocol
- Emergency Kit
- Safety devices and equipment are installed and functional.
- A first aid kit for use in managing clinic and/or laboratory accidents is accessible.
- Emergency equipment is readily accessible and functional.
REPORT OF THE REVIEW COMMITTEE ON DENTAL PUBLIC HEALTH EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Victor Badner. Committee Members: Dr. Bruce Dye, Dr. Maya Popova, and Dr. Robert Weyant. Dr. Shannon Smith-Stephens was unable to attend the meeting. Guests (Open Session Only): Dr. Frances Kim, executive director, American Association of Public Health Dentistry attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, Ms. Kirsten Nadler, manager, Advanced Dental Education, Dr. Sherin Tookes, director, and Mr. Eric Wiig, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Dental Public Health Education (DPH RC) was held on January 15, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO DENTAL PUBLIC HEALTH EDUCATION

Informational Report on Dental Public Health Programs Annual Survey Curriculum Data (p. 600): As directed at the Winter 2015 meeting, the DPH RC reviewed the aggregate data from the Curriculum Section of the Commission’s Annual Survey for Dental Public Health Programs conducted in August/September 2020.

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

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF DENTAL PUBLIC HEALTH EDUCATION

The Review Committee on Dental Public Health Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.
Report of the DPH RC
CODA Winter 2021

Respectfully submitted,

Dr. Victor Badner,
Chair, Review Committee on Dental Public Health Education
REPORT OF THE REVIEW COMMITTEE ON ENDODONTICS EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Roberta Pileggi substituting for Dr. Garry Myers who was unable to attend. Committee Members: Dr. Linda Casser, Dr. Gerald Glickman, Dr. Scott McClanahan, Dr. Ankur Patel, and Dr. Roberta Pileggi. Commissioner: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation (CODA), ex officio. Guest (Open Session Only): Mr. Srini Varadarajan, assistant executive director, American Association of Endodontics attended the policy portion of the meeting. Staff Members: Ms. Jennifer Snow, manager, Advanced Dental Education and Mr. Christopher Castaneda, senior project assistant, CODA. The meeting of the Review Committee on Endodontics Education (ENDO RC) was held on January 11, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO ENDODONTICS EDUCATION

Informational Report on Endodontics Programs Annual Survey Curriculum Data (p. 700): The Review Committee on Endodontics Education (ENDO RC) considered the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Section. The Committee discussed the data, noting the wide range in the number of clock hours (zero to 400) in the subject area of pathophysiology of pulpal/periradicular disease under Question 22d. The ENDO RC further noted that, under Question 21d, the maximum percentage of time that students/residents devoted to teaching was 11%; which exceeds the maximum of 10% as required by the Accreditation Standards. Given the variability in the way the data is reported through the Annual Survey, and by whom, the Committee noted that site visitors should verify the amount of time students/residents spend teaching through the course of site visits. The ENDO RC will continue to review the aggregate data of the Endodontics Annual Survey Curriculum Section.

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

Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics (p. 701): The Accreditation Standards for Advanced Dental Education Programs in Endodontics were adopted by the Commission on Dental Accreditation at its January 31, 2013 meeting for implementation January 1, 2014. According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a two-year program will be assessed after five (5) years. In accordance with this policy, the Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Endodontics was initiated in Spring 2019 with the results considered at the Commission’s Summer 2019 meeting.
In Summer 2019, the Endodontics Review Committee (ENDO RC) conducted an initial review of the validity and reliability study report. The Review Committee concluded that further study of the survey data was warranted. The ENDO RC believed that a small workgroup should be formed to further study the report and identify Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of a workgroup composed of members of the ENDO RC to further study the findings of the Endodontics Validity and Reliability Study and identify Accreditation Standards, if any, which warrant revision, with a report to the ENDO RC and Commission in Winter 2020. The workgroup conducted its meeting on October 11, 2019 and prepared a comprehensive Standards document reflecting proposed revisions.

At its Winter 2020 meeting, the ENDO RC considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics submitted by the workgroup. Following discussion, the Committee affirmed the revisions with the exception of the addition of the phrase “or its equivalent” to Standard 4-1. In an effort to simplify this standard, the Committee determined that the standard should be revised to state “An advanced dental education program in endodontics must encompass a minimum duration of 24 months of full-time study,” with the intent statement “To ensure that the program’s student/resident leave policy and procedure aligns with institutional policies with regard to leave and due process, and complies with a minimum program duration of 24 months.”

The Committee concluded, and the Commission concurred, that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics (Appendix 1, Policy Report p. 700) be circulated to the communities of interest for review and comment for a period of one (1) year, with Hearings conducted at the March 2020 American Dental Education Association (ADEA) and October 2020 American Dental Association (ADA) annual meetings, with further consideration at the Commission’s Winter 2021 meeting.

At its Winter 2021 meeting, the ENDO RC carefully considered all comments received during the comment period (Appendix 2 and Appendix 3, Policy Report p. 700). The ENDO RC also reviewed a comment submitted during the comment period found in Appendix 1, which was inadvertently omitted from Policy Report p. 700. The ENDO RC discussed the comments related to Standard 4-1 and affirmed its intent to simplify the Standard by revising the requirement from 104 weeks to 24 months minimum program duration. The ENDO RC believed the prior intent statement was overly prescriptive, and that the revision allows programs more latitude in that policies on due process and vacation, legal holidays, and sick leave are to be determined at the discretion of the institution. Following discussion, the Committee determined the proposed revisions found in Appendix 2 are appropriate.

In summary, the ENDO RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics noted in Appendix 2 be adopted by the Commission and implemented on July 1, 2022.
Recommendation: It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics found in Appendix 2, with an implementation date of July 1, 2022.

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ENDODONTICS EDUCATION

The Review Committee on Endodontics Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Garry Myers
Chair, Review Committee on Endodontics Education
July 9, 2020

Dr. Arthur Chen-Shu Jee  
Chair  
Commission on Dental Accreditation  
211 East Chicago Avenue  
Chicago, Illinois  60611

Dear Doctor Jee:

A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, at its June 2020 meeting, Council members considered and supported the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics.

On behalf of the Council, I thank you for the opportunity to comment on this important document.

Sincerely,

[Signature]

Linda C. Niessen, DMD, MPH  
Chair  
Council on Dental Education and Licensure

cc:  Dr. Anthony J. Ziebert, senior vice-president, Education and Professional Affairs  
Dr. Sherin Tooks, director, Commission on Dental Accreditation  
Ms. Peggy Soeldner, manager, Commission on Dental Accreditation  
Ms. Karen M. Hart, director, Council on Dental Education and Licensure
Commission on Dental Accreditation

At its Winter 2020 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Endodontics be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2020, for review at the Winter 2021 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from January 31, 2020 to December 1, 2020.

This document will be considered by the Commission in Winter 2021.

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Endodontics
Accreditation Standards for
Advanced Dental Education Programs
in Endodontics

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

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## Document Revision History

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Mission Statement of the
Commission on Dental Accreditation

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

Commission on Dental Accreditation
Adopted: August 5, 2016
ACCREDITATION STATUS DEFINITIONS

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

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

Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

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

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

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

Revised 6/17; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01; CODA: 12/87:9
Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

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

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

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

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

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all disciplines of advanced dental education, institution and programs. Each discipline develops discipline-specific standards for education programs in its discipline. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the
standards for the education content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.

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

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

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

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g. 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Endodontics Accreditation Standards

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

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

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

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

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

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

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

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

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

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

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

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

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

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

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

Resident: The individual enrolled in an accredited advanced dental education program in oral and maxillofacial surgery.

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

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

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

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

Endodontic Terms:

(The first four terms are approved by the American Board of Endodontics [ABE].)

Prospective Board Candidate: A student enrolled in their final year of an advanced education program of endodontics accredited by the Commission of Dental Accreditation of the ADA whose application and payment of the Written Examination fee have been accepted and approved by the Board.

Educationally Qualified Endodontist: An endodontist who has successfully completed an advanced education program in endodontics accredited by the Commission on Dental Accreditation of the ADA.

Board-Eligible Endodontist: An educationally qualified endodontist whose application and credentials have the approval of the ABE.

Board Certified Endodontist: An endodontist who has satisfied all requirements of the certification process of the ABE, has been declared Board Certified by the Directors of the ABE, and maintains Board certification. This individual is a Diplomate of the ABE.

Evidence-based Endodontics (EBE): The integration of the best research evidence with clinician expertise and patient values.

- best research evidence refers to relevant research from basic and applied sciences including clinical, in vivo animal, or in vitro laboratory trials.
- clinician expertise refers to the clinical skills and past experience that allows efficient and accurate assessment of the risks and benefits of potential interventions.
- patient values refer to the unique preferences, concerns and expectations of each patient, which must be integrated into clinical decisions.
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support
Advanced dental education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced dental education programs must be accredited by an accredited organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced dental education programs must be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced dental education programs must assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

The institution/program must have a formal system of quality assurance for programs that provide patient care.

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

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

**Ethics and Professionalism**

1-1 Graduates must receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

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

1-2 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

Intent: The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

1-3 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

Intent: The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

- For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

- (For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

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

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

2-1 The sponsoring institution must appoint a program director who: a) is a full-time faculty member and b) whose time commitment is no less than twenty-four hours per week to the advanced dental education program in endodontics.

Intent: To ensure that the program director has sufficient time to participate in all aspects of the program including direct student/resident contact in didactic and clinical activities.

2-2 Responsibilities of the program director must include:

a. Development of mission, goals, and objectives for the program;

b. Development and implementation of a curriculum plan;
c. Planning for and operation of the facilities used in the endodontic program;
d. Student/resident selection unless the program is sponsored by a federal service utilizing a centralized student/resident selection process;
e. Ensuring ongoing evaluation of student/resident performance and faculty teaching performance;
f. Evaluation of teaching program and faculty supervision in affiliated institutions;
g. Maintenance of records related to the educational program, including written instructional objectives and course outlines;
h. Overall continuity and quality of patient care as it relates to program;
i. Ongoing planning, evaluation and improvement of the quality of the program;
j. Preparation of graduates for certification by the American Board of Endodontics; and
k. Ensuring formal (written) evaluation of faculty members at least annually to assess their performance in the educational program.

Intent: To ensure that the program director has complete authority to administer all aspects of the advanced education program and that all administrative records are maintained within the institution.

2-3 The number of faculty and the professional education and development of faculty must be sufficient to meet the program’s objectives and outcomes.

2-4 There must be attending faculty responsible for all clinical activities.

2-4.1 Attending faculty must have specific and regularly scheduled clinic assignments to provide direct supervision appropriate to a student’s/resident’s level of training in all patient care.

2-5 Program directors and full time faculty must be provided time and resources to engage in scholarly pursuits, which may include:

a. Participation in continuing education in endodontics;
b. Participation in regional or national endodontic societies;
c. Participation in research; and

d. Presentation and publication of scientific/clinical studies.

2-6 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

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

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

The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.
3-1 The clinical facilities for students/residents in endodontics must be specifically identified and readily available.

3-1.1 The design of units must be suitable for all endodontic clinical procedures, including four-handed dentistry.

**Intent:** To ensure that students/residents, faculty, and clinical support personnel have the facilities/resources necessary to conduct the clinical phase of the program; that clinical operatories and surrounding space are sufficient to perform all endodontic procedures, including surgery, and to allow for patient comfort, access and space for clinical support personnel, and students/residents/faculty maneuverability.

3-2 Radiographic or imaging equipment and equipment specific for endodontic procedures must be readily available.

3-3 Lecture and seminar rooms, as well as audiovisual aids, must be available.

3-4 Appropriate information resources must be available, including access to biomedical textbooks, dental journals, the Internet and other sources pertinent to the area of endodontic practice and research.

3-5 Clinical support personnel must be sufficient to ensure efficient operation of clinical program and to provide students/residents with the opportunity to practice four-handed dentistry techniques.

**Intent:** To facilitate efficient delivery of dental care; to enhance the normal operation of endodontic practice; and to provide a simulated clinical practice environment; (Clinical support personnel are needed to keep from placing an undue burden of additional duties and responsibilities on the student/resident, potentially compromising the overall educational objectives of the program.)

3-6 Administrative support personnel must be sufficient to permit efficient operation of the program.

**Intent:** To ensure operations of the program are managed in an efficient and expeditious manner without placing undue hardship on the faculty and students/residents in the program.

3-7 Program resources must exist to support the number of students/residents enrolled.
Examples of evidence to demonstrate compliance may include:

- Annual budget for program including faculty and support staff
- Patient availability through appointment book and waiting lists
- Number of cases treated per student/resident as compared to previous year
- Number of dedicated dental units and their scheduled use
- Number of clinical/clerical support staff
- Number and availability of endodontic faculty and faculty/student/resident ratio
- List of equipment/supplies
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or “searching publication databases and appraisal of the evidence”)
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

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

Intent: To ensure that the students/residents of these programs receive the same educational requirements as set forth in these Standards.

If an institution or program enrolls part-time students/residents, the institution must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis must assure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.
4-1 An advanced dental education program in endodontics must encompass a minimum duration of 24 months (104 weeks) of full-time study.

**Intent:** To ensure that during the 104 weeks it is expected that endodontic students/residents will have a maximum of 8 weeks available for vacations, legal holidays, sick leave and personal time. To ensure that the program’s student/resident leave policy and procedure aligns with institutional policies with regard to leave and due process, and complies with a minimum program duration of 24 months.

4-2 The content of all didactic instruction included in the program curriculum must be documented.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Course objectives
- Lecture/seminar schedules
- Outcomes
- Competency statements

**BIOMEDICAL SCIENCES**

4-3 Instruction in the biomedical sciences must provide information emphasizing principles and recent developments in order to meet the advanced program’s objectives.

**Intent:** To ensure that developing new theories and techniques of endodontic treatment are included in the advanced program curriculum. Instruction should include the biologic and technical aspects of maintaining, replacing, and enhancing the natural dentition, including mechanisms for enhanced tissue healing and tissue regeneration.

4-4 Instruction must emphasize the interrelationships among the biomedical sciences and their application to clinical practice.

4-5 Instruction must be provided in:

a. Anatomy (gross and micro) of soft and hard tissues of the head and neck;
b. Embryology;
c. Infectious and immunologic processes in oral health and disease;
d. Pathophysiology of pulpal/periradicular disease;
e. Wound healing;
f. Oral medicine and oral pathology;
g. Pharmacotherapeutics;
h. Research methodology and statistics;
i. Neurosciences; and
j. Biomaterials.

**CLINICAL SCIENCES**

4-6 A minimum of 40% and a maximum of 60% of the total clock hours in a two-year (24 months) program must be devoted to clinical care.

4-7 Endodontic treatment must be evidence-based. (EBE is the integration of the best research evidence with clinician expertise and patient values).

Examples of evidence to demonstrate compliance may include:

- Endodontic literature applied to clinical treatment decisions
- Integration of current systematic literature reviews with treatment conferences
- Ethics applied to patient management

4-8 The educational program must provide in-depth instruction and clinical training so that students/residents are competent in:

a. Diagnosis, treatment planning and prognosis;
b. Non-surgical and surgical endodontic treatment and retreatment;

d. A variety of endodontic techniques;
e. Outcome evaluation;
f. Radiography and other diagnostic imaging technologies, including use of Limited Field of View (LFOV) Cone Beam Computed Tomography (CBCT);
g. Management of endodontic treatment of medically compromised patients;
h. Emergency treatment for endodontic conditions;
i. Management of patients with orofacial pain and anxiety;

**Intent:** Instruction and training in surgical endodontic treatment and retreatment is to ensure that students/residents are trained to provide comprehensive treatment which may include hard and soft tissue management in the surgical site and the removal of teeth as part of an endodontic treatment plan.

j. Preparation of space for intraradicular restorations in endodontically treated teeth;
k. Communication with patients and health care professionals; and
l. Use of magnification technologies.
**Intent:** To ensure that students/residents are trained in the use of instruments that provide magnification and illumination of the operative field beyond that of magnifying eyewear. In addition to the operating microscope, these instruments may include, but are not limited to, the endoscope, orascope or other developing magnification technologies.

4-9 The educational program must provide in-depth instruction and clinical training in:

- Vital pulp management;
- Endodontic management of developing permanent teeth;
- Revascularization/regenerative endodontics;
- Intracoronal bleaching procedures; and
- Endodontic management of traumatic dental injuries.

**Intent:** To ensure that students/residents are trained to manage all aspects of the endodontic care of teeth with traumatic injuries.

Examples of evidence to demonstrate compliance may include:

Procedures performed by students/residents, which may include, but are not limited to:

- Vital pulp therapy in situations in which traumatic crown fractures result in pulpal involvement.
- Root canal therapy for traumatically injured teeth in order to prevent or arrest inflammatory, infection-related root resorption.
- Monitoring and evaluating traumatized teeth and associated tissues to assess the pulpal status and healing over time (reattachment, revascularization, healing of root fractures, etc).
- Diagnosis and root canal treatment for teeth with pulp necrosis as a result of traumatic injuries.
- Induction of apical hard tissue barriers in developing teeth with open apices and necrotic pulps.
- Placement of apical barriers for immediate obturation of teeth with open apices.

4-10 The educational program must provide clinical and didactic instruction in:

- Diagnosis and treatment of periodontal conditions and defects in conjunction with the treatment of the specific tooth undergoing endodontic treatment therapy; treatment should be provided in consultation with the individuals who will assume the responsibility for the completion or supervision of any additional periodontal maintenance or therapy; and
b. Placement of intraradicular restorations and cores in endodontically
treated teeth; when the patient is referred, this treatment is accomplished
in consultation with the restorative dentist.

c. Implant dentistry; and

d. Extrusion procedures.

4-11 The educational program must provide instruction in the following areas:

a. The history of endodontics;

b. Teaching methodology;

c. Jurisprudence and risk management;

d. Practice management; and

e. Medical emergencies;

f. Implant dentistry; and

g. Extrusion procedures.

4-12 Students/residents must actively participate in seminars or conferences
involving literature and textbook reviews.

4-13 Students/residents must actively participate in endodontic and interdisciplinary
seminars and conferences evaluating diagnostic data, treatment plans, treatment
procedures, and outcomes assessment.

4-14 The program must include a system for follow-up evaluation of patients to enable
students/residents to assess the outcome of their treatment.

4-15 Comprehensive records of history, diagnosis, and treatment must be maintained
for each patient.

TEACHING/MENTORING

4-16 Students/residents must participate in teaching endodontics to predoctoral
and/or postdoctoral students/residents.

4-16.1 In a two-year (24 months) program, this participation must not exceed
10% of the total clock hours.

Intent: To enhance a student’s/resident’s ability to organize and evaluate teaching material,
to communicate information to others, and/or to mentor others. Teaching is to be in the
discipline of endodontics or other related disciplines, at the discretion of the program
director.
STANDARD 5 - ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS

ELIGIBILITY AND SELECTION

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

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

Specific written criteria, policies and procedures must be followed when admitting students/residents.

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

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

Intent: Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant’s past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing 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
EVALUATION

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

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

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

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

RIGHTS AND RESPONSIBILITIES

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

Intent: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a student/resident (for academic or disciplinary reasons). In addition to information on the program, students/residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the students/residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 - RESEARCH

Advanced dental education students/residents must engage in scholarly activity.

6-1 Students/residents must participate in research.

Intent: To ensure that each student/resident is capable of developing a research protocol and has an active role in conducting a research project.

6-1.1 The research experience and results must be compiled into a document in publishable format.

Examples of evidence to demonstrate compliance may include:

- Manuscript
- Master’s thesis
- Ph.D. Dissertation
- Progress report of on-going research activity
REPORT OF THE REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL PATHOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. John Hellstein. Committee Members: Dr. Ashley Clark, Mr. Jim Hinds, Dr. Kathryn Korff, and Dr. Vikki Noonan. Commissioner: Dr. Jeffery Hicks, chair, Commission on Dental Accreditation (CODA), ex-officio. Guest (Open Session Only): Ms. Lisa Mikita, executive director, American Academy of Oral and Maxillofacial Pathology, attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, Ms. Kirsten Nadler, manager, Advanced Dental Education, Dr. Sherin Tooks, director, and Ms. Bridget Blackwood, senior project assistant, CODA. The meeting of the Review Committee on Oral and Maxillofacial Pathology Education (OMP RC) was held on January 14, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL AND MAXILLOFACIAL PATHOLOGY EDUCATION

Informational Report on Oral and Maxillofacial Pathology Programs Annual Survey Curriculum Data (p. 800): As directed at the Winter 2015 meeting, the OMP RC reviewed the aggregate data from the Curriculum Section of the Commission’s Annual Survey for Oral and Maxillofacial Pathology Programs conducted in August/September 2020.

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

Informational Report on Conduct of Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology (p. 801): The Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology were adopted by the Commission on Dental Accreditation at its January 31, 2013 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, Policy Report p. 801), 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 applying to programs four years in length will be assessed seven years after implementation.

Accordingly, the validity and reliability study for oral and maxillofacial pathology education was due to be initiated in Spring 2020. However, due to the COVID-19 pandemic, the Commission, at its Summer 2020 meeting, directed the study be postponed until Spring 2021.

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. A sample format of the survey is presented in Appendix 2, Policy Report p. 801. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by June 1, 2021. Commission staff will prepare a report with results of the study for consideration by the Commission at its Summer 2021 meeting.

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

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORAL AND MAXILLOFACIAL PATHOLOGY EDUCATION**

The Review Committee on Oral and Maxillofacial Pathology Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. John Hellstein,
Chair, Review Committee on Oral and Maxillofacial Pathology Education
REPORT OF THE REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Sanjay Mallya. Committee Members: Dr. Boris Bacanurschi, Dr. Gene Kelber, and Dr. Sindhura Anamali Reddy. Guest (Open Session Only): Ms. Lisa Mikita, executive director, American Academy of Oral and Maxillofacial Radiology attended the policy portion of the meeting. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education, Ms. Kirsten Nadler, manager, Advanced Dental Education, and Ms. Bridget Blackwood, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Oral and Maxillofacial Radiology Education (OMR RC) was held on January 11, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION

Informational Report on Oral and Maxillofacial Radiology Programs Annual Survey Curriculum Data (p. 900): As directed at the Winter 2015 meeting, the OMR RC reviewed the aggregate data from the Curriculum Section of the Commission’s Annual Survey for Oral and Maxillofacial Radiology Programs conducted in August/September 2020.

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

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION

The Review Committee on Oral and Maxillofacial Radiology Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Sanjay Mallya
Chair, Review Committee on Oral and Maxillofacial Radiology Education
REPORT OF THE REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL SURGERY EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. William Nelson. Committee Members: Dr. George Kushner, Dr. Pushkar Mehra, Dr. Faisal Quereshy, Dr. Philip Rinaudo, and Ms. Cindy Stergar. Commissioners: Dr. Jeffery Hicks, chair, and Dr. Bruce Rotter, vice chair, Commission on Dental Accreditation (CODA), ex officio. Guests (Open Session Only): Ms. Mary Allaire-Schnitzer, associate executive director, American Association of Oral and Maxillofacial Surgeons (AAOMS); Dr. James Johnson, president-elect, AAOMS; Ms. Erin Killeen, executive vice president, American Board of Oral and Maxillofacial Surgery (ABOMS); Ms. Laurie Oddo, manager, Advanced Education and Resident Affairs, AAOMS; Dr. Paul Schwartz, vice president, AAOMS; and Dr. B.D. Tiner, president, AAOMS attended the policy portion of the meeting. Staff Members: Ms. Jennifer Snow, manager, Advanced Dental Education; Dr. Sherin Tooks, director; and Mr. Christopher Castaneda, senior project assistant, CODA. The meeting of the Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) was held on January 12, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO ORAL AND MAXILLOFACIAL SURGERY EDUCATION

Report on Oral and Maxillofacial Surgery Programs (Residency and Fellowship) Annual Survey Curriculum Sections (p. 1000): The Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) noted that the Annual Survey Curriculum Section is reviewed during the Winter Review Committee meeting in the year the survey will be distributed; which will next occur in 2021. The OMS RC considered both its residency and fellowship discipline-specific Annual Survey Curriculum Sections (Appendix 1 and Appendix 2, Policy Report p. 1000).

At its Winter 2021 meeting, following discussion of the need to collect anesthesia data on current final year residents, the OMS RC determined that data from final year residents at this point in the academic year (August/September) was not valuable. The Committee determined that the Annual Survey for residency programs should rely on cumulative anesthesia data from the last class of graduates. Therefore, the OMS RC recommended that Question #27 be struck from the Annual Survey Curriculum Section for residency programs, as found in Appendix 1. The Committee did not identify items warranting revision in the Annual Survey Curriculum Section for fellowship programs.

In summary, the OMS RC recommended that the Oral and Maxillofacial Surgery Annual Survey Curriculum Section for residency programs be revised to include the changes noted in Appendix 1, for use in Fall 2021. The OMS RC further recommended that the Annual Survey Curriculum Section for fellowship programs (Appendix 2, Policy Report p. 1000) be retained with no changes for use in Fall 2021.
**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Oral and Maxillofacial Surgery Annual Survey Curriculum Section for residency programs noted in Appendix I and direct implementation of the revised Annual Survey Curriculum Section in Fall 2021.

It is further recommended that the Commission on Dental Accreditation direct the Oral and Maxillofacial Surgery Annual Survey Curriculum Section for fellowship programs (Appendix 2, Policy Report p. 1000) be retained with no changes for use in Fall 2021.

**Progress Report on the 2019 Validity and Reliability Studies of the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery and the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery (p. 1001):** The Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery were adopted by the Commission on Dental Accreditation at its February 2012 meeting for implementation July 1, 2012. The Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery were adopted and implemented by the Commission on Dental Accreditation at its August 7, 2015 meeting.

According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a four-year program will be assessed after seven (7) years and the validity and reliability of the standards for a one-year program will be assessed after four (4) years. In accordance with this policy, the Validity and Reliability Studies of the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery and Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery were initiated in Summer/Fall 2019 with the results considered at the Winter 2020 meeting of the Commission.

In Winter 2020, the Oral and Maxillofacial Surgery Review Committee (OMS RC) conducted an initial review of the validity and reliability study reports. The Review Committee concluded that further study of the survey data was warranted. The OMS RC believed a small workgroup should be formed to further study the reports and identify the residency and fellowship Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of an Ad Hoc Committee composed of five (5) members of the OMS RC to further study the findings of the 2019 oral and maxillofacial surgery residency and fellowship Validity and Reliability Studies and identify Accreditation Standards, if any, which warrant revision, with a report to the OMS RC and Commission in Summer 2020. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee to consider standards revisions for Oral and Maxillofacial Surgery be directed to submit an update report in Winter 2021 rather than Summer 2020.
The committee conducted its meeting on September 21, 2020 and prepared comprehensive Standards documents reflecting a proposed revision to the residency standards (Appendix 1, Policy Report p. 1001) and no changes to the fellowship standards (Appendix 2, Policy Report p. 1001).

At this meeting, the Oral and Maxillofacial Surgery Review Committee (OMS RC) considered the comprehensive documents submitted by the Ad Hoc Committee that reflect all proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery and the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery Review as a result of the 2019 Validity and Reliability Studies. The OMS RC discussed the residency standards and further considered deletion of Standard 1-9 to align with a recent revision to the Oral and Maxillofacial Surgery Annual Survey Curriculum section. A question in the Survey required programs to submit information on cases operated at affiliated institutions in accordance with Standard 1-9. This question was eliminated from the Oral and Maxillofacial Surgery residency and fellowship annual surveys to avoid the risk (and associated $4000 fee to a program) of submission or upload of Protected Health Information. The Review Committee affirmed that the Standard that required this activity should be eliminated from the residency standards. Following discussion, the OMS RC determined that this revision should be immediately adopted and implemented as noted in Appendix 2.

In addition, the Committee affirmed that the fellowship standards are appropriate as written and that revisions are not warranted at this time. Therefore, the OMS RC recommended that the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery should be retained with no changes and immediately implemented as noted in Appendix 3.

In summary, the OMS RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Appendix 2) be adopted by the Commission with immediate implementation. The OMS RC further recommended that the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery (Appendix 3) be adopted by the Commission with immediate implementation.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Appendix 2) with immediate implementation.

It is further recommended that the Commission on Dental Accreditation adopt the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery Review (Appendix 3) with immediate implementation.
Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (p. 1002): At its Winter 2020 meeting, the Review Committee on Oral and Maxillofacial Surgery Education (OMS RC) considered proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery from the American Association of Oral and Maxillofacial Surgeons (AAOMS).

The Committee considered various items for rewording, renumbering, deletion, and the addition of several new standards related to patient safety and didactic and clinical experience in the comprehensive management of temporomandibular disorders and facial pain. Following discussion, the OMS RC determined that these proposed revisions to the July 1, 2020 Accreditation Standards should not be further considered in conjunction with the 2019 validity and reliability survey results, and should instead be circulated to the communities of interest for review and comment at that time.

The Committee concluded, and the Commission concurred, that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery (Appendix 1, Policy Report p. 1002) be circulated to the communities of interest for review and comment for a period of one (1) year, with Hearings conducted at the March 2020 American Dental Education Association (ADEA) and October 2020 American Dental Association (ADA) annual meetings, with further consideration at the Commission’s Winter 2021 meeting.

At its Winter 2021 meeting, the OMS RC considered both comments received during the comment period (Appendix 2 and Appendix 3, Policy Report p. 1002). Upon discussion of the proposed revisions, the OMS RC noted that although the revisions were primarily “housekeeping” in nature, the new requirement for didactic and clinical experience in the comprehensive management of temporomandibular disorders and facial pain may necessitate prior program preparation for compliance. Therefore, the Committee determined implementation of the revisions in one (1) year on January 1, 2022 is appropriate.

In summary, the OMS RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery noted in Appendix 4 be adopted by the Commission and implemented on January 1, 2022.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery found in Appendix 4, with an implementation date of January 1, 2022.
CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORAL AND MAXILLOFACIAL SURGERY EDUCATION

The Review Committee on Oral and Maxillofacial Surgery Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. William Nelson
Chair, Review Committee on Oral and Maxillofacial Surgery Education
Draft Annual Survey Curriculum Section for Oral and Maxillofacial Surgery Residency Programs

Additions are Underlined
Strikethroughs indicate Deletions

2020-21 Advanced
OMS programs

Start of Block: OMS Curriculum (Q21-34)

Part II - Oral and Maxillofacial Surgery Curriculum Section

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

21. Do residents from this program rotate to another educational site that has its own accredited oral and maxillofacial surgery program?

   ○ Yes (Specify institution) ____________________________________________

   ○ No

Please note that submission of a supplemental report to CODA is not required for this annual survey, unless specifically requested by the Commission.
22. For the most recently completed academic year (July 1, 2019 to June 30, 2020), please provide the number of procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member in each of the following major oral and maxillofacial surgery categories.

If none or not applicable, enter 0. Note that open treatment of bilateral mandibular fractures may be counted as separate procedures. Bilateral mandibular osteotomies may be counted as separate procedures. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

<table>
<thead>
<tr>
<th>Number of procedures</th>
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<tbody>
<tr>
<td>a. Trauma (must agree with Q23 total)</td>
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<tr>
<td>b. Pathology (must agree with Q24 total)</td>
</tr>
<tr>
<td>c. Orthognathic and Craniofacial (must agree with Q25 total)</td>
</tr>
<tr>
<td>d. Reconstructive / Cosmetic (must agree with Q26 total)</td>
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<tr>
<td>e. Other, please describe</td>
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Use this space to enter comments or clarifications for your answers on this page.

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Page Break
Part II - Oral and Maxillofacial Surgery Curriculum Section (continued)

In calculating the program responses to Questions 23 and 24, same day admission and discharge patients are to be counted as inpatients.

23. For the most recently completed academic year (July 1, 2019 to June 30, 2020), please provide the number of trauma procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member. Open treatment of bilateral mandibular fractures may be counted as separate procedures. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.
The total line should match the amount reported in Q22a (##).

a. Alveolus and Mandible Fractures (21441-21449, 21451-21470) : _______

b. Midface Fractures: Le Fort I (21421-21423) : _______

c. Midface Fractures: Le Fort II (21345-21348) : _______

d. Midface Fractures: Le Fort III (21431-21436) : _______

e. Malar (21355-21366) : _______

f. Nasoethmoid (21338-21340) : _______

g. Orbital (21385-21399, 21401-21408) : _______

h. Nasal (21315-21337) : _______

i. Frontal Sinus (21343-21344) : _______

j. Repair of Lacerations (12031-12057, 13120-13153, 13160, 40830-40839, 41250-41252, 42180-42182) : _______

k. Additional Trauma / TMJ codes (20690, 20692, 20693, 20694, 21100, 21480, 21485, 21490, 21495) : _______

Total : _______
24. For the most recently completed academic year (July 1, 2019 to June 30, 2020), please provide the number of pathology procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22b (##).

a. Sinus (31020, 31030, 31032, 31040, 31233, 31235, 31237-31240, 31254-31256, 31267, 31276, 31287, 31288, 31290-31297) : _______


c. Malignant Neoplasms of Bone and Soft Tissue (11620-11624, 11626, 11640-11644, 11646, 21015, 21016, 21034, 21044-21045, 21557, 21558, 30150, 30160, 31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31420, 38700, 38720, 38724, 40500-40530, 41110, 41112-41114, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 41825-41827, 42107, 42120, 42140, 42808, 42842, 42844, 42845, 42870, 42890, 42892, 42894) : _______

d. Temporomandibular Joint Surgery (21010, 21050, 21060, 21070, 29800, 29804) : _______

e. Salivary Gland and Duct Procedures (42300-42450, 42509, 42551-42665) : _______

f. Tracheostomy (31600-31603, 31605, 31610) : _______

g. Infections (40801, 41000, 41006-41009 41015-41018, 42000, 42700, 42720, 42725) : _______

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

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Part II - Oral and Maxillofacial Surgery Curriculum Section (continued)

In calculating the program responses to Questions 25 and 26, same day admission and discharge patients are to be counted as inpatients.

25. For the most recently completed academic year (July 1, 2019 to June 30, 2020), please provide the number of orthognathic and craniofacial procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member. Bilateral mandibular osteotomies may be counted as separate procedures. A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22c (##).

a. Mandible (21193-21199) : _______

b. Genioplasty (21121-21123) : _______

c. Maxilla (21141-21147, 21206) : _______

d. Orbit (21172-21180, 21182-21184, 21256, 21260-21268, 21275) : _______

e. Midface (21150, 21151, 21154, 21155, 21159, 21160, 21188) : _______

f. Cranial Vault / Transcranial (61550, 61552, 61556, 61557-61559, 61563, 61564, 62120, 62121, 62140-62143, 62145-62148) : _______

Total : _______
26. For the most recently completed academic year (July 1, 2019 to June 30, 2020), please provide the number of reconstructive procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member.

A resident must serve as operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member, not as first assistant to another resident.

The total line should match the amount reported in Q22d (##).

a. Nerve (64600, 64605, 64610, 64716, 64722, 64727, 64732-64744, 64864, 64885-64886, 64902, 64910, 64911) : _______

b. Cleft Lip (40700-40761) : _______

c. Cleft Palate / Pharyngoplasty (42200-42260, 42950) : _______

d. Flaps and Grafts (11960, 11971, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 14302, 14350, 15040, 15100, 15101, 15110, 15111, 15115, 15116, 15120, 15121, 15130, 15131, 15135, 15136, 15156, 15157, 15220, 15221, 15240, 15241, 15260, 15261, 15271-15278, 15572, 15740, 15750, 15756, 15758, 15760, 15770, 30580, 30600, 42145) : _______

e. Flaps and Grafts: Vestibuloplasty (15574-15576, 15610, 15620-15630, 15650, 15731, 15732, 15757) : _______

f. Flaps and Grafts: Soft Tissue Flaps (40500, 40525-40527, 42894) : _______

g. Bone, Cartilage and Tissue Grafts (20900, 20902, 20910, 20912, 20920, 20922, 20926, 21210-21235, 21247, 21255) : _______
h. Free Flaps (20955-20957, 20962, 20969, 20970, 20972, 21208-21209) : _______

i. Temporomandibular Joint (21240-21243) : _______

j. Vestibuloplasty (40840-40845) : _______

k. Lip Repair (40650, 40652, 40654) : _______

l. Salivary Gland and Duct (42500, 42505, 42507, 42509, 42510) : _______

m. Correction of Facial Nerve Paralysis (15840-15842, 15845) : _______
n. Blepharoplasty / Eyelid Procedures (15820-15823, 21280, 21282, 67901-67906, 67908, 67909, 67911, 67912, 67914-67917, 67921-67924, 67930, 67935, 67950, 67961, 67966, 67971, 67973-67975) : _______

o. Brow / Forehead (15824, 15826, 67900) : _______

p. Hard & Soft Tissue Augmentation / Osseous Reduction / Recontouring / Genioplasty / Facial Implants (21120, 21125, 21127, 21137-21139, 21181, 21208, 21209, 21270, 21295, 21296) : _______

q. Otoplasty (69300, 69310, 69320) : _______

r. Rhinoplasty (30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30520, 30540, 30545, 30560, 30620, 30630) : _______

s. Rhytidectomy & lipectomy (15819, 15825, 15828, 15829, 15838, 15876) : _______

t. Hair transplant (15775, 15776) : _______

u. Dermabrasion & peels (15870, 15781, 15783, 30120) : _______

v. Implants (21244, d6010) : _______

Total : _______

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

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Part II - Oral and Maxillofacial Surgery Curriculum Section (continued)

27. For each of the program's current final year residents, please provide their cumulative anesthetic experience.
Note that Total General Anesthesia/Deep Sedation includes all on and off-service general anesthetic experience.

Oral and Maxillofacial Surgery Standard 4.9.1 states: The cumulative anesthetic experience of each graduating resident must include administration of general anesthetic experience for a minimum of 300 cases. This experience must involve care for 50 patients younger than 13.
A minimum of 150 of the 300 cases must be ambulatory anesthetics for oral and maxillofacial surgery outside of the operating room.
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<td>g. Resident 7</td>
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h. Resident 8

287. For each member of the program's most recent graduating class, please provide their cumulative anesthetic experience. Note that Total General Anesthesia/Deep Sedation includes all on and off-service general anesthesia/deep sedation.

Oral and Maxillofacial Surgery Standard 4-9.1 states: The cumulative anesthetic experience of each graduating resident must include administration of general anesthesia/deep sedation for a minimum of 300 cases. This experience must involve care for 50 patients younger than 13. A
minimum of 150 of the 300 cases must be ambulatory anesthetics for oral and maxillofacial surgery outside of the operating room.
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h. Graduate 8

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

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298. Indicate the type of assignment and length of each rotation (in WEEKS) included in the residents' off-service program.

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<th>Length of Rotation</th>
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<tbody>
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<td>e. General surgery</td>
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<td>f. Plastic surgery</td>
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<td>g. Ear, nose and throat surgery</td>
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h. Other surgical rotations

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Page Break
Part II - Oral and Maxillofacial Surgery Curriculum Section (continued)

3029. Does each resident devote a minimum of 120 weeks to clinical oral and maxillofacial surgery over the course of their training?

   ○ Yes
   ○ No

310a. Is each resident assigned to anesthesia service for at least 20 weeks?

   ○ Yes
   ○ No

310b. Of the total amount of time spent in anesthesia service, how many weeks is the resident assigned to pediatric anesthesia?
   If no separate assignment is made to pediatric anesthesia, enter 0.

   __________________________________________

321a. Is each resident assigned to a clinical surgical experience for at least 16 weeks?

   ○ Yes
   ○ No
321b. Of the total amount of time spent in clinical surgery, how many weeks is the resident assigned to a surgical service (not to include oral and maxillofacial surgery)?

________________________________________________________________

332. Is each resident assigned to a clinical medical experience for at least eight (8) weeks?

☐ Yes

☐ No

343. Is each resident assigned to a clinical surgical or medical education experience, exclusive of all oral and maxillofacial surgery service assignments, for at least eight (8) additional weeks?

☐ Yes

☐ No

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

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End of Block: OMS Curriculum (Q21-34)
Commission on Dental Accreditation

Standards Following Validity and Reliability Study

Additions are Underlined
Strikethroughs indicate Deletions

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

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

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# Document Revision History

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<td>Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery</td>
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<tr>
<td>February 3, 2012</td>
<td>The Joint Commission Equivalency Statement</td>
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<tr>
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<td>Revision to Standard 5, Eligibility and Selection</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 THAT ARE FULLY OPERATIONAL:

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

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

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

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

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

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

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

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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**Preface**

Oral and Maxillofacial Surgery Standards

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

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

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

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all disciplines of advanced dental education, institutions and programs. Each discipline develops discipline-specific standards for educational programs in its discipline. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.
As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status.

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

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

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Oral and Maxillofacial Surgery Accreditation Standards

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

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

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

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

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

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

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

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

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

In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.
Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

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

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

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

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

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

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

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

Oral and Maxillofacial Surgery Terms:

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

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

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

Board Certified: as defined by the American Board of Oral and Maxillofacial Surgery.
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

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

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

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

Example of Evidence to demonstrate compliance may include:

- OMSITE

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the program director must have the authority, responsibility and privileges necessary to manage the program.
1-3  There must be adequate bed availability to provide for the required number of patient admissions and appropriate independent care by the oral and maxillofacial surgery service.

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- Clinic assignment schedule
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

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

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

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

a. Designation of a single program director;

b. The teaching staff;

c. The educational objectives of the program;

d. The period of assignment of residents; and

e. Each institution's financial commitment

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

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

1-9 Any program that rotates a resident to an affiliated institution which also sponsors its own separately accredited oral and maxillofacial surgery residency program must submit each year a supplement to its Annual Survey. The supplement must identify the affiliated institution by name and the oral and maxillofacial surgery cases on which the rotating resident was surgeon or first assistant to an attending surgeon. This report must be signed by the program director of the sponsoring institution and the chief of oral and maxillofacial surgery at the affiliated institution.

Oral and Maxillofacial Surgery Standards
1-109 All standards in this document must apply to training provided in affiliated institutions.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Accreditation of Off-Campus Sites found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

Intent: The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

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

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

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

Intent: Other activities do not dilute a program director’s ability to discharge his/her primary obligations to the educational program.
The responsibilities of the program director must include:

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

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

2-2 Teaching Staff: The teaching staff must be of adequate size and must provide for the following:
2-2.1 Provide direct supervision in all patient care settings appropriate to a resident’s competence and level of training.

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

Examples of evidence to demonstrate compliance may include:

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

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

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<th>CODA authorized enrollment per year (n)</th>
<th>Required Program Director F.T.E.</th>
<th>Required minimum F.T.E. of second faculty member</th>
<th>Required cumulative additional F.T.E. of faculty who are not program director</th>
<th>Required Total faculty F.T.E. for program</th>
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2-2.3 Eligible oral and maxillofacial surgery members of the teaching staff, with greater than a .5 FTE commitment appointed after January 1, 2000, who have not previously served as teaching staff, must be diplomates of the American Board of Oral and Maxillofacial Surgery or in the process of becoming board certified. Foreign trained faculty must be comparably qualified.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the oral and maxillofacial surgery faculty.

Examples of Evidence to demonstrate compliance may include:

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

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

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

**Examples of evidence to demonstrate compliance may include:**
Participation in development activities related to teaching, learning, and assessment  
Attendance at regional and national meetings that address contemporary issues in education and patient care  
Mentored experiences for new faculty  
Scholarly productivity  
Presentations at regional and national meetings  
Examples of curriculum innovation  
Maintenance of existing and development of new and/or emerging clinical skills  
Documented understanding of relevant aspects of teaching methodology  
Curriculum design and development  
Curriculum evaluation  
Student/Resident assessment  
Cultural Competency  
Ability to work with students/residents of varying ages and backgrounds  
Use of technology in didactic and clinical components of the curriculum  
Evidence of participation in continuing education activities
**STANDARD 3 – FACILITIES AND RESOURCES**

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

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

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

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

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

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

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

*Intent:* Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.
The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.

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

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

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

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

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

3-6 Adequate and accessible diagnostic imaging facilities must be available to residents to utilize for patient care.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or “searching publication databases and appraisal of the evidence”)
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

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

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

If an institution and/or program enrolls part-time residents, the institution must have guidelines regarding enrollment of part-time residents. Part-time residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls residents on a part-time basis must ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time residents; and (2) there are an equivalent number of weeks spent in the program.
4-1 An advanced dental education program in oral and maxillofacial surgery must encompass a minimum duration of four (4) years of full-time study.

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

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

Examples of evidence to demonstrate compliance may include:

- Complete schedule of resident activity

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

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

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

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

4-3 The residency program in oral and maxillofacial surgery must include education and training in the basic and clinical sciences, which is integrated into the training program. A distinct and specific curriculum must be provided in anesthesia, clinical medicine and surgery.
The integrated clinical science curriculum must include off-service rotations, lectures and seminars given during the oral and maxillofacial surgery training program by oral and maxillofacial surgery residents and attending staff.

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

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

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

Examples of evidence to demonstrate compliance may include:

- Lecture schedules
- Curriculum; behavioral objectives
- Attendance sign-in sheets
- Policy of anesthesia department related to on-call participation by residents if residents are not permitted to be on-call
- Rotation schedules

**4-3.1 Anesthesia and Medical Service:**

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

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

Examples of evidence to demonstrate compliance may include:

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

4-3.2 Surgical Service:

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

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

Examples of evidence to demonstrate compliance may include:

- Resident rotation schedules

4-3.3 Other Rotations:

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

Examples of evidence to demonstrate compliance may include:

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

Examples of evidence to demonstrate compliance may include:

- Seminar schedules for at least one year
- Resident log of lectures attended
- Course outlines
- Sign-in sheets

BASIC SCIENCES

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

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

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

Examples of evidence to demonstrate compliance may include:

- Resident log of lectures attended
- Course outlines
- Goals and objectives of biomedical sciences curriculum
- Sign-in sheets
- Schedule showing curriculum in the mandated areas for a typical year
PHYSICAL DIAGNOSIS

4-6 A formally structured didactic and clinical course in physical diagnosis must be provided by individuals privileged to perform histories and physical examinations. Resident competency in physical diagnosis must be documented by qualified members of the teaching staff. This instruction must be initiated in the first year of the program to ensure that residents have the opportunity to apply this training throughout the program on adult and pediatric patients.

**Intent:** A medical student/resident level course in physical diagnosis, or a faculty led, formally structured and comprehensive physical diagnosis course that includes didactic and practical instruction. The complete history and physical examination includes a psychiatric assessment, when appropriate.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Course syllabi
- Course schedules
- Credentialing letter from course director that resident has mastered skills

4-6.1 Patients admitted to oral and maxillofacial surgery service must have a complete history and physical examination. The majority of these examinations must be performed by an oral and maxillofacial surgery resident.

CLINICAL ORAL AND MAXILLOFACIAL SURGERY

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

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

Examples of evidence to demonstrate compliance may include:
• Records kept by program director that show comparability of surgical experiences in the various aspects of oral and maxillofacial surgery across years and among residents.

• Oral and Maxillofacial Surgery Benchmarks

MINIMUM CLINICAL REQUIREMENTS

OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE

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

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

Examples of evidence to demonstrate compliance may include:

• Resident rotation schedules

• Outpatient clinic schedules

• Outpatient surgery case log

• Dentoalveolar-related didactic course materials

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

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

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

The post-operative aspects of training must include the evaluation and management of implant tissues and complications associated with the placement of implants.
Examples of evidence to demonstrate compliance may include:

- Implant-related didactic course materials
- Patient records, indicating interaction with restorative dentists

**GENERAL ANESTHESIA AND DEEP SEDATION**

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

Examples of evidence to demonstrate compliance may include:

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

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

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

Examples of evidence to demonstrate compliance may include:

- Resident’s anesthetic log.
- Clinical tracking system.
- Anesthesia records.
- Oral and Maxillofacial Surgery Benchmarks
4-9.2 The graduating resident must be trained to competence in the delivery of general anesthesia/deep sedation to patients of at least 8 years of age and older.

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

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience

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

Examples of evidence to demonstrate compliance may include:

- Didactic Schedules
- Resident Anesthetic Logs
- Detailed curriculum plans
- Patient charts
- Simulation experience

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

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

4-9.6 Advanced Cardiac Life Support (ACLS) must be obtained in the first year of residency and must be maintained throughout residency training.
Examples of evidence to demonstrate compliance may include:

- ACLS certification records and cards

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

Examples of evidence to demonstrate compliance may include:

- PALS certification records and cards

ADMISSIONS

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

MAJOR SURGERY

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

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

Examples of evidence to demonstrate compliance may include:

- Department and institution general operating room statistics and logs

Oral and Maxillofacial Surgery Standards -35-
• Patient Medical Records
• Schedules showing that resident was present in pre- and post-operative visits
• Progress notes or resident logs showing resident was present during pre- and post-operative visits
• Resident logbook of all procedures with which resident had active participation

4-12 In the trauma category, in addition to mandibular fractures, the surgical management and treatment of maxillary, nasal and orbito-zygomatico-maxillary complex injuries must be included.

4-12.1 Trauma management includes, but is not limited to, tracheotomies, open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region and repair of facial, oral, soft tissue injuries and injuries to specialized structures.

4-13 In the pathology category, experience must include management of temporomandibular joint pathology and at least three other types of procedures.

4-13.1 Pathology management includes, but is not limited to, major maxillary sinus procedures, treatment of temporomandibular joint pathology, salivary gland/duct surgery, management of head and neck infections, (incision and drainage procedures), and surgical management of benign and malignant neoplasms and cysts.

4-14 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.

4-14.1 Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial bones as well as the treatment of obstructive sleep apnea. Surgical procedures in this category include, but are not limited to, ramus and body procedures, subapical segmental osteotomies, Le Fort I, II and III procedures and craniofacial operations. Comprehensive care must include consultation and treatment by an orthodontic specialist when indicated; and a sleep medicine team should be included when indicated.

Intent: Evidence of resident pre- and post-operative care and intra-operative participation in the treatment of the orthognathic patient and the sleep apnea patient.

Examples of evidence to demonstrate compliance may include:
• Evidence of collaborative care (with orthodontist and/or sleep medicine team)
• Oral and maxillofacial surgery record with orthodontic and/or sleep medicine involvement

4-15 In the reconstructive and cosmetic category, both bone grafting and soft tissue grafting procedures must be included. Residents must learn the harvesting of bone and soft tissue grafts during the course of training.

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

Examples of evidence to demonstrate compliance may include:

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

4-15.1 Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of hard and soft tissue maxillofacial defects, insertion of craniofacial implants, facial cleft repair, peripheral nerve reconstruction and other reconstructive surgery.

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

4-15.2 Cosmetic surgery should include but is not limited to three of the following types of procedures: rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty, and scar revision.

Examples of evidence to demonstrate compliance may include:

• Patient records revealing resident experience in reconstructive and cosmetic surgery

4-16 Accurate and complete records of the amount and variety of clinical activity of the oral and maxillofacial surgery teaching service must be maintained. These records must include a detailed account of the number and variety of procedures
performed by each resident. Records of patients managed by residents must
evidence thoroughness of diagnosis, treatment planning and treatment.

4-16.1 Residents must keep a current log of their operative cases.

4-17 Emergency Care Experience: Residents must be provided with emergency care
experience, including diagnosing, rendering emergency treatment and assuming
major responsibility for the care of oral and maxillofacial injuries. The
management of acute illnesses and injuries, including management of oral and
maxillofacial lacerations and fractures, must be included in this experience. A
resident must be available to the emergency service at all times.

4-17.1 Each resident must be certified in Advanced Trauma Life Support
(ATLS) prior to completion of training.

4-18 The program must provide instruction in the compilation of accurate and
complete patient records.

Examples of evidence to demonstrate compliance may include:

• Seminar or lecture schedule on patient record keeping

4-19 The program must provide training in interpretation of diagnostic imaging.

Ethics and Professionalism

4-20 Graduates must receive instruction in the application of the principle of ethical
reasoning, ethical decision making and professional responsibility as they pertain to the
academic environment, research, patient care, and practice management.

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

4-21 The program must include participation in practice and risk management
seminars and instruction in coding and nomenclature.

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

Examples of evidence to demonstrate compliance may include:
• Seminar or lecture schedules on practice and risk management
• Familiarity with AAOMS Parameters of Care
STANDARD 5 - ADVANCED DENTAL EDUCATION RESIDENTS

ELIGIBILITY AND SELECTION

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge
5-1 If the program has determined that graduates of U. S. or Canadian accredited medical schools are eligible for admission, the candidate must obtain a dental degree from a predoctoral dental education program accredited by the Commission on Dental Accreditation prior to starting the required 120 weeks of core OMS training.

**EVALUATION**

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

**DUE PROCESS**

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

Oral and Maxillofacial Surgery Standards

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RIGHTS AND RESPONSIBILITIES

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

**Intent**: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a resident (for academic or disciplinary reasons). In addition to information on the program, residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 – RESEARCH

Advanced dental education residents must engage in scholarly activity.

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

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

Examples of evidence to demonstrate compliance may include:

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

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

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in research design and analysis
- Participation in a clinical trials course

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

Examples of evidence to demonstrate compliance may include:

- Didactic schedules demonstrating education in the critical evaluation of scientific literature through journal club or other educational seminars
Commission on Dental Accreditation

Standards Following Validity and Reliability Study

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery
Accreditation Standards for
Clinical Fellowship Training Programs in
Oral and Maxillofacial Surgery

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## Document Revision History

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<tr>
<td>August 7, 2015</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revised Policy on Reporting Program Changes</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revision to Standards 6-2.2 and 6-4.2</td>
<td>Adopted and Implemented</td>
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<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
<td>Adopted and Implemented</td>
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<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
<td>Implemented</td>
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<tr>
<td>August 4, 2017</td>
<td>Revision to Standard 1, Affiliations</td>
<td>Adopted</td>
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<tr>
<td>August 4, 2017</td>
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<td>Adopted and Implemented</td>
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<tr>
<td>February 2, 2018</td>
<td>Addition of Standards 6-4.2, 6-4.3, and 6-4.4.1</td>
<td>Adopted</td>
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<tr>
<td>July 1, 2018</td>
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<tr>
<td>August 3, 2018</td>
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<td>Adopted</td>
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<tr>
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<tr>
<td>July 1, 2019</td>
<td>Addition of Standards 6-4.2, 6-4.3, and 6-4.4.1</td>
<td>Implemented</td>
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<tr>
<td>February 12, 2021</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 THAT ARE FULLY OPERATIONAL:

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

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

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

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

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

PROGRAMS THAT ARE NOT FULLY OPERATIONAL: A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.
Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).

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

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

**Preface**

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

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

A fellowship in oral and maxillofacial surgery is a planned post-residency program that contains advanced education and training in a focused area of the discipline. The focused areas include: Cosmetic Facial Surgery; Oral/Head and Neck Oncologic Surgery; Pediatric Craniomaxillofacial Surgery (Cleft and Craniofacial Surgery); Microvascular Reconstructive Surgery; and Endoscopic Maxillofacial Surgery.

Accreditation actions by the Commission on Dental Accreditation are based upon information gained through written submissions by program directors and evaluations made on site by assigned site visitors. The Commission has established review committees to review site visit and progress reports and make recommendations to the Commission. Review committees are composed of representatives nominated by dental organizations and nationally accepted certifying boards. The Commission has the ultimate responsibility for determining a program’s accreditation status. The Commission is also responsible for adjudication of appeals of adverse decisions and has established policies and procedures for appeal. A copy of policies and procedures may be obtained from the Director, Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, Illinois 60611.
This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate fellowship programs in each discipline for accreditation purposes. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the essential educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by fellowships in the particular area.

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

**AUTHORIZED ENROLLMENT**

Oral and maxillofacial surgery fellowship programs are accredited for a specified number of fellows in each year of the program. Prior authorization is required for an increase in enrollment beyond the authorized level in any year, for any reason and regardless of whether the increase is a one-time-only or a permanent change in enrollment. Failure to comply with this policy will jeopardize the program's accreditation status.

Please review the Commission’s Policy on Enrollment Increases in Advanced Dental Education Programs found in the Evaluation and Operational Policies and Procedures manual (EOPP).

**DEFINITION OF TERMS USED IN ADVANCED DENTAL EDUCATION PROGRAM ACCREDITATION STANDARDS**

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

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

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

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

Oral and Maxillofacial Surgery Fellowship Standards
May or Could: Indicates freedom or liberty to follow a suggested alternative.

Levels of Knowledge:

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

Understanding: Adequate knowledge with the ability to apply.

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

Levels of Skills:

Proficient: The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.

Competent: The level of skill displaying special ability or knowledge derived from training and experience.

Exposed: The level of skill attained by observation of or participation in a particular activity.

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of fellowship student achievement.

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

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

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

Hospitals that sponsor fellowships must be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor fellowships must be accredited by an agency recognized by the United States Department of Education or its equivalent. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of fellowship programs must assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.
United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) must demonstrate successful achievement of Service-specific organizational inspection criteria. The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the administrator must have the authority, responsibility, and privileges necessary to manage the program.

1-1 Fellowships which are based in institutions or centers that also sponsor oral and maxillofacial surgery residency training programs must demonstrate that the fellowship and residency programs are not in conflict. The fellowship experience must not compete with the residency training program for surgical procedures. Separate statistics must be maintained for each program.

Examples of evidence may include:

- resident interviews as well as separate statistics for the fellowship and residents

1-2 Members of the teaching staff participating in an accredited fellowship program must be able to practice the full scope of the discipline in the focused area and in accordance with their training, experience and demonstrated competence.

**USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS**

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

1-3 All arrangements with major and minor activity sites, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

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

1-4 Documentary evidence of agreements, for major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

a. Designation of a single program director;

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b. The teaching staff;
c. The educational objectives of the program;
d. The period of assignment of fellows; and
e. Each institution’s financial commitment.

**Intent:** The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by a director who is board certified.

2-1 Program Director: The program must be directed by a single individual. The responsibilities of the program director must include:

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

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

2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.

2-1.4 Responsibility for adequate educational resource materials for education of the fellows, including access to adequate learning resources.

2-1.5 Responsibility for selection of fellows and ensuring that all appointed fellows meet the minimum eligibility requirements.

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

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

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

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the fellowship faculty. Such evidence may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;

b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media;

c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.

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

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

**Examples of evidence to demonstrate compliance may include:**
- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

Fellows, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

Intent: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.
STANDARD 4 – CURRICULUM AND PROGRAM DURATION

The fellowship program must be designed to provide special knowledge and skills beyond residency training. Documentation of all program activities must be assured by the program director and available for review.

4-1 The fellowship program is a structured post-residency program which is designed to provide special knowledge and skills. The goals of the fellowship must be clearly identified and documented.

4-2 The duration of the fellowship must be a minimum of twelve months.

4-3 The fellowship program must include a formally structured curriculum. The curriculum should include a list of topics which will be discussed with the fellow(s).

4-4 The fellowship program must provide a complete sequence of patient experiences which includes:

   a. pre-operative evaluation;
   b. adequate operating experience;
   c. diagnosis and management of complications;
   d. post-operative evaluation.

4-5 The fellow must maintain a surgical case log of all procedures and should include at least the date of the procedure, patient name, patient identification number, geographic location where procedure was performed, type of anesthesia/sedation, preoperative diagnosis, the operative procedure performed and the level of participation (surgeon or first assistant).
STANDARD 5 – FELLOW
ELIGIBILITY AND SELECTION

Oral and maxillofacial surgeons who have completed their formal oral and maxillofacial surgery residency training are eligible for fellowship consideration.

5-1 Nondiscriminatory policies must be followed in selecting fellows.

5-2 There must be no discrimination in the selection process based on professional degree(s).

EVALUATION

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

a. Periodically, but at least semiannually, evaluates the knowledge, skills and professional growth of its fellowship students, using appropriate written criteria and procedures;

b. Provide to fellowship students an assessment of their performance, at least semiannually;

c. Maintains a personal record of evaluation for each fellowship student which is accessible to the fellowship student and available for review during site visits.

Intent: A copy of the final written evaluation stating that the fellow has demonstrated competency to practice independently should be provided to each individual upon completion of the fellowship.

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the fellowship students must be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all fellowship students must be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.
STANDARD 6 - FELLOWSHIP PROGRAMS

Those enrolled in an accredited clinical fellowship in oral and maxillofacial surgery complete advanced training in a focused area.

6-1 Fellowship Program:
A fellowship is a structured post-residency educational experience devoted to enhancement and acquisition of skills in a focused area and must be taught to a level of competence.

6-2 Cosmetic Facial Surgery:
is that area of oral and maxillofacial surgery that treats congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures.

6-2.1 Goals/Objectives: To provide comprehensive clinical and didactic training as primary surgeon in the broad scope of cosmetic maxillofacial surgery.

6-2.2 Surgical Experience: Surgical experience must include the following procedures in sufficient number and variety to ensure that objectives of the training are met. No absolute number can ensure adequate training but experience suggests that a minimum of 125 maxillofacial cosmetic procedures is required. These procedures include, but are not limited to: blepharoplasty, brow lifts, treatment of skin lesions, skin resurfacing, cheiloplasty, genioplasty, liposuction, otoplasty, rhinoplasty, rhytidectomy, hard and soft tissue augmentation and contouring procedures.

6-3 Oral/Head and Neck Oncologic Surgery:
is that area of oral and maxillofacial surgery which manages patients with tumors of the head and neck.

6-3.1 Goals/Objectives: To provide comprehensive clinical and didactic training which will allow the maxillofacial surgeon to function as a primary oncologic surgeon in a head and neck cancer team at the completion of training.

6-3.2 Surgical Experience: Surgical experience must include the following procedures in sufficient number and variety to ensure that objectives of the training are met. No absolute number can ensure adequate training but experience suggests that at least 90 major surgical procedures should be documented. These procedures include, but are not limited to: extirpative surgery for malignant and benign tumors, neck dissections, major soft and hard tissue reconstruction, as well as free, local and regional flap
procedures.

Category I (Minimum 60 total procedures for categories a & b)

a. Excision of benign/malignant tumors involving hard and soft tissues.

b. Excision of benign and malignant salivary gland tumors

Category II (Minimum 20 procedures)


Category III (Minimum 10 procedures)

a. Surgical Airway Management.

6-3.3 The fellow **must** be trained in the role of radiation therapy and chemotherapy in the treatment and management of malignant tumors of the maxillofacial region. The fellow should participate on the tumor board.

6-3.4 Microvascular Reconstructive Surgery: is that area of oral and maxillofacial surgery that uses microvascular surgical techniques to permit transplantation of tissues from distant sites of the body in order to reconstruct defects of the head and neck.

6-3.4.1 Goals/Objectives: To provide comprehensive clinical and didactic training that will allow the oral and maxillofacial surgeon to perform microvascular reconstructions.

6-3.4.2 Surgical Experience: Surgical experience **must** include a minimum of 40 hours of microsurgical laboratory training and primary or first assist surgeon in at least 30 microvascular surgical reconstruction procedures, which includes flap harvest, inset and microvascular anastomosis.

6-3.5 Fellowship programs **must** declare the scope of the training program.

Type I: Oral/Head and Neck Oncologic Surgery

Type II: Oral/Head and Neck Oncologic Surgery and Microvascular Reconstructive Surgery

**Intent:** Programs will be responsible for meeting the portion of the standard that applies to the declared type of program.
6-4 Pediatric Craniomaxillofacial Surgery (Cleft and Craniofacial Surgery):
is that area of oral and maxillofacial surgery that focuses on the diagnosis, as well as the
surgical and adjunctive treatment in the neonate, infant, child and adolescent, of the
following:
- congenital or developmental cleft and craniofacial deformities
- pathology of the craniomaxillofacial region
- trauma to the craniomaxillofacial region

6-4.1 Goals/Objectives: To provide a structured, didactic curriculum and broad experience
in fundamental areas of craniofacial and pediatric oral and maxillofacial surgery. The
goal is to prepare the fellow to function as a primary surgeon on an American Cleft
Palate/Craniofacial Association (ACPCA)-recognized cleft and craniofacial team.
The educational program should include anesthetic techniques and perioperative
medical management of pediatric surgical patients.

6-4.2 Craniofacial surgery: is the type of surgery that may traverse the cranial base and
refers to combined oral and maxillofacial surgery/neurosurgery to treat, e.g.,
hypertelorism, Crouzon syndrome, Apert syndrome, and isolated craniosynostosis.

6-4.3 Fellowship programs must declare the scope of the training program.
Type I: Craniofacial and Cleft (Categories I, II, II, IV)
Type II: Craniofacial (Categories II, III, IV)
Type III: Cleft (Categories I, III, IV)

6-4.4 Surgical Experience: The experience must include a minimum of 20 procedures in
each of the categories delineated by the declared program Type (I, II, III). The
cumulative surgical experience must include a minimum of 80 procedures.

Category I (Minimum 20 Procedures)
Cleft Lip/Palate Related Surgery
(to include primary and secondary procedures)

Category II (Minimum 20 Procedures)
Craniomaxillofacial Surgery to include Orthognathic Surgery,
Transcranial Surgery, Reconstruction, Distraction Osteogenesis, and
other skeletofacial surgery.
(Of the 20 procedures, orthognathic procedures must not exceed 5.)
Category III (Minimum 20 Procedures)
   Pediatric Hard and Soft Tissue Trauma

Category IV (Minimum 20 Procedures)
   Hard and Soft Tissue Pathology

6-4.4.1 In Type I and II programs, surgical experience must include a minimum of 5 transcranial procedures.

6-4.5  PALS: The fellow must maintain certification in Pediatric Advanced Life Support (PALS).

6-4.6 The program must participate in a craniofacial and/or cleft treatment team respectively.

6-5  Microvascular Reconstructive Surgery
Microvascular Reconstructive Surgery is that area of oral and maxillofacial surgery that uses microvascular surgical techniques to permit transplantation of tissues from distant sites of the body in order to reconstruct defects.

6-5.1  Goals/Objectives: To provide comprehensive clinical and didactic training that will allow the oral and maxillofacial surgeon to perform microvascular reconstructions.

6-5.2  Surgical Experience: Surgical experience must include a minimum of 40 hours of microsurgical laboratory training and primary or first assist surgeon in at least 30 microvascular surgical reconstruction procedures which includes flap harvest, inset and microvascular anastomosis.

6-6  Endoscopic Maxillofacial Fellowship
Endoscopic Maxillofacial Surgery is that area of oral and maxillofacial surgery that utilizes high definition video technology coupled with minimal access exposure to execute precise surgical maneuvers.

6-6.1  Goals/Objectives: To provide a comprehensive clinical and didactic training in minimally invasive endoscopic techniques either as the primary procedure or endoscopic assisted procedures. To advance technology and surgical procedures in order to provide precise intervention and reduce morbidity. The
goal is to prepare the fellow to be competent in doing endoscopic assisted procedures.

6-6.2 Surgical Experience: Surgical procedures may include: TMJ Arthroscopy (Diagnostic and Advanced), Sialoendoscopy, Endoscopic assisted Orthognathic Surgery, Endoscopic assisted Maxillofacial Trauma, Endoscopic assisted TMJ Total Joint Reconstruction and sinus endoscopy.

6-6.3 Surgical procedures performed by the fellow, as a first assistant or primary surgeon, must include a minimum of 100 endoscopic maxillofacial surgical procedures to ensure that the objectives of the training are achieved. The 100 endoscopic maxillofacial surgical procedures must include no less than:

a. 30 double puncture, advanced, temporomandibular joint arthroscopic procedures
b. 10 Sialoendoscopic procedures
c. 10 Sinus endoscopic procedures
STANDARD 7 – INVESTIGATIVE STUDY

Fellows must engage in scholarly activity. Such efforts may include:

7-1 Participation in clinical and/or basic research particularly in projects funded following peer review

7-2 Publication of the result of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media

7-3 Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.

Examples of evidence to demonstrate compliance may include:

a. Investigation in laboratories or clinics

b. Comprehensive summaries of scientific literature or preparation of statistical analyses based in clinical case records
Commission on Dental Accreditation

At its Winter 2020 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2020, for review at the Winter 2021 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from January 31, 2020 to December 1, 2020.

This document will be considered by the Commission in Winter 2021.

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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

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

Examples of evidence to demonstrate compliance may include:

- Seminar schedules for at least one year
- Resident log of lectures attended
- Course outlines
- Sign-in sheets

**BASIC SCIENCES**

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

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

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

Examples of evidence to demonstrate compliance may include:

- Resident log of lectures attended
- Course outlines
• Goals and objectives of biomedical sciences curriculum
• Sign-in sheets
• Schedule showing curriculum in the mandated areas for a typical year

PHYSICAL DIAGNOSIS

4-6 A formally structured didactic and practical clinical course in physical diagnosis must be provided by individuals privileged to perform histories and physical examinations. Resident competency in physical diagnosis must be documented by qualified members of the teaching staff. This instruction must be initiated in the first year of the program to ensure that residents have the opportunity to apply this training throughout the program on adult and pediatric patients. Resident competency in physical diagnosis must be documented prior to the completion of the program.

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

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Course syllabi
- Course schedules
- Credentialing letter from course director that resident has mastered skills

4-6.1 Patients admitted to oral and maxillofacial surgery service must have a complete history and physical examination. The majority of these examinations must be performed by an oral and maxillofacial surgery resident.

CLINICAL ORAL AND MAXILLOFACIAL SURGERY

4-7 The program must provide a complete, progressively graduated sequence of outpatient, inpatient and emergency room experiences. The residents’ exposure to non-surgical management and major and minor surgical procedures must be integrated throughout the duration of the program.
In addition to providing the teaching and supervision of the resident activities described above, there must be patients of sufficient number and variety to give residents exposure to and competence in the full scope of oral and maxillofacial surgery. The program director must demonstrate that the objectives of the standards have been met and must ensure that all residents receive comparable clinical experience.

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

Examples of evidence to demonstrate compliance may include:

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

**MINIMUM CLINICAL REQUIREMENTS**

**OUTPATIENT ORAL AND MAXILLOFACIAL SURGERY EXPERIENCE**

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

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

Examples of evidence to demonstrate compliance may include:
- Resident rotation schedules
- Outpatient clinic schedules
- Outpatient surgery case log
- Dentoalveolar-related didactic course materials
4-8.1 **Dental implant training must include didactic and clinical experience in comprehensive preoperative, intraoperative and post-operative management of the implant patient.**

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

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

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

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

- Implant-related didactic course materials
- Patient records, indicating interaction with restorative dentists

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

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

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

MAJOR SURGERY

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

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

Examples of evidence to demonstrate compliance may include:

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

4-121.1 In the trauma category, in addition to mandibular fractures, the surgical management and treatment of maxillary, nasal and orbito-zygomatico-maxillary complex injuries must be included.

**Intent:** 4-121.1 Trauma management includes, but is not limited to, tracheotomies, open and closed reductions of fractures of the mandible, maxilla, zygomato-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region and repair of facial, oral, soft tissue injuries and injuries to specialized structures.

4-131.2 In the pathology category, experience must include management of temporomandibular joint pathology and at least three other types of procedures.

**Intent:** 4-131.2 Pathology of the temporomandibular joint includes, but is not limited to, internal derangement arthritis, post-traumatic dysfunction, and neoplasms. Management of temporomandibular joint pathology may include medical or outpatient procedures. Other pathology management includes, but is not limited to, major maxillary sinus procedures, treatment of temporomandibular joint pathology, salivary gland/duct surgery, management of head and neck infections, (incision and drainage procedures), and surgical management of benign and malignant neoplasms and cysts.

4-141.3 In the orthognathic category, procedures must include correction of deformities in the mandible and the middle third of the facial skeleton.
Intent: 4-14.1 Orthognathic surgery includes the surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial bones as well as the treatment of obstructive sleep apnea. Surgical procedures in this category include, but are not limited to, ramus and body procedures, subapical segmental osteotomies, Le Fort I, II and III procedures and craniofacial operations. Comprehensive care must include consultation and treatment by an orthodontic specialist when indicated; and a sleep medicine team should be included when indicated. Intent: Evidence of residents participating in the pre- and post-operative care and intra-operative participation in the treatment of the orthognathic patient and the sleep apnea patient.

Examples of evidence to demonstrate compliance may include:

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

4-15.1.4 In the reconstructive and cosmetic category, both bone grafting and soft tissue grafting procedures must be included. Residents must learn the harvesting of bone and soft tissue grafts during the course of training.

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

Examples of evidence to demonstrate compliance may include:

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

4-15.11.5 Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of hard and soft tissue maxillofacial defects, insertion of craniofacial implants, facial cleft repair, peripheral nerve reconstruction and other reconstructive surgery.

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

4-15.2 Cosmetic surgery should include but is not limited to three of the following types of procedures: rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty, and scar revision.
Proposed Oral and Maxillofacial Surgery Standards Revisions
Report of the OMS RC
CODA Winter 2021

Examples of evidence to demonstrate compliance may include:

- Patient records revealing resident experience in reconstructive and cosmetic surgery

4-162 Accurate and complete records of the amount and variety of clinical activity of the oral and maxillofacial surgery teaching service must be maintained. These records must include a detailed account of the number and variety of procedures performed by each resident. Records of patients managed by residents must evidence thoroughness of diagnosis, treatment planning and treatment.

4-16.1 4-12.1 Residents must keep a current log of their operative cases.

4-173 Emergency Care Experience: Residents must be provided with emergency care experience, including diagnosing, rendering emergency treatment and assuming major responsibility for the care of oral and maxillofacial injuries. The management of acute illnesses and injuries, including management of oral and maxillofacial lacerations and fractures, must be included in this experience. A resident must be available to the emergency service at all times.

4-173.1 Each resident must be certified in Advanced Trauma Life Support (ATLS) prior to completion of training.

4-184 The program must provide instruction in the compilation of accurate and complete patient records.

Examples of evidence to demonstrate compliance may include:

- Seminar or lecture schedule on patient record keeping

4-195 The program must provide training in interpretation of diagnostic imaging.

Ethics and Professionalism

4-2016 Graduates must receive instruction in the application of the principle of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.
Intent: Graduates should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

4-2417 The program must include participation in practice and risk management seminars and instruction in coding and nomenclature.

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

Examples of evidence to demonstrate compliance may include:

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

Patient Safety

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

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

Examples of evidence to demonstrate compliance may include:

- Documentation of an active, ongoing clinical safety training program. This may include participation in institution-wide programs, or documentation of training in Crew Resource Management, Root Cause Analysis, or other safety-focused protocols
- Formative and summative evaluation of residents’ knowledge of and engagement and compliance with safety initiatives (e.g. use of Benchmarks)

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

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

Examples of evidence to demonstrate compliance may include:

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

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

Examples of evidence to demonstrate compliance may include:

- Documentation of routine procedural time-outs
- Checklists for preanesthetic preparation, patient and procedure readiness verification, or similar
- Readily available cognitive aids (e.g. charts, placards, checklists, guides) for management of anesthetic and or/medical emergencies
CONSIDERATION OF MATTERS RELATED TO ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION

Informational Report on Orthodontics and Dentofacial Orthopedics Programs (Residency and Fellowship) Annual Survey Curriculum Data (p. 1100): The Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Sections.

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

Progress Report on the 2019 Validity and Reliability Studies of the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics and the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (p. 1101): The Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics were adopted by the Commission on Dental Accreditation at its January 31, 2013 meeting for implementation January 1, 2014. The Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics were adopted and implemented by the Commission on Dental Accreditation at its August 7, 2015 meeting.

According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a two-year program will be assessed after five (5) years and the validity and reliability of the standards for a one-year program will be assessed after four (4) years. In accordance with this policy, the Validity and Reliability Studies of the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics and Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics were initiated in Summer/Fall 2019 with the results considered at the Winter 2020 meeting of the Commission.
In Winter 2020, the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) conducted an initial review of the validity and reliability study reports. The Review Committee concluded that further study of the survey data was warranted. The ORTHO RC believed a small workgroup should be formed to further study the reports and identify the residency and fellowship Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of a workgroup composed of at least four (4) Orthodontics and Dentofacial Orthopedics Review Committee members and no more than two (2) additional individuals representing the American Association of Orthodontists (AAO) to further study the findings of the 2019 orthodontics residency and fellowship Validity and Reliability Studies and identify Accreditation Standards, if any, which warrant revision, with a report to the ORTHO RC and Commission in Summer 2020. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc Committee conducted its meeting on November 10, 2020 and prepared a comprehensive fellowship Standards document reflecting proposed revisions as a result of its charges (Appendix 1, Policy Report p. 1101). The proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics as submitted by the Ad Hoc Committee as a result of its charges is found in Appendix 5, Policy Report p. 1103.

At this meeting, the ORTHO RC considered the proposed revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics submitted by the Ad Hoc Committee. The ORTHO RC noted the proposed deletion of the requirement for a formal curriculum in research methodology and biostatistics based on the validity and reliability study results, as well as the proposed reorganization of Standard 7—Research based on the revised definition of the term “should.” Following discussion, the ORTHO RC affirmed the proposed revisions to the fellowship standards submitted by the Ad Hoc Committee, as found in Appendix 1.

In summary, the ORTHO RC recommended that the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (Appendix 1) be circulated to the communities of interest for review and comment, with Hearings conducted at the March 2021 American Dental Education Association and October 2021 American Dental Association meetings, with comments reviewed at the Commission’s Winter 2022 meetings.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions to the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics, found in Appendix 1, to the communities of interest for review and comment, with Hearings conducted at the March 2021 American Dental Education Association and October 2021
Report of the ORTHO RC
CODA Winter 2021

American Dental Association annual meetings, with comments reviewed at the Commission’s Winter 2022 meetings.

Consideration of the Use of the Term “Should” Within the Accreditation Standards (p. 1102): At its Summer 2019 meeting, the Commission directed the revision or addition, as applicable, of the definition of “Should,” as noted below, 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. The revised definition of “Should” within the Definition of Terms, is as follows: Should: Indicates a method to achieve the standard; highly desirable, but not mandatory. Per the Commission’s directive, the revised definition of “Should” will be incorporated into the residency and fellowship standards resulting from the validity and reliability studies.

At its Winter 2020 meeting, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) determined and the Commission concurred that, because of the amount of data provided in the validity and reliability report, and to ensure an in-depth review of the instances of “Should,” it would be beneficial to combine this exercise with the validity and reliability study review with a report submitted for consideration at the Summer 2020 meeting of the ORTHO RC and Commission. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc committee conducted its meeting on November 10, 2020, where it reviewed its three (3) charges, held a high-level discussion of the results of the validity and reliability studies, and discussed proposed changes to the residency standards. The committee also considered the use of the term “should” in both the residency and fellowship standards. A comprehensive Standards document reflecting proposed revisions to the fellowship standards as a result of the committee’s charges is found in Appendix 1, Policy Report p. 1101. The proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics as submitted by the Ad Hoc Committee as a result of its charges is found in Appendix 5, Policy Report p. 1103.

At this meeting, the ORTHO RC reviewed the comprehensive residency and fellowship Standards documents submitted by the Ad Hoc Committee as a result of its charges. The committee affirmed the proposed reorganization of the term “should” within three (3) separately numbered Standard 7-Research items to “examples of evidence” within the fellowship standards as noted in Appendix 1. The ORTHO RC also affirmed that the comprehensive residency Standards document submitted by the Ad Hoc Committee found in Appendix 5, Policy Report p. 1103 was appropriate, noting that no changes to the residency standards were warranted based on the revised definition of the term “should.”

Recommendation: This report in informational in nature and no action is requested.
Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p. 1103): At its Winter 2019 meeting, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics from the American Association of Orthodontists.

The Committee considered the proposed revisions to the Orthodontics Standards and found the several proposed revisions pertaining to faculty/space resources all to be appropriate. The Committee also supported all of the proposed revisions that relate to the types of patients/conditions presenting for treatment. The ORTHO RC concluded, and the Commission concurred, that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (Appendix 1, Policy Report p. 1103) be circulated to the communities of interest for review and comment for a period of one (1) year, including Hearings during the March 2019 American Dental Education Association (ADEA) and September 2019 American Dental Association (ADA) annual meetings, with comments reviewed at the ORTHO RC and Commission meetings in Winter 2020.

Two (2) comments were received at the 2019 ADEA Hearing; two (2) comments were received at the 2019 ADA Hearing; and eight (8) written comments were received during the comment period (Appendix 2, 3 and 4, Policy Report p. 1103). At its Winter 2020 meeting, the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) conducted an initial review of the proposed revisions and all comments received. The Review Committee concluded that further study of the proposed revisions was warranted. The ORTHO RC determined and the Commission concurred that, because of the amount of data provided in the validity and reliability reports, and to ensure an in-depth review of the proposed revisions to the residency standards, it would be beneficial to combine this exercise with the validity and reliability study review with a report submitted for consideration at the Summer 2020 meeting of the ORTHO RC and Commission. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc committee conducted its meeting on November 10, 2020. Per its three (3) charges, the Committee held a high-level discussion of the results of the validity and reliability studies, discussed proposed changes to the residency standards, and considered the use of the term “should” in the residency standards. During its meeting, the Ad Hoc Committee reviewed Standard 4-3.4 and proposed that “ABO standards” should be changed to “ABO Assessment Tools” as a more accurate description. This was the only change made to the proposed revisions that previously circulated and garnered comments. As a result of its charges, the Ad Hoc Committee prepared a comprehensive Standards document reflecting proposed revisions (Appendix 5, Policy Report p. 1103).
At its Winter 2021 meeting, the ORTHO RC carefully considered the comprehensive residency Standards document submitted by the Ad Hoc Committee (Appendix 5, Policy Report p. 1103). The Committee also discussed all comments received during the comment period (Appendix 2, 3 and 4, Policy Report p. 1103). With regard to the proposed revision to Standard 2-9 requiring a minimum of one (1) full-time equivalent (FTE) faculty to four (4) students/residents for the entire program, the ORTHO RC believed the proposed revision holds programs accountable to providing sufficient faculty coverage for student/resident oversight. The ORTHO RC also considered the proposed revision to Standard 2-10 requiring that, for clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents. Following discussion, the ORTHO RC concurred with the Ad Hoc Committee that the intent of the revision is to provide a quality clinical education with proper oversight.

The ORTHO RC affirmed that the proposed revisions were appropriate, and that no additional changes to the residency standards were warranted as a result of the 2019 Validity and Reliability Study or due to the revised definition of “should,” as found in Appendix 2. This document reflects the residency standards as a result of the 2019 Validity and Reliability Study, with the proposed revisions submitted by the Ad Hoc Committee.

In addition, the ORTHO RC thoroughly discussed an implementation date for the revised residency standards, intending to allow orthodontics and dentofacial orthopedics programs time to comply with the revised standards; particularly those related to faculty. The Committee believed that a July 1, 2022 implementation date would be an appropriate timeframe, noting that all programs would be required to comply with the revised standards on that date.

In summary, the ORTHO RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics noted in Appendix 2 be adopted by the Commission and implemented on July 1, 2022.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics found in Appendix 2, with an implementation date of July 1, 2022.

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.
CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE
COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF
ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION

The Review Committee on Orthodontics and Dentofacial Orthopedics Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. Brent Larson
Chair, Review Committee on Orthodontics and Dentofacial Orthopedics Education
Commission on Dental Accreditation

Standards Following Validity and Reliability Study

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics
Accreditation Standards for
Clinical Fellowship Training Programs in
Craniofacial and Special Care Orthodontics
Commission on Dental Accreditation
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Chicago, Illinois 60611
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Craniofacial and Special Care Orthodontics Fellowship Standards

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### Document Revision History

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<th>Date</th>
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<tr>
<td>August 7, 2015</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics</td>
<td>Adopted and Implemented</td>
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<tr>
<td>August 7, 2015</td>
<td>Revision to Policy on Reporting Program Changes in Accredited Programs</td>
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<tr>
<td>August 7, 2015</td>
<td>Revised Policy on Enrollment Increases in Advanced Dental Specialty Programs</td>
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<tr>
<td>February 5, 2016</td>
<td>Revision to Standard 6.2.2</td>
<td>Adopted and Implemented</td>
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<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
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<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
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Craniofacial and Special Care Orthodontics Fellowship Standards

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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 That Are Fully Operational:

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

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

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

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

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

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

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

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

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

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

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

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

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Preface

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

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

A fellowship in craniofacial and special needs orthodontics is a planned post-residency program that contains advanced education and training in a focused area of the discipline of orthodontics. The focused areas include:

- Cleft lip/palate patient care;
- Syndromic patient care;
- Orthognathic Surgery;
- Craniofacial Surgery and Special Care Orthodontics.

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate fellowship programs in each discipline for accreditation purposes. The general and discipline specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the essential educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by fellowships in the particular discipline.

General standards are identified by the use of a single numerical listing (e.g., I). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Craniofacial and Special Care Orthodontics Accreditation Standards

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

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

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

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

**Levels of Knowledge:**

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

- **Understanding:** Adequate knowledge with the ability to apply.

- **Familiarity:** A simplified knowledge for the purpose of orientation and recognition of general principles.

**Levels of Skills:**

- **Proficient:** The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.

- **Competent:** The level of skill displaying special ability or knowledge derived from training and experience.

- **Exposed:** The level of skill attained by observation of or participation in a particular activity.
Other Terms:

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

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of fellowship student achievement.

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

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

1-1 Fellowships which are based in institutions or centers that also sponsor orthodontic
residency training programs must demonstrate that the fellowship and residency
programs are not in conflict. The fellowship experience must not compete with
the residency training program for cases. Separate statistics must be maintained
for each program.

1-2 Members of the teaching staff participating in an accredited fellowship program
must be able to practice the full scope of the discipline in the focused area and in
accordance with their training, experience and demonstrated competence.
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

1-3 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-4 Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

- Designation of a single program director;
- The teaching staff;
- The educational objectives of the program;
- The period of assignment of students/fellows; and
- Each institution’s financial commitment.

Intent: The items are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

1-5 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.

1-6 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

Intent: It is the responsibility of the program director to ensure that all faculty, including those at sites where educational activity occurs, are qualified.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by a director who has documented expertise in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics. Additionally, the program director must either be board certified in orthodontics or have previously served as a director in a craniofacial orthodontic fellowship program prior to January 1, 2008.

Examples of evidence to demonstrate compliance may include: Board certification certificate or current CV identifying previous directorship in a Craniofacial Orthodontic Fellowship and letter from the employing institution verifying service.

2-1 Program Director: The program must be directed by one individual. The responsibilities of the program director must include:

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

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

2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.

2-1.4 Responsibility for adequate educational resource materials for education of the students/fellows, including access to adequate learning resources.

2-1.5 Responsibility for selection of students/fellows and ensuring that all appointed students/fellows meet the minimum eligibility requirements.

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

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

2-2.1 Provide direct supervision appropriate to a student’s/fellow’s competence, level of training, in all patient care settings.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the fellowship faculty. Such evidence may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;
b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed scientific media;

c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.

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

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

Examples of evidence to demonstrate compliance may include:

Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Student/Resident assessment
Cultural Competency
Ability to work with students/residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

Students/Fellows, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

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

The use of private office facilities as a means of providing clinical experiences in advanced dental education is not approved, unless the discipline has included language that defines the use of such facilities in its discipline-specific Standards.
Intent: Required orthodontic fellowship clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.

3-1 Adequate space must be designated specifically for the clinical fellowship training program in Craniofacial and Special Care Orthodontics.

Intent: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.

3-2 Facilities must permit the students/fellows to work effectively with trained allied dental personnel.

Intent: A program is expected to have auxiliaries available to assist the students/fellows so the program can meet the educational Standards.

Examples of evidence to demonstrate compliance may include:

- Schedule of dental assistants’ assignments

3-3 Radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. Imaging equipment must be available.

3-4 Students/Fellows in a Craniofacial and Special Care Orthodontic program must have access to adequate space, equipment, and physical facilities to do research.

Intent: Adequate space is necessary to do research, but does not need to be dedicated to craniofacial and special care orthodontic research.

3-5 Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/fellows to achieve the educational goals of the program.

Intent: The intent is to assure the students/fellows in Craniofacial and Special Care Orthodontics utilize their time for educational purposes.

3-6 Clinical facilities must be provided within the sponsoring, affiliated institution or surgical center to fulfill the educational needs of the program.

3-7 Sufficient space must be provided for storage of patient records, models and other related diagnostic materials.

3-8 These records and materials must be readily available to effectively document active treatment progress and immediate as well as long term post-treatment results.
Intent: Students/Fellows are expected to have easy access to active, post treatment, and retention records. These records should be complete.

Radiography equipment must be available and accessible to the craniofacial clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.

Intent: High quality radiographic images are essential for orthodontic and dentofacial orthopedic therapy. Three dimensional cone-beam CT images of the dentition, face and TMJs are acceptable if clinically indicated.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

The fellowship program must be designed to provide special knowledge and skills beyond residency training. Documentation of all program activities must be assured by the program director and available for review.

4-1 The fellowship program is a structured post-residency program which is designed to provide special knowledge and skills for management of Craniofacial Anomalies and Special Care (CFA&SC) patients. These patients have craniofacial anomalies that affect the face and stomatognathic system and require special care due to physical mental and/or psychological conditions. The goals of the fellowship program must be clearly identified and documented.

4-2 The duration of the fellowship program must be a minimum of twelve months.

4-3 The fellowship program must include a formally structured curriculum. The curriculum must include the following experiences for each student/fellow:
   a. regularly scheduled grand rounds case presentations
   b. historical and current scientific literature review
   c. research methodology and biostatistics
d. training in the allied medical sciences and social services required to manage the unique needs of CFA&SC patients and their families

4-4 The fellowship program must provide a complete sequence of patient experiences which includes:
   a. pre-treatment evaluation and orthodontic record taking;
   b. diagnosis and treatment planning;
   c. advanced training in the use of the specialized orthodontic appliances required for the management of CFA&SC patients;
   d. retention and long-term post-treatment evaluation.

4-5 The student/fellow must maintain a treatment log of all patients under their care with associated treatment plans/ procedures performed and include at least the date of the procedure, patient name, patient identification number, and the outcome of the procedure, and long-term follow-up plans when applicable.
STANDARD 5 – STUDENTS/FELLOWS

ELIGIBILITY AND SELECTION

Orthodontists who have completed their formal orthodontic residency training are eligible for fellowship program consideration.

5-1 Nondiscriminatory policies must be followed in selecting students/fellows.

5-2 There must be no discrimination in the selection process based on professional degree(s).

Specific written criteria, policies and procedures must be followed when admitting students/fellows.

EVALUATION

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

a. Periodically, but at least semiannually, evaluates the knowledge, skills, ethical conduct and professional growth of its fellowship students, using appropriate written criteria and procedures;

b. Provide to fellowship students an assessment of their performance, at least semiannually;

c. Maintains a personal record of evaluation for each fellowship student which is accessible to the fellowship student and available for review during site visits.

Intent: A copy of the final written evaluation stating that the student/fellow has demonstrated competency to practice independently should be provided to each individual upon completion of the fellowship program.

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the fellowship students must be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all fellowship students must be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.
STANDARD 6 - FELLOWSHIP PROGRAMS

Those enrolled in an accredited clinical fellowship program in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics complete advanced training in a focused area:

6-1 Fellowship Program: A fellowship is a structured post-residency educational experience devoted to enhancement and acquisition of skills in a focused area and must be taught to a level of proficiency.

6-2 Craniofacial and Special Care Orthodontics:

Craniofacial is that area of orthodontics that treats patients with congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures. Special Care is that area of orthodontics that treats patients with special needs including disabilities and medically compromised patients who require comprehensive treatment.

6-2.1 Goals/Objectives: To provide comprehensive clinical and didactic training as the orthodontist, who works with a craniofacial team treating patients with a broad scope of craniofacial deformities and special needs situations.

6-2.2 Clinical Experience: Clinical experience must include the following procedures and must exist in sufficient number and variety to assure that objectives of the training are met:

a. experience with pre-surgical orthopedics for infants born with cleft lip and palate;

b. orthodontic therapy for patients with craniofacial deformities from the primary through adult dentition;

c. orthodontic management of patients with cleft or craniofacial anomalies;

d. surgical/orthodontic treatment planning;

e. pre and post surgical orthodontic management;

f. surgical splint design and construction;

g. observation of surgical procedures, including splint placement;

h. orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs;

i. participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists providing restorative services for CFA & SC patients;
j. exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients.

k. supervised participation in craniofacial team activities.

l. participate in craniofacial team meetings.

Examples of Evidence to demonstrate compliance may include:

- Roster of who attends craniofacial team meetings
- Schedule as to how often the craniofacial team meets
- Sense of what is discussed at meetings of craniofacial team, e.g., meeting minutes.
STANDARD 7 - RESEARCH

Students/Fellows must engage in an evidence-based research project approved by the director of the program, which should include one or more of the following:

- Analyses based on clinical case records.
- Participation in clinical and/or basic research particularly in projects funded following peer review and Institutional Review Board (IRB) approval.
- Publication of case reports or hypotheses-driven research in peer reviewed journals related to the field of Craniofacial Anomalies and Special Care (CFA&SC) orthodontics.
- Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.

Examples of evidence to demonstrate compliance may include:

a. Basic Sciences or Clinical Research Investigation
b. Meta-Analyses or Systematic Reviews of scientific literature
c. Analyses based on clinical case records. Participation in clinical and/or basic research particularly in projects funded following peer review and Institutional Review Board (IRB) approval.
d. Publication of case reports or hypotheses-driven research in peer reviewed journals related to the field of Craniofacial Anomalies and Special Care (CFA&SC) orthodontics.
e. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.
At its Winter 2019 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2019, for review at the Winter 2020 Commission meeting.

This document represents the proposed revisions based upon review of comment received from communities of interest from February 8, 2019 to December 1, 2019. This document also represents the Standards following Validity and Reliability Study.

This document will be considered by the Commission in Winter 2021.

Additions are Underlined
Strikethroughs indicate Deletions

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

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## Document Revision History

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<td>Revised Mission Statement</td>
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<td>January 31, 2013</td>
<td>Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics</td>
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<td>February 6, 2015</td>
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<td>Adopted and Implemented</td>
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<td>August 3, 2018</td>
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<td>August 2, 2019</td>
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<td>Adopted</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 That Are Fully Operational:

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

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

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

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

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

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

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation

Orthodontics and Dentofacial Orthopedics Standards
classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).

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

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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

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

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

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards Orthodontics and Dentofacial Orthopedics Standards.
which are common to all disciplines of advanced dental education, institutions and programs. Each discipline develops discipline-specific standards for educational programs in its discipline. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.

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

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

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

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in
Orthodontic and Dentofacial Orthopedic
Accreditation Standards

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

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

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

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

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

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

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

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

**Competent:** Having the knowledge, skills and values required of the graduates to begin independent, unsupervised discipline-specific practice.
In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.

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

Other Terms:

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

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

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

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

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

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

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

Formative Assessment*: guiding future learning, providing reassurance, promoting reflection, and shaping values; providing benchmarks to orient the learner who is approaching a relatively unstructured body of knowledge; and reinforcing students’ intrinsic motivation to learn and inspire them to set higher standards for themselves.
Summative Assessment*: making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility; and providing professional self-regulation and accountability.

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

Ethics and Professionalism

1-1 Graduates must receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the program director must have the authority, responsibility and privileges necessary to manage the program.
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

1-2 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-3 Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

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

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

1-4 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.

1-5 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

Intent: It is the responsibility of the program director to ensure that all faculty, including those at sites where educational activity occurs, are qualified.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Accreditation of Off-Campus Sites found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

Intent: The director of an orthodontic program is to be certified by the American Board of Orthodontics.

The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

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

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

2-1 The program must be directed by one individual.

2-2 The program director position must be full-time as defined by the institution.

2-23 There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.

Intent: The program director is expected to be intimately involved in all aspects of the program.
Examples of evidence to demonstrate compliance may include:

- Program’s director’s weekly schedule
- Institution’s definition of full-time and part-time commitment
- Program director’s job description

2-34 A majority of the discipline-specific instruction and supervision must be conducted by individuals who are educationally qualified in orthodontics and dentofacial orthopedics.

2-45 Besides maintaining clinical skills, the director must have teaching experience in orthodontics and dentofacial orthopedics. For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.

2-56 Periodic faculty meetings must be held for the proper function and improvement of an advanced dental education program in orthodontics and dentofacial orthopedics.

Examples of evidence to demonstrate compliance may include:

- Schedules and minutes of faculty meetings
- Action taken as a result of faculty meetings
- Records of attendance at faculty meetings

2-67 The faculty must have knowledge of the required biomedical sciences relating to orthodontics and dentofacial orthopedics. Clinical instruction and supervision in orthodontics and dentofacial orthopedics must be provided by individuals who have completed an advanced dental education program in orthodontics and dentofacial orthopedics approved by the Commission on Dental Accreditation (grandfathered), or by individuals who have equivalent education in orthodontics and dentofacial orthopedics.

2-78 In addition to their regular teaching responsibilities with the department, full-time faculty must have adequate time for their own professional development.

2-9 The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.
**Intent:** Full-time faculty have the obligation to teach, conduct research and provide service to the institution and/or profession.

Examples of evidence to demonstrate compliance may include:

- Weekly schedules of full-time faculty
- Curriculum vita of full-time faculty, including academic ranks
- Schedule of faculty commitments in teaching, research and service

2-810 **For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty must be is sufficient to provide full supervision of the clinical portion of the program.**

2-11 **The faculty covering clinic must be orthodontists.**

2-912 **Faculty evaluations must be conducted and documented at least annually.**

Examples of evidence to demonstrate compliance may include:

- Faculty evaluation records
- Credentials and advanced education of faculty
- Institution plan for professional development

2-1013 **There must be evidence of an ongoing systematic procedure to evaluate the quality of treatment provided in the program.**

Examples of evidence to demonstrate compliance may include:

- Records of case presentations and evaluation
- Patient charts available for audit
- Protocol for treatment

2-1114 **The program director and faculty must prepare students/residents to pursue certification by the American Board of Orthodontics.**

2-1114.a **The program director must document the number of graduates who become certified by the American Board of Orthodontics.**

2-1215 **The program must show evidence of an ongoing faculty development process.**
**Intent:** Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

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

Intent: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.
The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.

**Intent**: Required orthodontic clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.

3-1 Adequate space must be designated specifically for the advanced dental education program in orthodontics and dentofacial orthopedics. **For each clinic session to which a student/resident is assigned, the program must provide a minimum of one (1) clinic chair per student/resident.**

**Intent**: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.

3-2 Facilities must permit the students/residents to work effectively with trained allied dental personnel.

**Intent**: A program is expected to have auxiliaries available to assist the students/residents so the program can meet the educational Standards.

Examples of evidence to demonstrate compliance may include:

- Schedule of dental assistants’ assignments

3-3 Radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. Imaging equipment must be available.

3-4 Students/Residents in an orthodontic program must have access to adequate space, equipment, and physical facilities to do research.

**Intent**: Adequate space is necessary to do research, but does not need to be dedicated to orthodontic research.

3-5 Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/residents to achieve the educational goals of the program.

**Intent**: The intent is to ensure the students/residents utilize their time for educational purposes.
3-6 Clinical facilities must be provided within the sponsoring or affiliated institution to fulfill the educational needs of the program.

3-7 Sufficient space must be provided for storage of patient records, models and other related diagnostic materials.

3-8 These records and materials must be readily available to effectively document active treatment progress and immediate as well as long term post-treatment results.

Intent: Students/Residents are expected to have easy access to active, post treatment, and retention records. These records should be complete.

3-9 Digital radiography equipment must be available and accessible to the orthodontic clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.

Intent: High quality radiographic images are essential for orthodontic and dentofacial orthopedic therapy. Three dimensional cone-beam CT images of the dentition, face and TMJs are acceptable if the equipment is convenient.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

Curriculum Approach: Evidence-Based Dentistry (EBD)

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. *(Adopted by the American Association of Orthodontists House of Delegates 05/24/2005)*

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

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

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

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or “searching publication databases and appraisal of the evidence”)
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

The level of discipline-specific instruction in certificate and degree-granting programs must be comparable.
Intent: The intent is to ensure that the student/residents of these programs receive the same educational requirements as set forth in these Standards.

If an institution and/or program enrolls part-time students/residents, the institution must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents
must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis must assure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

4-1 Program Duration: Advanced dental education programs in orthodontics and dentofacial orthopedics must be a minimum of twenty-four (24) months and 3700 scheduled hours in duration.

Examples of evidence to demonstrate compliance may include:

- Class schedules and outlines

4-2 Biomedical Sciences: A graduate of an advanced dental education program in orthodontics must be competent to:

a. Develop treatment plans and diagnosis based on information about normal and abnormal growth and development;
b. Use the concepts gained in embryology and genetics in planning treatment;
c. Include knowledge of anatomy and histology in planning and carrying out treatment; and
d. Apply knowledge about the diagnosis, prevention and treatment of pathology of oral tissues.

Examples of evidence to demonstrate compliance may include:

- Course outlines and case treatment records
- Outcome assessment of clinical performance

4-3 Clinical Sciences:

4-3.1 Orthodontic treatment must be evidence-based. (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.) (Adopted by the American Association of Orthodontists House of Delegates 05/24/2005)

Examples of evidence to demonstrate compliance may include:

Orthodontics and Dentofacial Orthopedics Standards
• orthodontic literature applied to clinical treatment decisions
• integration of current systematic literature reviews with treatment conferences
• ethics applied to patient management

4-3.2 An advanced dental education program in orthodontics and dentofacial orthopedics requires extensive and comprehensive clinical experience, which must be representative of the character of orthodontic problems encountered in private practice.

**Intent**: The intent is to ensure there is diversity in the patient population so that the students/residents will learn to treat a variety of orthodontic problems from the primary to adult dentition.

Examples of evidence to demonstrate compliance may include:

- Case treatment records
- Percentage of each category of patient care

4-3.3 Experience must include treatment of all types of malocclusion, whether in the permanent or transitional dentitions, and should include treatment of the primary dentition when appropriate.

Examples of evidence to demonstrate compliance may include:

- Case treatment records

4-3.4 A graduate of an advanced dental education program in orthodontics must be competent to:

a. Coordinate and document detailed interdisciplinary treatment plans which may include care from other providers, such as restorative dentists and oral and maxillofacial surgeons or other dental specialists;
b. Treat and manage developing dentofacial problems which can be minimized by appropriate timely intervention;
c. Use dentofacial orthopedics in the treatment of patients when appropriate;
d. Treat and manage major dentofacial abnormalities and coordinate care with oral and maxillofacial surgeons and other healthcare providers;

e. Provide all phases of orthodontic treatment including initiation, completion and retention;

f. Treat patients with at least one contemporary orthodontic technique;

**Intent:** It is intended that the program teach one or more methods of comprehensive orthodontic treatment.

g. Manage patients with functional occlusal and temporomandibular disorders;

h. Treat or manage the orthodontic aspects of patients with moderate and advanced periodontal problems;

i. Develop and document treatment plans using sound principles of appliance design and biomechanics;

j. Obtain and create long term files of quality images of patients using techniques of photography, radiology and cephalometrics, including computer techniques when appropriate;

k. Use dental materials knowledgeably in the fabrication and placement of fixed and removable appliances;

l. Develop and maintain a system of long-term treatment records as a foundation for understanding and planning treatment and retention procedures;

m. Practice orthodontics in full compliance with accepted Standards of ethical behavior;

**Intent:** A program may be in compliance with the standard on ethical behavior when ethical behavior is acquired through continuous integration with other courses in the curriculum.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Case treatment records

n. Manage and motivate patients to participate fully with orthodontic treatment procedures; and

o. Study and critically evaluate the literature and other information pertaining to this field.
p. Identify patients with sleep-related breathing disorders/sleep apnea;
q. Identify patients with Craniofacial Anomalies and Cleft Lip and Palate;
r. Treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure; and
s. Treat and effectively manage Class II malocclusions, defined as a bilateral end-on or greater Class II molar or a unilateral full cusp Class II molar, through a non-surgical treatment approach.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Clinical outcomes assessment
- ABO Assessment Tools: Discrepancy Index, Cast-Radiograph Evaluation, Case Management Forms

p. Manage patients with intellectual and developmental disabilities.

4-4 Supporting Curriculum. The orthodontic graduate must have understanding of:

a. Biostatistics;
b. History of Orthodontics and Dentofacial Orthopedics;
c. Jurisprudence;
d. Oral Physiology;
e. Pain and Anxiety Control;
f. Pediatrics;
g. Periodontics;
h. Pharmacology;
i. Preventive Dentistry;
j. Psychological Aspects of Orthodontic and Dentofacial Orthopedic Treatment;
k. Public Health Aspects of Orthodontics and Dentofacial Orthopedics;
l. Speech Pathology and Therapy;
m. Practice Management; and
n. The variety of recognized techniques used in contemporary orthodontic practice.

Examples of evidence to demonstrate compliance may include:
1. Course outlines
STANDARD 5 - ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS

ELIGIBILITY AND SELECTION

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

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

Specific written criteria, policies and procedures must be followed when admitting students/residents.

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

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

Intent: Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant’s past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing 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

Orthodontics and Dentofacial Orthopedics Standards
course equivalency or other measures to demonstrate equal scope and level of knowledge
5-1 A committee of orthodontic faculty members must be responsible for the selection of students/residents for postdoctoral training unless the program is sponsored by a federal service utilizing a centralized student/resident selection process.

Examples of evidence to demonstrate compliance may include:

- Institutional/program policies on eligibility and selection
- Minutes from meetings of committee of orthodontic faculty members

**EVALUATION**

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

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

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

**DUE PROCESS**

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

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

Intent: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a student/resident (for academic or disciplinary reasons). In addition to information on the program, students/residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the students/residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 - RESEARCH

Advanced dental education students/residents must engage in scholarly activity.

6-1 Students/Residents must initiate and complete a research project to include critical review of the literature, development of a hypothesis and the design, statistical analysis and interpretation of data.

Examples of evidence to demonstrate compliance may include:

- List of student/resident scholarly activity
- List of student/resident research projects
- Copies of student/resident research protocol
- List of completed manuscripts that are result of student/resident research
- Copy of completed manuscripts that are result of student/resident research
- Student/Resident manuscripts submitted for publication
- List of published manuscripts
- Papers/manuscripts published by graduates after leaving program
CONSIDERATION OF MATTERS RELATED TO PEDIATRIC DENTISTRY EDUCATION

**Informational Report on Pediatric Dentistry Programs Annual Survey Curriculum Data (p. 1200):** As directed at the Winter 2015 meeting, the PED RC reviewed the aggregate data from the Curriculum Section of the Commission’s Annual Survey for Pediatric Dentistry Programs conducted in August/September 2020.

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

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PEDIATRIC DENTISTRY EDUCATION

The Review Committee on Pediatric Dentistry Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.
Respectfully submitted,

Dr. Joel Berg,
Chair, Review Committee on Pediatric Dentistry Education
REPORT OF THE REVIEW COMMITTEE ON PERIODONTICS EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. James Katancik. Committee Members: Dr. Linda Hatzenbuehler, Dr. Georgia Johnson, Dr. Paul Luepke, Dr. Angela Palaioiologou-Gallis, and Dr. Jaqueline Sobota. Commissioners: Dr. Jeffery Hicks, chair, and Dr. Bruce Rotter, vice-chair, Commission on Dental Accreditation (CODA), ex officio. Staff Members: Ms. Jennifer Snow, manager, Advanced Dental Education; Dr. Sherin Tooks, director; and Mr. Christopher Castaneda, senior project assistant, CODA. The meeting of the Review Committee on Periodontics Education (PERIO RC) was held on January 14, 2021 via a virtual conference meeting.

CONSIDERATION OF MATTERS RELATED TO PERIODONTICS EDUCATION

Informational Report on Periodontics Programs Annual Survey Curriculum Data (p. 1300): The Review Committee on Periodontics Education (PERIO RC) considered the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Section.

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

Progress Report on the 2019 Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Periodontics (p. 1301): The Accreditation Standards for Advanced Dental Education Programs in Periodontics were adopted by the Commission on Dental Accreditation at its January 31, 2013 meeting for implementation January 1, 2014. According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a three-year program will be assessed after six (6) years. In accordance with this policy, the Validity and Reliability Study of the Accreditation Standards for Advanced Dental Education Programs in Periodontics was initiated in Summer/Fall 2019 with the results considered at the Winter 2020 meeting of the Commission.

In Winter 2020, the Periodontics Review Committee (PERIO RC) conducted an initial review of the validity and reliability study report and concluded that further study of the survey data was warranted. The PERIO RC believed the six (6) members of the PERIO RC should further study the report and identify Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the members of the PERIO RC to further study the findings of the Periodontics Validity and Reliability Study and identify Accreditation Standards, if any, which warrant revision, with a report to the PERIO RC and Commission in Summer 2020. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee to consider standards revisions for Periodontics be directed to submit an update report in Winter 2021 rather than Summer 2020.
The Ad Hoc Committee conducted its meetings on September 24, 2020 and November 13, 2020 and prepared a comprehensive Standards document reflecting proposed revisions as a result of the validity and reliability study, as well as the review of the instances of “Should” within the Accreditation Standards (Appendix 1, Policy Report p. 1301).

At its Winter 2021 meeting, the PERIO RC considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics submitted by the Ad Hoc Committee. Following discussion, and review of the reorganization of numbered Standards containing “should” statements to “intent” statements, the PERIO RC affirmed the proposed revisions as found in Appendix 1.

In summary, the PERIO RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics found in Appendix 1 be circulated to the communities of interest for review and comment, with Hearings conducted at the March 2021 American Dental Education Association and October 2021 American Dental Association meetings, with comments reviewed at the Commission’s Winter 2022 meetings.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics, found in Appendix 1, to the communities of interest for review and comment, with Hearings conducted at the March 2021 American Dental Education Association and October 2021 American Dental Association annual meetings, with comments reviewed at the Commission’s Winter 2022 meetings.

**Consideration of the Use of the Term “Should” Within the Accreditation Standards (p. 1302):** At its Summer 2019 meeting, the Commission directed the revision or addition, as applicable, of the definition of “Should,” as noted below, 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. The revised definition of “Should” within the Definition of Terms, is as follows: *Should: Indicates a method to achieve the standard; highly desirable, but not mandatory.*

At is Winter 2020 meeting, the Review Committee on Periodontics Education (PERIO RC) concluded and the Commission concurred that, because of the amount of data provided in the validity and reliability report, and to ensure a thorough review of the instances of “Should,” it would be beneficial to combine this exercise with the validity and reliability study review with a report submitted for consideration at the Summer 2020 meeting of the PERIO RC and Commission. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee to consider standards revisions for Periodontics be directed to submit an update report in Winter 2021 rather than Summer 2020. The Ad Hoc Committee conducted its meetings on September 24, 2020 and November 13, 2020 and prepared a comprehensive
Standards document reflecting proposed revisions as a result of its charges (Appendix 1, Policy Report p. 1301).

At its Winter 2021 meeting, the PERIO RC considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics submitted by the Ad Hoc Committee. Following discussion, and review of the reorganization of numbered Standards containing “should” statements to “intent” statements, the PERIO RC affirmed the proposed revisions as found in Appendix 1.

In summary, the PERIO RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Periodontics found in Appendix 1 be circulated to the communities of interest for review and comment, with Hearings conducted at the March 2021 American Dental Education Association and October 2021 American Dental Association meetings, with comments reviewed at the Commission’s Winter 2022 meetings.

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

**CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE**

Matters related to more than one review committee are included in a separate report.

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PERIODONTICS EDUCATION**

The Review Committee on Periodontics Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

Matters related to accreditation status of programs are included in a separate report.

Respectfully submitted,

Dr. James Katancik
Chair, Review Committee on Periodontics Education
Commission on Dental Accreditation

Standards Following Validity and Reliability Study

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Periodontics
Accreditation Standards for
Advanced Dental Education Programs
in Periodontics

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-4653
www.ada.org/coda
## Document Revision History

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<tr>
<td>August 10, 2012</td>
<td>Revised Mission Statement</td>
<td>Adopted and Implemented</td>
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<tr>
<td>January 31, 2013</td>
<td>Revision to Policy on Accreditation of Off Campus Sites</td>
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<td>January 31, 2013</td>
<td>Revision to Standard 5, Eligibility and Selection</td>
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<td>Accreditation Standards for Advanced Specialty Education Programs in Periodontics</td>
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<td>August 9, 2013</td>
<td>Revised Policy on Accreditation of Off-Campus Sites</td>
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<td>Revised Instructions for Completing Self Study</td>
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<td>Revised Accreditation Status Definitions</td>
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Periodontics Standards
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Accreditation Standards for Advanced Dental Education
Programs in Periodontics
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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 That Are Fully Operational:
Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

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

Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

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

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

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

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

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.
Reaffirmed: 8/18; 8/13; Adopted: 8/11

Periodontics Standards
-10-
Preface

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

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

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

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate advanced dental education programs in each discipline for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all disciplines of advanced dental education, institutions and programs. Each discipline develops discipline-specific standards for educational programs in its discipline. The general and discipline-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for
the educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular discipline.

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

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

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

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Periodontics Accreditation Standards

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

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

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

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

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

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

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

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

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

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

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

- **Board Certified Periodontist:** A periodontist who has satisfied all requirements of the certification process of the American Board of Periodontology (ABP), has been declared Board Certified by the Directors of the ABP, and maintains Board certification. This individual is a Diplomate of the ABP.

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

- **Sponsoring institution:** primary responsibility for advanced dental education programs.

- **Affiliated institution:** support responsibility for advanced dental education programs.

- **Advanced dental education student/resident:** a student/resident enrolled in an accredited advanced dental education program.

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

- **A certificate program:** a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

- **Student/Resident:** The individual enrolled in an accredited advanced dental education program.

- **Resident:** The individual enrolled in an accredited advanced dental education program in oral and maxillofacial surgery.

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

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

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

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

Periodontics Standards
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

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

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

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

Ethics and Professionalism

1-1 Graduates must receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

The institution/program must have a formal system of quality assurance for programs that provide patient care.

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the program director must have the authority, responsibility and privileges necessary to manage the program.
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

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

1-2 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-3 The following items must be covered in such inter-institutional agreements:

   a. Designation of a single program director;
   b. Teaching staff and means for calibration where competency assessments occur;
   c. Availability and adequacy of staff;
   d. Student/Resident oversight and responsibility;
   e. The educational objectives of the program;
   f. The period of assignment of students/residents; and
   g. Each institution’s financial commitment.

Intent: The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

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

Intent: The director of an advanced dental education program is to be certified by nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

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

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

2-1 The program director should be an experienced educator in periodontics and should be a full-time faculty member with a primary commitment to periodontics.

2-2 The program director must have primary responsibility for the organization and execution of the educational and administrative components of the program. The director must devote sufficient time to the program to include the following:
a. Utilize a faculty that can offer a diverse educational experience in biomedical, behavioral and clinical sciences;
b. Promote cooperation between periodontics, general dentistry, related dental specialties and other health sciences;
c. Select students/residents qualified to undertake training in periodontics unless the program is sponsored by a federal service utilizing a centralized student/resident selection process;
d. Develop and implement the curriculum plan;
e. Evaluate and document student/resident and faculty performance;
f. Document educational and patient care records as well as records of student/resident attendance and participation in didactic and clinical programs; and
g. Responsibility for the quality and continuity of patient care.

Intent: The program director should be an experienced educator in periodontics and should be a full-time faculty member with a primary commitment to periodontics.

2-32 The program director must prepare graduates to seek certification by the American Board of Periodontology.

a. The program director must track Board Certification of program graduates.

2-43 A combination of full-time and part-time faculty is most desirable. The number and time commitment of faculty must be sufficient to provide didactic and administrative continuity. Part-time faculty should contribute to the didactic as well as the clinical component of the program.

2-54 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

2-65 Faculty must be assigned for all clinical sessions and immediately available for consultation with students/residents and patients. There must be direct supervision by periodontists of students/residents who are performing periodontal and dental implant related surgical procedures.

2-76 Faculty must take responsibility for patient care and actively participate in the development of treatment plans and evaluation of all phases of treatment provided by students/residents.
Faculty must be formally evaluated at least annually by the program director to determine their effectiveness in the educational program.

In addition to their regular responsibilities in the program, full-time faculty must have adequate time to develop and foster advances in their own education and capabilities in order to ensure their constant improvement as clinical periodontists, teachers and/or researchers.

**Intent:** The program director and faculty should demonstrate their continued pursuit of new knowledge in periodontics and related fields.

The program director and faculty must actively participate in the assessment of the outcomes of the educational program.
STANDARD 3 - FACILITIES AND RESOURCES

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

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

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

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

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

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

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

Intent: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.
The use of private office facilities as a means of providing clinical experiences in advanced
dental education is only approved when the discipline has included language that defines the use
of such facilities in its discipline-specific standards.

3-1 Adequate clinical and radiographic facilities must be readily available in
order to meet the objectives of the program. State-of-the-art imaging
resources should be accessible to the student/resident. There must be a
sufficient number of operatories to efficiently accommodate the number of
students/residents enrolled. One operatory should be available to each
student/resident during clinic assignments.

Intent: State-of-the-art imaging resources should be accessible to the
student/resident. One operatory should be available to each student/resident
during clinic assignments. Hospital facilities should be available to enhance the
clinical program. Facilities should be available to support research.

3-2 Hospital facilities should be available to enhance the clinical program.

3-3 Facilities should be available to support research.

3-42 Clinical photography is essential for case documentation. Students/Residents
must have clinical photographic equipment available.

3-53 The institution must provide audiovisual and reproduction capabilities for
student/resident seminars.

3-64 Students/Residents must have ready access to dental and biomedical libraries
containing equipment for retrieval and duplication of information.

3-75 Adequate support personnel must be assigned to the program to ensure
chairside and technical assistance.

3-8 Intent: Dental hygiene support should be available for the clinical program.
Adequate facilities should be provided for this activity.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

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

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

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

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or “searching publication databases and appraisal of the evidence”)
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

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

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

If an institution or program enrolls part-time students/residents, the institution must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis must assure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.
4-1 The goal of the curriculum is to allow the student/resident to attain skills representative of a clinician competent in the theoretical and practical aspects of periodontics. The program duration must be three consecutive academic years with a minimum of 30 months of instruction. At least two consecutive years of clinical education must take place in a single educational setting.

BIOMEDICAL SCIENCES

4-2 Although students/residents entering postdoctoral programs will have taken biomedical science courses in their predoctoral dental curriculum, this material must be updated and reviewed in the program at an advanced level. Education in the biomedical sciences must provide the scientific basis needed to understand and carry out the diagnostic and therapeutic skills within the scope of periodontics.

4-3 Formal instruction in the biomedical sciences must enable students/residents to achieve the following competencies:

a. Identification of patients at risk for periodontal diseases and use of suitable preventive and/or interceptive treatments;

b. Diagnosis and treatment of patients with periodontal diseases and related conditions according to scientific principles and knowledge of current concepts of etiology, pathogenesis, and patient management; and

c. Critical evaluation of the scientific literature.

4-4 Formal instruction must be provided to achieve in-depth knowledge in each of the following areas:

a. Gross, surgical and ultrastructural anatomy;

b. Microbiology with emphasis on periodontal diseases;

c. Inflammatory mechanisms and wound healing with emphasis on periodontal diseases;

d. Infectious processes in oral and periodontal diseases;

e. Immunology with emphasis on oral and periodontal diseases;

f. Oral pathology;

g. Etiology, pathogenesis, histopathology, and natural history of periodontal diseases;

h. Epidemiology, including risk assessment, of periodontal diseases;

i. Genetics, epigenetics and the concepts of molecular biology as they relate to oral and periodontal diseases;

j. Biostatistics, research design and methods; and
k. Behavioral sciences especially as they affect patient behavior modification
and communication skills with patients and health professionals.

Intent: Various methods may be used for providing biomedical science instruction,
such as traditional course presentations, seminars, self-instructional module systems
and rotations through hospital, clinical and research departments. It is recognized
that the approach to be utilized will depend on the availability of teaching resources
and the educational policies of the individual school and/or department.

CLINICAL SCIENCES

4-5 The educational program must provide training to the level of competency for the
student/resident to:

a. Collect, organize, analyze and interpret data;
b. Interpret conventional and three-dimensional images as they relate to
periodontal and dental implant therapy;
c. Formulate diagnoses and prognoses;
d. Develop a comprehensive treatment plan;
e. Understand and discuss a rationale for the indicated therapy;
f. Evaluate critically the results of therapy;
g. Communicate effectively to patients the nature of their periodontal health
status, risk factors and treatment needs;
h. Communicate effectively with dental and other health care professionals,
interpret their advice and integrate this information into the treatment of
the patient;
i. Integrate the current concepts of other dental disciplines into
periodontics;
j. Organize, develop, implement and evaluate a periodontal maintenance
program;
k. Utilize allied dental personnel effectively; and
l. Integrate infection control into clinical practice.

4-6 Each student/resident must: (a) treat a variety of patients with different
periodontal diseases and conditions as currently defined by The American
Academy of Periodontology; and (b) complete an adequate number of
documented moderate to severe periodontitis cases to achieve competency

4-7 The program must maintain an ongoing record of the number and variety of
clinical experiences accomplished by each student/resident must be maintained.
This must include periodontal diagnosis, disease severity, periodontal treatment, as well as patient's age, gender and health status.

4-8 The educational program must provide clinical training for the student/resident to the level of competency. This must include, but is not limited to, the following treatment methods for health, comfort, function and esthetics:

a. Nonsurgical management of periodontal diseases, including:
   1. Biofilm control;
   2. Mechanical scaling and root planing therapy;
   3. Local and systemic adjunctive therapy; and
   4. Occlusal therapy.

b. Surgical management of periodontal diseases and conditions, including:
   1. Resective surgery, including gingivoplasty, gingivectomy, periodontal flap procedures, osteoplasty, ostectomy, and tooth/root resection;
   2. Regenerative and reparative surgery including osseous grafting, guided tissue regeneration, the use of biologics, and utilization of tissue substitutes, where appropriate; and
   3. Periodontal plastic and esthetic surgery techniques including gingival augmentation, root coverage procedures and crown lengthening surgery.

   Intent: The emphasis of surgical training should be periodontal surgical procedures.

c. Tooth extraction in the course of periodontal and implant therapy.

4-9 The educational program must provide didactic instruction and clinical training in oral medicine and periodontal medicine.

4-9.1 In depth didactic instruction must include the following:
   a. Aspects of medicine and pathology related to the etiology, pathogenesis, diagnosis and management of periodontal diseases and other conditions in the oral cavity;
   b. Mechanisms, interactions and effects of drugs used in the prevention, diagnosis and treatment of periodontal and other oral diseases;
   c. Mechanisms, interactions and effects of therapeutic agents used in the management of systemic diseases that may influence the progression of periodontal diseases or the management of patients with periodontal diseases;
   d. Principles of periodontal medicine to include the interrelationships of periodontal status and overall health; and
- Clinical and laboratory assessment of patients with specific instruction in:
  1. Physical evaluation;
  2. Laboratory evaluation;

4-9.2 Clinical training to the level of competency must include the following:

a. Periodontal treatment of medically compromised patients;

b. Management of patients with periodontal diseases and interrelated systemic diseases or conditions; and

c. Management of non-plaque related periodontal diseases and disorders of the periodontium.

4-10 The educational program must provide didactic instruction and clinical training in dental implants, as defined in each of the following areas:

4-10.1 In depth didactic instruction in dental implants must include the following:

a. The biological basis for dental implant therapy and principles of implant biomaterials and bioengineering;

b. The prosthetic aspects of dental implant therapy;

c. The examination, diagnosis and treatment planning for the use of dental implant therapy;

d. Implant site development;

e. The surgical placement of dental implants;

f. The evaluation and management of peri-implant tissues and the management of implant complications;

g. Management of peri-implant diseases; and

h. The maintenance of dental implants.

4-10.2 Clinical training in dental implant therapy to the level of competency must include:

a. Implant site development to include hard and soft tissue preservation and reconstruction, including ridge augmentation and sinus floor elevation;

b. Surgical placement of implants; and

c. Management of peri-implant tissues in health and disease.
d. Provisionalization of dental implants.

Intent: To provide clinical training that incorporates a collaborative team approach to dental implant therapy, enhances soft tissue esthetics and facilitates immediate or early loading protocols. This treatment should be provided in consultation with the individuals who will assume responsibility for completion of the restorative therapy.

4-11 The educational program must provide training for the student/resident in the methods of pain control and sedation to achieve:

a. In-depth knowledge in all areas of minimal, moderate and deep sedation as prescribed by the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*; and

b. Clinical training to the level of competency in adult minimal enteral and moderate parenteral sedation as prescribed by the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*.

Intent: To follow the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* regarding all aspects of training in minimal enteral and moderate parenteral sedation including didactic instruction, health status assessment, monitoring, airway management, emergency care, and number of required cases. The ADA Guidelines were developed and approved by the ADA Council on Dental Education and Licensure and adopted by the ADA House of Delegates.

4-12 The educational program must provide instruction in the following interdisciplinary areas:

a. The management of orofacial pain to a level of understanding;

b. Orthodontic procedures in conjunction with periodontal therapy to a level of understanding;

c. Surgical exposure of teeth for orthodontic purposes, to a level of understanding;

d. Management of endodontic-periodontal lesions to a level of understanding; treatment should be provided in consultation with the individuals who will assume the responsibility for the completion of the case or supervision of endodontics therapy; and

Intent: Treatment should be provided in consultation with the individuals who will assume the responsibility for the completion of the case or supervision of endodontics therapy.
e. The management of patients with disabilities to a level of understanding.

4-13 The educational program must provide instruction to the level of understanding in the management of a periodontal practice.

4-13.1 The use of private office facilities not affiliated with a university as a means of providing clinical experiences in advanced dental education is not approved. However, visiting private offices to view office design and practice management techniques is encouraged.

4-14 Students/residents must have training and experience in teaching of periodontology, which should include interaction with dental students, residents and/or dental hygiene students. The teaching curriculum must not exceed 10% of the total program time.

*Intent: Training and experience in teaching of periodontology should include interaction with dental students, residents, and/or dental hygiene students.*
STANDARD 5 - ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS
ELIGIBILITY AND SELECTION

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

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

Specific written criteria, policies and procedures must be followed when admitting students/residents.

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

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

Intent: Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant’s past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing 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
EVALUATION

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

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

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

5-1 Written criteria for evaluating the quality of a student’s/resident’s performance must be used. These criteria must be shared with appropriate staff and students/residents.

5-1.1 A record of each student’s/resident’s clinical and didactic activities must be maintained and reviewed as part of each student’s/resident’s evaluation.

5-1.2 Evaluation results must be provided to students/residents in writing.

5-1.3 Documentation of evaluation meetings with students/residents, along with records of students’/residents’ activities, and formal evaluations of students/residents must be kept in a permanent file.

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

**RIGHTS AND RESPONSIBILITIES**

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

Intent: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a student/resident (for academic or disciplinary reasons). In addition to information on the program, students/residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the students/residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 - RESEARCH

Advanced dental education students/residents must engage in scholarly activity.

6-1 Graduates of periodontal training programs must possess a general understanding of the theory and methods of performing research.

6-1.1 Postdoctoral students/residents must be given the opportunity to participate in research.
CONSIDERATION OF MATTERS RELATED TO PROSTHODONTICS EDUCATION

Informational Report on Prosthodontics Programs Annual Survey Curriculum Data (p. 1400): As directed at the Winter 2015 meeting, the PROS RC reviewed the aggregate data from the Curriculum Section of the Commission’s Annual Survey for Prosthodontics Programs conducted in August/September 2020.

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

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

Matters related to more than one review committee are included in a separate report.

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF PROSTHODONTICS EDUCATION

The Review Committee on Prosthodontics Education considered site visitor appointments for 2021-2022. The Committee’s recommendations on the appointments of individuals are included in a separate report.

CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS

Matters related to accreditation status of programs are included in a separate report.
Respectfully submitted,

Dr. John Agar,
Chair, Review Committee on Prosthodontics Education
INFORMATIONAL REPORT ON REVIEW COMMITTEE AND COMMISSION MEETING DATES

**Background:** Below is the meeting schedule for all Review Committees and the Commission through summer 2023. Review Committees meet at least two (2) weeks prior to the Commission meeting.

### REVIEW COMMITTEE AND COMMISSION MEETING DATES

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<td>Feb. 3 10:00 a.m.</td>
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<td>Aug. 5 8:30 a.m.</td>
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*Closed CODA Strategic Plan Mega Issue Discussion on August 4, 2021.

**2022 and 2023 meeting dates are tentative, pending final room availability.

**Informational Report on Review Committee and Commission Meeting Dates (p. 1500) (All Review Committees):** All 14 review committees of the Commission reviewed meeting dates with no further comment.

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

Prepared by: Dr. Sherin Tooks
REMINDER OF PROFESSIONAL CONDUCT POLICY AND PROHIBITION AGAINST HARASSMENT

**Background**: Members of the Commission, as well as members of the Commission’s committees, are reminded that the Commission supports the American Dental Association’s policy on professional conduct and prohibition against harassment (Appendix 1, Policy Report p. 1501).

**Reminder of Professional Conduct Policy and Prohibition Against Harassment (p. 1501) (All Review Committees)**: All 14 review committees of the Commission reviewed the Reminder of Professional Conduct Policy and Prohibition Against Harassment, with no further comment.

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

Prepared by: Dr. Sherin Tooks
CONSIDERATION OF RESOLUTIONS ADOPTED BY THE ADA HOUSE OF DELEGATES AND THE ADA BOARD OF TRUSTEES RELATED TO THE COMMISSION ON DENTAL ACCREDITATION AND DENTAL EDUCATION

**Background:** The American Dental Association’s (ADA) House of Delegates met October 15-19, 2020 virtually in Chicago, Illinois. Several of the resolutions adopted by the House of Delegates are related to education, accreditation and the Commission on Dental Accreditation (CODA). A summary of those resolutions is provided in Appendix 1, Policy Report p. 1502. Some of the resolutions are considered informational in nature; others may require action.

The ADA’s Board of Trustees met on April 3-6, 2020 and June 12-13, 2020 virtually in Chicago, Illinois. The Board of Trustees adopted resolutions pertaining to the Commission on Dental Accreditation (CODA). A summary of those resolutions is provided in Appendix 2, Policy Report p. 1502. Some of the resolutions are considered informational in nature; others may require action.

**Consideration of Resolutions Adopted by the ADA House of Delegates and the ADA Board of Trustees Related to the Commission on Dental Accreditation and Dental Education (p. 1502) (All Review Committees):** All 14 review committees of the Commission considered the resolutions adopted by the ADA House of Delegates and ADA Board of Trustees, noting the specific resolutions related to the Commission on Dental Accreditation. There were no comments received from any review committee.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
REPORT OF THE STANDING COMMITTEE ON FINANCE

Background: The Commission on Dental Accreditation (CODA) established a Standing Committee on Finance to assist the Chair in planning the Commission’s annual budget. The Finance Committee’s charge is to monitor, review and make recommendations to the Commission concerning the annual budget, provide administrative oversight of the administrative fund, and review and make recommendations regarding the Intercompany Memorandum of Understanding and Services Agreement.

January 20, 2021 Finance Committee Meeting: The Standing Committee on Finance conducted a virtual meeting on Wednesday, January 20, 2021. The following members of the Standing Committee were present for the meeting: Dr. John Agar, Dr. Victor Badner, Dr. Kevin Haubrick, Dr. Sanjay Mallya, Mr. Charles McClemens, Dr. Bruce Rotter (Committee Chair, and CODA Vice Chair), Dr. Marybeth Shafer and Dr. Alan Stein. Dr. Jeffery Hicks, chair, CODA, ex-officio, was also in attendance. Dr. Sherin Took, director, CODA, Ms. Dawn Herman, Mr. Gregg Marquardt, Ms. Kirsten Nadler, Ms. Michelle Smith, Ms. Jennifer Snow, Ms. Peggy Soeldner, managers, CODA, were in attendance. Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, Mr. Naveed Mughal, manager, Financial Services, Education and Professional Affairs, ADA, and Dr. Anthony Ziebert, senior vice president, Education and Professional Affairs, ADA, were in attendance.

Review of the Finance Committee’s Charge, History, and Background of CODA Funding and Fees: In preparation for the meeting, the Standing Committee on Finance reviewed the materials developed by staff. The Standing Committee initiated its meeting with a review of the charge to the Committee and the History and Background of CODA Funding and Fees (Appendix 1). The Committee also reviewed the American Dental Association’s 2022 budget preparation schedule, noting that the Commission will begin its 2022 budget planning in March 2021.

The Committee noted that in 2014 and 2015 substantial annual fee increases were applied to CODA-accredited programs, resulting in CODA’s move toward complete fiscal responsibility. In 2014, CODA also implemented a policy to double an accredited program’s annual fee in the year in which a program’s regular site visit is scheduled. As a result of fee increases, CODA has achieved complete fiscal responsibility for the accreditation program such that CODA has covered its total expenses, both direct and indirect, since 2015. While year-end actuals have not been finalized, it is expected that CODA will also cover its total (direct and indirect/shared services) expenses for the prior budget year, 2020.

The Standing Committee also considered additional fees that might be charged to programs and reviewed the Commission’s current policies on fees, including international consultation fees. A discussion of annual fees, international consultation fees, the shared services agreement, and Commission fee-related policies is provided elsewhere in this report.
Review of CODA Administrative Fund (Administrative Fund): The Finance Committee reviewed the Balance Sheet and Disbursement Tracking Sheet of the Commission’s Administrative Fund (Appendix 2). The Committee discussed the history of the Administrative Fund, noting that in Fall 2014 the ADA Board of Trustees removed the monetary cap on the Commission’s Administrative Fund (formerly called the CODA Research and Development Fund) and granted CODA administrative oversight of the Fund, with an annual informational report to the Board. Most recently, in Winter 2020, at the suggestion of the ADA-CODA Relationship Workgroup, the Commission converted the Research and Development Fund to an Administrative Fund, and notified the ADA Board of Trustees. In April 2020, the ADA Board of Trustees notified the Commission that it had placed a cap of $300,000 on CODA’s Administrative Fund. In August 2020, the Commission requested information on the decision-making process and rationale that led to the cap, but has yet to receive this information from the ADA.

Since 2015, the Commission has collected annual administrative fees at the rate of $35 per accredited program. In Winter 2020 the Commission directed that the Administrative Fund fee be increased in 2021 from $35 to $100 per program; subsequently, at its Summer 2020 meeting, the Commission directed that the 2021 Administrative Fund fee be waived.

The Committee noted that two (2) requests for Administrative Fund disbursements were approved in 2016. The total cost of both disbursements was $34,551, which was $8,449 less than the approved amount of $43,000. The Committee noted that no research and development funds were expended in 2020, since the Commission’s planned Summer 2020 Mega Issue Discussion on Educational Activity Sites, which was to be supported through the Fund, was canceled due to the COVID-19 pandemic. The Committee also noted that in Summer 2020, the Commission approved use of administrative funds to support a facilitator and any additional expenses related to the Commission’s development of a 2022-2026 Strategic Plan.

Further, as the Commission moves forward with its current and future strategic plan, the Administrative Fund may be used to support enhancements to business resources, human resources and technology resources, as needed, in various aspects of the CODA accreditation program. The Committee noted that the Commission’s continued development of an electronic accreditation tool may necessitate future use of funds to enhance and maintain the electronic accreditation tool. The Finance Committee will consider requests for future disbursement, as requested, and make recommendations to the Commission related to the Administrative Fund.

The Finance Committee concluded its discussion noting that the Commission’s Standing Committee on Quality Assurance and Strategic Planning (QASP) had met in preparation for the Winter 2021 CODA meeting. It was learned that QASP planned to submit recommendations to the Commission that CODA inform both the ADA-CODA Workgroup and ADA President of CODA’s concerns related to the cap placed on the Administrative Fund, and to request review and discussion by the ADA-CODA Workgroup to affect meaningful dialogue related to the terms of the Fund, including but not limited to negotiation of a greater cap. The Finance
Committee believed this was an excellent approach and supported QASP in these recommendations.

The Finance Committee also considered the Administrative Fund in relation to the Commission’s report entitled “Timeline (Long-Term Plan) to Assume Total Expenses,” noted below.

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the recommendations of the Standing Committee on Quality Assurance and Strategic Planning, to engage in communication with the ADA President and ADA-CODA Workgroup, to affect meaningful dialogue related to CODA’s Administrative Fund and the cap imposed by the ADA, noting the support of the Commission’s Standing Committee on Finance in furthering the dialogue with the ADA.

**Review of Shared Services (Indirect Expenses):** The Standing Committee noted that in Winter 2015 the Commission directed that shared services (indirect expenses) be calculated based on actual expenses, on an annual basis, prospectively within the Commission’s budget beginning in 2015. The Finance Committee reviewed the shared service data for 2014 through 2019 found in the Shared Services Cost Allocation Reports (*Appendix 3*). The Committee noted that the shared services for 2019, the last fiscal year for which data is available, resulted in a cost allocation of $697,091 to the Commission, which was $49,658 less than the prior year, and $96,782 less than the 2018 shared services allocation.

In October 2018, the Commission and ADA entered into a Shared Services Agreement which set forth the understanding between the two (2) agencies regarding their working relationship and certain services performed by the ADA as requested by the Commission. Within the Agreement, the initial costs for a particular year are based on a percentage of the ADA’s actual overhead expenses for the immediate preceding year, subject to adjustments at the end of the year for ADA’s actual overhead expenses and CODA shared cost factors for the year. Under the Shared Services Agreement, the ADA and CODA are to meet at the end of each year to review and approve the actual calculations to ensure they are a complete and accurate report on the general shared services costs.

The Committee noted that the Shared Services Agreement was extended for a period of two (2) calendar years, and expired on January 1, 2020. The Committee noted that in July 2020 and again following the Commission’s Summer 2020 meeting, letters were sent to the ADA expressing CODA’s concerns with the Administrative Fund cap and the language in the Shared Services Agreement related to the Administrative Fund cap (*Appendix 4, Commission Members Only*). The Commission did not receive a response from the ADA related to CODA’s communications.

While a formalized shared services agreement is preferred and considered a best practice, the Finance Committee noted that the spirit of the agreement remains functional since shared services continue to be tracked and reported by the ADA Accounting Department. The Finance
Committee believed that the shared services agreement could be revisited following further discussion between the Commission and ADA on the Administrative Fund cap.

**Finance Committee Recommendation:** This report is informational in nature and no action is required.

**Consideration of Ongoing Business and CODA Directives:**

**Timeline (Long-Term Plan) to Assume Total Expenses and Authority to Determine and Manage Annual Operating Budget:** As noted above (see sections on Review of Administrative Fund and Review of Shared Services), the Standing Committee on Finance discussed that the Commission has assumed all expenses (direct and indirect) since 2015. Since that time, the Commission has also received information related to the Shared Services for which it reimburses the American Dental Association for services provided to the Commission. In order to assume complete fiscal responsibility, in accordance with the Commission’s Strategic Plan Goal 2-Objective 2 action items, the Commission has engaged in a Shared Services Agreement with the ADA and maintained an Administrative Fund to support projects and other initiatives that may not have been budgeted for a specific year. The Finance Committee also noted that in Summer 2017, the Commission postponed its request to obtain sole authority to set and administer its annual budget, in accordance with Strategic Plan Goal 2-Objective 2 action items, until the year 2020. In Winter 2020, the Commission on Dental Accreditation direct a delay for two (2) years, until 2022, of its plan to obtain sole authority to set and administer its annual operating budget. Given the April 2020 ADA Board of Trustees action to place a cap on the Administrative Fund, and since the ADA-CODA Shared Services Agreement expired on January 1, 2020, the Standing Committee believed that CODA should review and discuss its goals related to assuming authority to determine and manage its annual operating budget at the time that it conducts its 2022-2026 strategic planning activities in Summer 2021.

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation direct consideration of the Commission’s goals related to assuming authority to determine and manage its annual operating budget at the time that it conducts its 2022-2026 strategic planning activities in Summer 2021.

**Consideration of CODA Proposed 2022 Operating Budget and Fees:** The Standing Committee discussed the CODA fees and the proposed 2022 CODA budget. The Committee considered current fees, trends in the number of accredited programs, trends in the CODA budget, 2022 CODA Budget Notes, 2011-2022 Expenses and Revenue of the Commission, 2019-2021 Annual Fees and Application Fees, and the International Consultation and Accreditation (PACV) Fees (Appendix 5). The Finance Committee also considered the potential budgetary impact related to scenarios of a 0% and 2% annual fee increase. The Finance Committee noted that the Commission’s 2021 fees reflected no (0%) fee increase over 2020.

**Annual Fees and Application Fees:** The Finance Committee noted that the ADA’s contribution to CODA has decreased over the years, with CODA covering 100% of its total expenses (direct and indirect) from 2015 to the present, based upon the current shared services model and
CODA’s fee structure. Although the Commission is an agency of the ADA, the Commission has a robust conflict of interest policy that prevents the ADA from undue influence on accreditation decisions and accreditation policies.

The Finance Committee discussed CODA fees, including the potential negative impact that substantial increases in annual fees and other accreditation fees could have on accredited programs. The Committee noted that annual fees were significantly increased in 2014 and 2015; further, in 2014 the Commission directed that program annual fees be doubled in the year of a regular site visit. With the increase in annual fees, application fees, and other fees in 2014 and 2015, the Finance Committee noted that the Commission has assumed all of its total expenses (direct and indirect) since 2015.

The Commission has attempted to maintain reasonable accreditation fees for programs while assuming complete fiscal responsibility toward its total (direct and indirect) expenses. The Finance Committee noted that the 2021 fees were increased 0% beyond 2020 fees. The Finance Committee continues to monitor annual fees to account for inflation and potential increase in travel expenses, along with other needs the Commission may have regarding its strategic plan initiatives, technology, communication, and resources to administer the accreditation program and to maintain a balanced budget.

Following discussion of annual fees and application fees, the Committee determined that there will be no (0%) fee increase in 2022, which will result in projected revenue covering 154% of its direct expenses and 122% of its total (direct and indirect) expenses. The Committee believed that the 2022 Annual Fees should be retained as prescribed in 2020 and 2021, since the Commission is likely to cover all expenses without the increase in annual fees. Therefore, the annual fees will be as follows: $8,210 for predoctoral dental education programs, $2,050 for dental assisting, dental hygiene, dental therapy, and advanced dental education programs, and $1,460 for dental laboratory technology programs. Additionally, the Committee affirmed the directive of the Commission that in the year a program is due for a regular accreditation site visit, the annual fee should be doubled.

The Finance Committee believed that in 2022 the application fees of 2021 should also be retained as follows: $67,400 for predoctoral dental education programs and $16,850 for allied and advanced education programs.

The proposed 2022 Annual Fee and Application Fee schedule is found in Appendix 6.

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation:

- Adopt a 0% increase in annual fees for all disciplines in 2022; $8,210 for predoctoral dental education programs, $2,050 for dental assisting, dental hygiene, dental therapy, and advanced dental education programs, and $1,460 for dental laboratory technology programs.
• Affirm that during the year a program is due for a regular accreditation site visit, the annual fee will be doubled.
• Maintain the application fees of $67,400 for predoctoral dental education programs and $16,850 for allied and advanced education programs.

**International Fees (For CODA Accreditation Process):** The Committee considered the application fee, annual accreditation fee, site visit fee, and site visit administration fee for international predoctoral dental education programs. Similar to its decision for U.S.-based programs, the Committee believed that the 2022 application fee for international programs should be retained at $76,660 with no (0%) fee increase, and the annual fee should be retained at $19,283 with no (0%) fee increase. The Committee also affirmed the Commission’s policy that international programs pay all site visit expenses (actual expenses) for all site visits during the application and regular site visit schedule and that international programs pay an administrative fee of 25% of the total site visit cost for coordination of each site visit.

As the Commission’s international accreditation program develops, the Commission will establish data benchmarks on the time and resources that are needed by CODA to support the international process, which will be helpful to the Finance Committee as it considers the need for future fee increases.

The proposed 2022 International Predoctoral Dental Education Program Annual Fee and Application Fee schedule is found in Appendix 6.

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation:
• Maintain the international predoctoral dental education application fee of $76,660 in 2022.
• Maintain the international predoctoral dental education annual accreditation fee of $19,283 in 2022.
• Affirm that in 2022 international predoctoral dental education programs pay all site visit expenses (actual expenses) for all site visits during the application and regular site visit schedule.
• Affirm that in 2022 international predoctoral dental education programs pay an administrative fee of 25% of the total site visit cost for coordination of each site visit.
• Maintain the International Consulting Fee (outside of PACV process) of $5,000.
• Affirm that all international fees must be paid in U.S. Dollars.

**Other Accreditation Fees:** The Committee also discussed additional fees that may be assessed to programs, including the Administrative Fund fee, special focused site visit administrative fee, the HIPAA policy violation fee, and the email/contact distribution fee. The proposed 2022 Fee Schedule for other accreditation fees is found in Appendix 6.
The Committee recommended that in 2022 the Commission maintain the fees of 2021 for the special focused site visit administrative fee, the HIPAA policy violation fee, and the email/contact distribution fee. The Committee also recommended that the Commission amend its Administrative Fund fee, and assess a fee of $25 per program in the year 2022.

**Finance Committee Recommendations:** It is recommended that the Commission on Dental Accreditation:

- Maintain the Special Focused Site Visit Administrative Fee of $5,000.
- Maintain the CODA Fee for Non-Compliance with CODA Policy on HIPAA of $4,000 per program per submission.
- Maintain the Email/Contact Distribution List Fee of a $200 minimum.
- Assess the CODA Administrative Fund fee of $25 per program in 2022.

*International Fees (For International Consultation and Accreditation PACV Process):* The Finance Committee discussed the Preliminary Accreditation and Consultation Visit (PACV) international consultation and accreditation fees. The Finance Committee concluded that the current PACV international consultation and accreditation fees should be maintained (*Appendix 7*).

**Finance Committee Recommendation:** It is recommended that the Commission on Dental Accreditation maintain the current PACV International Consultation and Accreditation Fees (*Appendix 7*).

**Commission Policies Related to Fees:** The Standing Committee on Finance reviewed the Commission’s policies related to fees (*Appendix 8*), noting that no changes are warranted at this time.

**Finance Committee Recommendation:** This report is informational in nature and no action is required.

**Commission Recommendations:**

Prepared by: Dr. Sherin Tooks
History and Background of CODA Funding and Fees

Until 1995, the ADA provided full financial support for accreditation activities. This support linked to ADA’s decision to initiate an accreditation program in 1938 and its goal of ensuring the long-term viability of the profession through support for quality dental education.

Accreditation fees were first charged in 1995, according to the formula recommended by Resolution B-71-1993. In 1996, the Board directed that the ADA support 65% of accreditation expenses; this required a 50% increase in accreditation fees in 1997. Since that time, CODA has made recommendations regarding its budget, including fees, to the Board of Trustees and House of Delegates following ADA’s standard budget process. Each year, there has been pressure through the budgeting process for CODA to increase revenues and/or reduce expenses to support a greater proportion of accreditation expenses.

In 1999, CODA added a separate fee for new program applications for accreditation and additional fees for programs with multiple sites. CODA’s ratio of revenue to expenses increased from approximately 35% to near 50% in 1999 and has been 50% or greater since 2000. Accordingly, CODA revenue has covered at least 50% of direct expenses, and the ADA has covered the remainder of direct expenses and all indirect expenses.

In 2003, CODA adopted a policy of maintaining this balance and implementing regular, annual, cost-of-living fee increases. In addition, in some years, CODA has implemented greater fee increases to fund special projects, such as development of site-visit consultant training materials.

In 2008, the Commission began considering requests for accreditation from international predoctoral dental education programs. Revenues and expenses for the international program are handled in a separate cost center from the main CODA budget.

In 2009, the ADA Monitoring Committee and the Commission agreed to form a Joint Workgroup on CODA Structure and Finances to conduct an in-depth study and analysis of issues related to CODA Task Force Recommendations 1-3:

- 1-CODA should restructure to better meet the current and future needs of the dental profession and the public. (Structure)
- 2-CODA should conduct a comprehensive investigation of appropriate structures. This investigation should build on and extend the work of the Task Force. (Structure)
- 3-CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure. (Structure)

The Joint Workgroup first evaluated the Commission structure, and then the Joint Workgroup evaluated the financial implications. In regards to CODA finances, historically both ADA and
CODA have discussed potential policy relating to the proportion of CODA expenses that should be supported by the ADA. However, such policy has never been adopted due to the limitation of the annual operating budget approval process. ADA’s current budget format reflects only revenues and direct expenses. There is currently no reliable or documented process for determining and allocating indirect support provided by ADA. Workgroup members concurred that ADA has traditionally valued education and will likely need to support approximately half the cost of accreditation to maintain a strong educational system for the profession. Accordingly, in response to CODA Task Force Recommendation #3, the Joint Workgroup recommended a funding model with a goal of CODA assuming responsibility for 50% of total expenses, including both direct and indirect expenses. At the time of this analysis, it was determined that to achieve a 50-50% split in expenses, program fees would have to increase at a rate of 7.2% per year for six years, a rate approximately 3% higher than CODA’s anticipated annual cost-of-living increases. This recommendation was also based on the accepted ADA indirect cost rate of 37.5%, which is currently being re-evaluated by the ADA. It is anticipated though, that the ADA indirect cost rate will not be significantly different than the current 37.5%. At the 2010 ADA Annual Session, the House of Delegates endorsed the 50-50% split with the Commission for expenses, achieved through a 7.2% increase in annual fees per year for six years.

In 2011, the Commission increased the annual fees and the application fees for 2012 by 5.75%. As the Commission and the ADA budgets are now zero-based, and as the number of site visits for 2012 was anticipated to increase only very slightly compared to 2011, the expenses for site visits in 2012 was anticipated to be comparable to 2011. In 2011, accreditation fees and application fees were higher than projected, while expenses were significantly lower than expected. The reason for lower expenses was three-fold: a decrease in the number of RC’s holding in-house meetings; a decrease in staff travel to ADEA, ASPA, and CDAC meetings; and a decrease in the cost of site visitor travel. For 2011, the CODA-ADA expense ratio was 53%-47%. Future increases in annual fees may vary from the originally proposed 7.2% increase per year due to the zero-based budgeting system now in place and the fact that the 7.2% amount should be viewed only as an estimate based on available data and assumptions at the time of the original analysis.

The Commission was concerned that the increased annual fee may have an adverse financial impact some educational programs, especially those housed in community colleges. The Commission determined that a way to off-set this increased rate of dues increase for the programs would be to extend the site visit schedule from seven to eight years. There are additional expenses associated with a site visit that must be borne by the educational program, including costs associated with production of the self-study document; the hiring of outside consultants; and cosmetic facilities improvements. Over time, an eight year cycle would lower these expenses. In addition, there would be a modest cost savings to the Commission itself, as the expense of site visitor airfare, housing, and meals incurred during the actual site visit are borne by the Commission. The extension of the site visit schedule would be in conjunction with
the development of procedures for interim monitoring of educational programs. The Commission’s Standing Committee on Quality Assurance will review this topic in association with the Commission’s Mission and Vision.

In Winter 2012, the Commission increased the annual fees and the application fees for 2013 by 4% in order to more closely align the CODA-ADA expense ratio to 50%-50%. The Commission also initiated an administrative fee of $1,250 to be charged to programs that undergo a special-focused site visit, with immediate implementation. At its June 2012 meeting, the Board of Trustees preliminarily approved an ADA budget that called for the Commission to generate an additional $72,000 in revenue for 2013, which represented an additional increase of 4% beyond the increase approved by the Commission in Winter 2012. At the Summer 2012 meeting, the Commission approved the additional 4% increase to the annual fees and application fees, resulting in a total increase of 8% for 2013.

In Winter 2013, the Commission noted that in 2010, the American Dental Association House of Delegates endorsed a 50-50% split with the Commission expenses, achieved through a 7.2% increase in annual fees per year for six years. At its meeting, the Commission directed that the 2014 Annual Fees be increased to $6,000 for predoctoral programs; $1,500 for dental assisting, dental hygiene and oral and maxillofacial surgery programs; $1,050 for dental laboratory technology programs; and $1,000 for all advanced education programs except oral and maxillofacial surgery. The Commission also directed a policy be implemented in 2014 to double annual fees in the year in which a program’s regular accreditation site visit is scheduled. The Commission directed an increase in application fees for 2014 to $50,000 for predoctoral programs and $15,000 for all other programs. The Commission also directed an increase in the administrative fee for special focused site visits to $4000, effective immediately. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2014 it would assume responsibility for approximately 95% of its direct expenses and 69% of its total expenses.

In Winter 2014, the Commission reviewed its annual budget history, noting the 2010 ADA House of Delegates endorsement of a 50-50% split with CODA on the Commission’s expenses over a six year period. The Commission has for the past several years increased its fees to assume greater fiscal responsibility. To that end, the Commission directed that the 2015 annual fees be $6,480 for predoctoral programs, $1,620 for dental assisting, dental hygiene, and all advanced education programs, and $1,140 for dental laboratory technology programs. Additionally, there would be a doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were maintained at $50,000 for predoctoral program applications and $15,000 for all other dental program applications, and special focused site visit administrative fees were maintained at $4000. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2015 it would assume responsibility for approximately 114% of its direct expenses and 88% of
its total expenses. The Commission also developed an international fee schedule as follows: $50,000 application fee to international programs applying for Commission accreditation; the international program must pay all site visit expenses (actual expenses) for all site visits during the application process and regular site visit schedule; a 25% administrative fee on the total site visit cost to the program for coordination of each site visit; a $10,000 annual accreditation fee in 2015 for international programs; and the international program must pay the Commission in U.S. dollars. The Commission approved a policy on criteria and operational guidelines for the administration and use of the Research and Development Fund. The Commission directed that revenue and expenses of international activity be recorded as a separate program activity center, including feedback from international programs, for review at future Finance Committee and Commission meetings. The Commission directed that staff investigate other potential revenue sources for the Commission with further discussion in 2015.

In Winter 2015, the Commission reviewed its annual budget noting that for the past several years it had increased fees to assume greater fiscal responsibility. In 2010 ADA House of Delegates endorsement of a 50-50% split with CODA on the Commission’s expenses over a six year period. The Commission adopted a 4% increase in the 2016 annual fees as follows: $6,740 for predoctoral programs, $15,000 for predoctoral international programs, $1,685 for dental assisting, dental hygiene, and all advanced education programs, and $1,186 for dental laboratory technology programs. Additionally, there would be a doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were increased to $60,000 for predoctoral program applications, $65,000 for predoctoral international program applications, and maintained at $15,000 for all other dental program applications, and special focused site visit administrative fees were maintained at $4000. With regard to international predoctoral programs, the Commission required that international programs pay all site visit expenses (actual expenses) for all site visits during the application process and regular site visit schedule, a 25% administrative fee on the total site visit cost to the program for coordination of each site visit, and the international program must pay the Commission in advance in U.S. dollars. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2016 it would assume responsibility for approximately 116% of its direct expenses and 91% of its total expenses. The Commission also directed that shared services (indirect expenses) be calculated based on actual expenses, on an annual basis, prospectively within the Commission’s budget beginning in 2015.

In Winter 2016, the Commission reviewed its annual budget noting that it had assumed greater fiscal responsibility over the past several years. The Commission adopted a 4% increase in the 2017 annual fees as follows: $7,010 for predoctoral dental education programs, $15,600 for predoctoral international programs, $1,750 for dental assisting, dental hygiene, dental therapy, and advanced dental education programs, and $1,235 for dental laboratory technology programs. Additionally, there would be a doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were increased to $62,400 for predoctoral
program applications, $67,600 for predoctoral international program applications, and maintained at $15,600 for all other dental program applications, and special focused site visit administrative fees were maintained at $4000. The Commission also maintained all of its policies related to fees associated with accreditation of international predoctoral programs. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2017 it would assume responsibility for approximately 116% of its direct expenses and 91% of its total expenses. The Commission also directed that shared services (indirect expenses) be calculated based on actual expenses, on an annual basis, prospectively within the Commission’s budget beginning in 2015. In Summer 2016, the Commission reviewed CODA’s actual 2015 revenue and expense based on final year-end calculations. The Committee identified that CODA covered 128% of its direct expenses and 100%, less $4,887, of its total (direct and indirect) expenses in 2015.

In Winter 2017, the Commission reviewed its annual budget. Since 2015 the Commission has assumed total responsibility for its direct and indirect expenses. The Commission adopted an 8% increase in the 2018 annual fees as follows: $7,580 for predoctoral dental education programs, $16,850 for predoctoral international programs, $1,890 for dental assisting, dental hygiene, dental therapy, and advanced dental education programs, and $1,340 for dental laboratory technology programs. Additionally, there would be a doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were also increased by 8% to $67,400 for predoctoral program applications, $73,010 for predoctoral international program applications, and $16,850 for all other dental program applications. The special focused site visit administrative fees was increased to $4320. The Commission also maintained all of its policies related to fees associated with accreditation of international predoctoral programs. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2018 it would assume responsibility for approximately 139% of its direct expenses and 112% of its total expenses. Noting the Commission prior directive that shared services (indirect expenses) be calculated based on actual expenses, on an annual basis, prospectively within the Commission’s budget beginning in 2015, in summer 2017, the Commission reviewed CODA’s actual 2016 revenue and expense based on final year-end calculations. The Committee identified that CODA covered 134% of its direct expenses and 106% of its total (direct and indirect) expenses in 2016.

In Winter 2018, the Commission reviewed its annual budget. The Commission adopted a 4% increase in the 2019 annual fees as follows: $7,890 for predoctoral dental education programs, $17,530 for predoctoral international programs, $1,970 for dental assisting, dental hygiene, dental therapy, and advanced dental education programs, and $1,400 for dental laboratory technology programs. Additionally, there would be a doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were maintained at $67,400 for predoctoral program applications, $73,010 for predoctoral international program applications, and $16,850 for all other dental program applications. The special focused site visit
administrative fee was maintained at $4,320. As a result of ongoing submission of material prohibited by the Commission’s policies and procedures for privacy and data security, the Commission increased its penalty fee from $1000 to $4000, effective immediately. The Commission also updated all of its policies related to fees. With the approved increase in annual fees, application fees, and other fees assessed by the Commission, the Commission noted that in 2019 it would assume responsibility for approximately 145% of its direct expenses and 113% of its total expenses. Since 2015 the Commission has assumed total responsibility for its direct and indirect expenses. Noting the Commission prior directive that shared services (indirect expenses) be calculated based on actual expenses, on an annual basis, prospectively within the Commission’s budget beginning in 2015, in summer 2018, the Commission reviewed CODA’s actual 2017 revenue and expense based on final year-end calculations. The Committee identified that CODA covered 132% of its direct expenses and 105% of its total (direct and indirect) expenses in 2017.

In Winter 2019, the Commission reviewed its annual budget. The Commission adopted a 4% increase in the 2020 annual fees as follows: $8,210 for predoctoral dental education programs, $2,050 for dental assisting, dental hygiene, dental therapy, and advanced dental education programs, and $1,460 for dental laboratory technology programs. Additionally, the Commission affirmed doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were maintained at $67,400 for predoctoral program applications and $16,850 for allied and advanced dental program applications. The international predoctoral application fee was increased by 5% to $76,660 in 2020. The special focused site visit administrative fee was increased to $5,000. The Commission’s administrative fee related to the policies and procedures for privacy and data security was maintained at $4000. The Commission also updated its policies related to fees, as applicable. The Commission noted that in 2020 it would assume responsibility for approximately 147% of its direct expenses and 115% of its total expenses based upon the adopted budget. Since 2015 the Commission has assumed total responsibility for its direct and indirect expenses. Noting the Commission prior directive that shared services (indirect expenses) be calculated based on actual expenses, on an annual basis, prospectively within the Commission’s budget beginning in 2015, in summer 2019, the Commission reviewed CODA’s actual 2018 revenue and expense based on final year-end calculations. The Committee identified that CODA covered 162% of its direct expenses and 124% of its total (direct and indirect) expenses in 2018. The Shared Services allocation for 2018 year-end reflected a reduction in final 2018 shared services expenses from $793,873 to $746,749 (a reduction of $47,124).

In Winter 2020, the Commission reviewed its annual budget. The Commission adopted a 0% increase in the 2021 annual fees. Therefore, the fees remained as they were in 2020 (noted above). The Commission affirmed doubling of the annual fee during the year a program is due for a regular accreditation site visit. Application fees were maintained as dictated for 2020 (noted above). Fees were maintained at $76,660 for international predoctoral program applications and $19,283 for international predoctoral program annual fees. The Commission
affirmed its policies related to additional fees for international predoctoral programs. The Commission also maintained its special focused site visit administrative fee, administrative fee related to CODA’s Policy on HIPAA, and email/contact distribution fee. The Commission eliminated the fee for electronic conversion of paper documents, noting all programs must provide CODA with an electronic copy of the program’s report. The Research and Development Fund was renamed to the CODA Administrative Fund, with revision of the CODA policy on the fund, and with an increase in the annual administrative fee from $35 to $100 per program. Subsequently, at its Summer 2020 meeting, the Commission waived the Administrative Fund for 2020, due to the COVID-19 pandemic. The Commission also refunded programs the doubled annual fee if the program’s site visit did not occur in 2020 as a result of the COVID-19 pandemic. The Commission also updated its policies related to fees, as applicable. The Commission noted that in 2021 it would assume responsibility for approximately 150% of its direct expenses and 117% of its total (direct and indirect) expenses based upon the adopted budget. Since 2015 the Commission has assumed total responsibility for its direct and indirect expenses. In summer 2020, the Commission reviewed CODA’s actual 2019 revenue and expense based on final year-end calculations. The Committee identified that CODA covered 164% of its direct expenses and 127% of its total (direct and indirect) expenses in 2019. In Winter 2020, the Commission notified the American Dental Association Board of Trustees of its modification to the CODA Administrative Fund (formerly CODA Research and Development Fund), and subsequently in Summer 2020 communicated with the Board of Trustees about its concern related to the Board’s cap placed on the CODA Administrative Fund. Additionally, in Summer 2020, the Commission notified the ADA of its agreement with the revisions to the Shared Services Agreement, which expired on January 1, 2020, with the exception of the language that imposed a cap on CODA’s Administrative Fund.
CODA ADMINISTRATIVE FUND

K. POLICY ON CODA ADMINISTRATIVE FUND

In 2020, the Commission on Dental Accreditation approved the reclassification of its Research and Development Fund (R&D Fund) to an Administrative Fund.

The Commission on Dental Accreditation Administrative Fund may include but is not limited to the following uses:

- Commission studies and activities related to quality assurance and strategic planning
- Conduct of business through newly formed ad hoc or sub-committees not previously budgeted; engagement of site visitors to gain unique expertise or to provide training
- Ongoing review and enhancement of business resources, human resources, and technology resources in various aspects of the CODA accreditation program
- Expenses related to Shared Services Agreement with the American Dental Association not previously budgeted
- Other business purposes as applicable to the work of the Commission on Dental Accreditation

Criteria Guideline for Distribution of Funds:

1. Funds $5,000 or less: Funds in this category are classified as discretionary funds that may be used by the CODA Director. A maximum of $5,000 per use is permissible, with a requirement for immediate reporting on the use of the funds, via email, to the Finance Committee for informational purposes. The discretionary funds do not require a formal request by a CODA committee, nor do they require prior approval for use by the Finance Committee or Commission.

2. Funds between $5,001 and $20,000: Projects which require this level of funding must be reviewed and approved by the Finance Committee prior to use. Approval by the Commission is not required.

3. Funds greater than $20,000: Projects which require funding in excess of $20,000 must be submitted for review and approval by the Commission upon recommendation of the Finance Committee.

All Funding Disbursements:

- The Finance Committee and Commission will review a full accounting of the Administrative Fund and uses of the fund at each finance committee and Commission meeting.
- Fund allocations requiring approval by the Finance Committee or the Commission require formal requests/proposals from the Commission’s review committees or standing committees; disbursement of funds within the Director’s discretionary allocation do not require formalized requests.

Adopted: 2/20
### Administrative Fund Balance Sheet (2014-2020, and projection for 2021)

#### Administrative Fund Flow Statement (2014-present)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Opening Balance</th>
<th>Assessments collected *</th>
<th>Misc.</th>
<th>REF</th>
<th>Operational Expenses</th>
<th>Net activity for the year</th>
<th>Ending Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>-</td>
<td>37,082</td>
<td></td>
<td></td>
<td></td>
<td>37,082</td>
<td>37,082</td>
</tr>
<tr>
<td>2015</td>
<td>37,082</td>
<td>51,225</td>
<td></td>
<td></td>
<td></td>
<td>51,225</td>
<td>88,307</td>
</tr>
<tr>
<td>2016</td>
<td>88,306</td>
<td>50,540</td>
<td></td>
<td></td>
<td>(34,551)</td>
<td>15,989</td>
<td>104,295</td>
</tr>
<tr>
<td>2017</td>
<td>104,295</td>
<td>50,715</td>
<td></td>
<td></td>
<td></td>
<td>50,715</td>
<td>155,010</td>
</tr>
<tr>
<td>2018</td>
<td>155,010</td>
<td>50,150</td>
<td>500</td>
<td>2</td>
<td></td>
<td>50,650</td>
<td>205,660</td>
</tr>
<tr>
<td>2019</td>
<td>205,660</td>
<td>49,980</td>
<td></td>
<td></td>
<td></td>
<td>49,980</td>
<td>255,640</td>
</tr>
<tr>
<td>2020</td>
<td>255,640</td>
<td>49,630</td>
<td></td>
<td></td>
<td>(34,000)</td>
<td>3</td>
<td>271,270</td>
</tr>
<tr>
<td>2021</td>
<td>305,270</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td>(34,000)</td>
<td>271,270</td>
</tr>
</tbody>
</table>

*No of Programs, Assessment Fee/program, Collected amount

Ref 1
- **Travel** $ (24,853)
- **Consulting** $ (9,698)
**Total** $ (34,551)

Ref 2
- **Honoraria - Dr. Sherin Tooks Milken Institute School of Public Health**
  - $15,000 consultant
  - $14,000 for extra day at CODA meeting for Mega Issue on Strategic Plan
  **Total 34,000**

Notes:
- In April 2020, the ADA Board of Trustees issued a $300,000 cap on CODA’s Administrative Fund.
- In Summer 2020, CODA directed that the $100 per program administrative fund be waived in 2021.
**Administrative Fund Disbursement Tracking Sheet**

In 2020, the Commission on Dental Accreditation approved the reclassification of its Research and Development Fund (R&D Fund) to an Administrative Fund.

The Commission on Dental Accreditation Administrative Fund may include but is not limited to the following uses:

- Commission studies and activities related to quality assurance and strategic planning
- Conduct of business through newly formed ad hoc or sub-committees not previously budgeted; engagement of site visitors to gain unique expertise or to provide training
- Ongoing review and enhancement of business resources, human resources, and technology resources in various aspects of the CODA accreditation program
- Expenses related to Shared Services Agreement with the American Dental Association not previously budgeted
- Other business purposes as applicable to the work of the Commission on Dental Accreditation

Criteria Guideline for Distribution of Funds:

1. **Funds $5,000 or less:** Funds in this category are classified as discretionary funds that may be used by the CODA Director. A maximum of $5,000 per use is permissible, with a requirement for immediate reporting on the use of the funds, via email, to the Finance Committee for informational purposes. The discretionary funds do not require a formal request by a CODA committee, nor do they require prior approval for use by the Finance Committee or Commission.

2. **Funds between $5,001 and $20,000:** Projects which require this level of funding must be reviewed and approved by the Finance Committee prior to use. Approval by the Commission is not required.

3. **Funds greater than $20,000:** Projects which require funding in excess of $20,000 must be submitted for review and approval by the Commission upon recommendation of the Finance Committee.

All Funding Disbursements:

- The Finance Committee and Commission will review a full accounting of the Administrative Fund and uses of the fund at each finance committee and Commission meeting.
- Fund allocations requiring approval by the Finance Committee or the Commission require formal requests/proposals from the Commission’s review committees or standing committees; disbursement of funds within the Director’s discretionary allocation do not require formalized requests.
<table>
<thead>
<tr>
<th>Requestor</th>
<th>Description of Request</th>
<th>Amount of Request</th>
<th>Date of Request</th>
<th>Approval &amp; Disbursement Dates</th>
<th>Outcome of Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>QASP</td>
<td>Activities Related to Development of Strategic Plan for 2017-2021 (Expenses of facilitator and QASP member travel to conduct strategic planning session)</td>
<td>Up to $25,000</td>
<td>April 2016 Mail Ballot to Finance Committee; April/May 2016 Mail Ballot to CODA</td>
<td>CODA Mail Ballot approved 5/2/16; Disbursement is ongoing to cover facilitator and QASP member travel</td>
<td>Development of CODA 2017-2021 Strategic Plan</td>
</tr>
<tr>
<td>CODA Directed Activity</td>
<td>Activities related to conduct of December 2016 Dental Therapy Site Visitor Training</td>
<td>Up to $18,000</td>
<td>November 2016 Mail Ballot to Finance Committee</td>
<td>Finance Committee Mail Ballot approved 11/10/16; Disbursement will follow the December 13-14, 2016 training to cover cost of site visitor travel and food and beverage expenses for two-day workshop</td>
<td>Training of 13 dental therapy site visitors</td>
</tr>
<tr>
<td>CODA Directed Activity</td>
<td>Activities Related to Development of Strategic Plan for 2022-2026 (Expenses of facilitator and travel to conduct Mega Issue in Summer 2021)</td>
<td>Not specified</td>
<td>QASP Report to CODA, Summer 2020 CODA meeting</td>
<td>Summer 2020 CODA meeting, TBD disbursement as needed</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Shared Services (Indirect Expenses)

<table>
<thead>
<tr>
<th>Departmental cost</th>
<th>Amount Allocated</th>
<th>% age of Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>$73,031</td>
<td>10%</td>
</tr>
<tr>
<td>Conference Services</td>
<td>$30,599</td>
<td>4%</td>
</tr>
<tr>
<td>Communications</td>
<td>$62,743</td>
<td>8%</td>
</tr>
<tr>
<td>Finance and Operations</td>
<td>$95,736</td>
<td>13%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>$320,963</td>
<td>43%</td>
</tr>
<tr>
<td>Legal</td>
<td>$126,165</td>
<td>17%</td>
</tr>
<tr>
<td>HQ Building Square Footage **</td>
<td>$45,474</td>
<td>6%</td>
</tr>
<tr>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Total Shared Services Pool</td>
<td><strong>$754,711</strong></td>
<td>**</td>
</tr>
</tbody>
</table>

HC Amount per FTE for the area
SF Based on a dollar per square foot occupied

**

Square footage for 19th floor is 13,263 (Stacking plan attached)
CODA occupies approximately 20% which equals

\[0.2 \times 13,263 = 2,653 \text{ SF}\]

19th Floor CODA
13263 2653
## American Dental Association

### 2015 Shared Services Cost Allocation - CODA

<table>
<thead>
<tr>
<th>Departmental cost</th>
<th>Amount Allocated</th>
<th>% age of Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>$62,242</td>
<td>8%</td>
</tr>
<tr>
<td>Conference Services</td>
<td>$28,712</td>
<td>4%</td>
</tr>
<tr>
<td>Communications</td>
<td>$63,807</td>
<td>9%</td>
</tr>
<tr>
<td>Finance and Operations</td>
<td>$77,404</td>
<td>10%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>$343,583</td>
<td>46%</td>
</tr>
<tr>
<td>Legal</td>
<td>$126,261</td>
<td>17%</td>
</tr>
<tr>
<td>HQ Building Square Footage **</td>
<td>$45,326</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total Shared Services Pool</strong></td>
<td><strong>$747,336</strong></td>
<td></td>
</tr>
</tbody>
</table>

**HC**  Amount per FTE for the area  
**SF**  Based on a dollar per square foot occupied  
**  Square footage for 19th floor is 13,263  
CODA occupies approximately 20% which equals  

\[ 0.2 \times 13,263 = 2,653 \text{ SF} \]

<table>
<thead>
<tr>
<th>19th Floor</th>
<th>CODA</th>
</tr>
</thead>
<tbody>
<tr>
<td>13263</td>
<td>2653</td>
</tr>
</tbody>
</table>
Note: Communications has been removed and HQ Building Square Footage has been adjusted to external market value.

**2017 Note:** The Shared Service Agreement of 2018 represents cost for services based on 2017 actual services rendered, which was estimated at $717,462.00.
## 2018 Shared Services cost as per shared service agreement

<table>
<thead>
<tr>
<th>Departmental cost</th>
<th>Amount Allocated</th>
<th>% age of Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>$54,916</td>
<td>7%</td>
</tr>
<tr>
<td>Conference Services</td>
<td>$109,581</td>
<td>14%</td>
</tr>
<tr>
<td>Finance and Operations</td>
<td>$114,988</td>
<td>14%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>$315,312</td>
<td>40%</td>
</tr>
<tr>
<td>Legal</td>
<td>$121,434</td>
<td>15%</td>
</tr>
<tr>
<td>HQ Building Square Footage **</td>
<td>$77,642</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Total Shared Services Pool</strong></td>
<td><strong>$793,873</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Explanation

#### HC Amount per FTE for the area

#### SF Based on a dollar per square foot occupied

**

Square footage for 19th floor is 13,263
CODA occupies approximately 20% which equals

\[ \frac{0.2 \times 13,263}{1} = 2,653 \text{ SF} \]

<table>
<thead>
<tr>
<th>19th Floor</th>
<th>CODA</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,263</td>
<td>2,653</td>
</tr>
</tbody>
</table>

## 2018 Final Allocations Provided to CODA (June 17, 2019)

<table>
<thead>
<tr>
<th></th>
<th>Per Contract</th>
<th>New Allocation</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR</td>
<td>54,916</td>
<td>55,936</td>
<td>1,020</td>
</tr>
<tr>
<td>CC</td>
<td>109,581</td>
<td>97,458</td>
<td>(12,123)</td>
</tr>
<tr>
<td>Finance</td>
<td>114,988</td>
<td>114,860</td>
<td>(128)</td>
</tr>
<tr>
<td>IT</td>
<td>315,312</td>
<td>285,018</td>
<td>(30,294)</td>
</tr>
<tr>
<td>Legal</td>
<td>121,434</td>
<td>113,899</td>
<td>(7,535)</td>
</tr>
<tr>
<td>Facilities</td>
<td>77,642</td>
<td>79,578</td>
<td>1,936</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>793,873</strong></td>
<td><strong>746,749</strong></td>
<td><strong>(47,124)</strong></td>
</tr>
</tbody>
</table>
American Dental Association

2019 Shared Services cost as per shared service agreement

<table>
<thead>
<tr>
<th>Departmental cost</th>
<th>Amount Allocated</th>
<th>% age of Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>$ 46,157</td>
<td>7%</td>
</tr>
<tr>
<td>Conference Services</td>
<td>$ 100,742</td>
<td>14%</td>
</tr>
<tr>
<td>Finance and Operations</td>
<td>$ 107,562</td>
<td>15%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>$ 254,456</td>
<td>37%</td>
</tr>
<tr>
<td>Legal</td>
<td>$ 106,607</td>
<td>15%</td>
</tr>
<tr>
<td>HQ Building Square Footage **</td>
<td>$ 81,567</td>
<td>12%</td>
</tr>
<tr>
<td>Total Shared Services Pool</td>
<td>$697,091</td>
<td></td>
</tr>
</tbody>
</table>

HC ** Amount per FTE for the area
SF Based on a dollar per square foot occupied

Square footage for 19th floor is 13,263
CODA occupies approximately 20% which equals

0.2 x 13,263 = 2,653 SF

19th Floor CODA
13263 2653
Page Holder for Appendix 4, Commission Members Only

Communications Between CODA and ADA on the Intercompany Memorandum of Understanding and Services Agreement and the CODA Administrative Fund
# Review of Current CODA Fees (All Fees) and Fee Related Policies

## CODA Accreditation Fees for 2019, 2020, and 2021

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2019* Annual Fee</th>
<th>2020* Annual Fee</th>
<th>2021* Annual Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predoctoral (DDS/DMD) U.S. Program</td>
<td>7,890</td>
<td>8,210</td>
<td>8,210</td>
</tr>
<tr>
<td>Predoctoral International Program</td>
<td>17,530</td>
<td>19,283</td>
<td>19,283**</td>
</tr>
<tr>
<td>Dental Public Health Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Endodontic Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral Pathology Program</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral &amp; Max. Radiology Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral &amp; Max. Surgery Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>OMS Clinical Fellowships</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Orthodontic Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Ortho Clinical Fellowships</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Pediatric Dentistry Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Periodontic Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Prosthodontic Programs</td>
<td>1,970</td>
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<td>2,050</td>
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<tr>
<td>Gen. Practice Residency Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Adv. General Dentistry Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral Medicine Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Dental Anesthesiology Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral Facial Pain Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Dental Hygiene Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Dental Assisting Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Dental Lab Tech Programs</td>
<td>1,400</td>
<td>1,460</td>
<td>1,460</td>
</tr>
<tr>
<td>Dental Therapy Programs</td>
<td>1,970</td>
<td>2,050</td>
<td>2,050</td>
</tr>
</tbody>
</table>

**CODA Administrative Fund Fee** (Annual Administrative Fee Per Program)

- $35
- $35
- $100***

## Application Fee

<table>
<thead>
<tr>
<th>Application Fee</th>
<th>2019*</th>
<th>2020*</th>
<th>2021*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied /Advanced Application Fee</td>
<td>16,850</td>
<td>16,850</td>
<td>16,850</td>
</tr>
<tr>
<td>Predoctoral Application Fee</td>
<td>67,400</td>
<td>67,400</td>
<td>67,400</td>
</tr>
<tr>
<td>Predoctoral International Application Fee</td>
<td>73,010</td>
<td>76,660</td>
<td>76,660</td>
</tr>
</tbody>
</table>

**Special Focused Site Visit Administrative Fee**

- 4,320
- 5,000
- 5,000

* Beginning in 2014, during the year of a site visit the annual fee is doubled.
** Predoctoral International Program Fees are noted below, in lieu of doubling of annual fee during the year of a site visit.
***Administrative Fund Fee waived in 2021 (CODA, Summer 2020)
**Additional Fees Assessed by CODA 2014-2021**

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Accreditation Fee</td>
<td>See above</td>
</tr>
<tr>
<td>Application Fee</td>
<td>See above</td>
</tr>
<tr>
<td>Special Focused Site Visit Administrative Fee</td>
<td>$4,000 (2016 &amp; 2017); $4,320 (2018 &amp; 2019); $5,000 (2020 and 2021)</td>
</tr>
<tr>
<td>CODA Penalty for Non-compliance CODA Policy on HIPAA</td>
<td>$1,000 (2017); $4,000 per program per submission (2018, 2019, 2020 &amp; 2021)</td>
</tr>
<tr>
<td>Email/Contact Distribution List Fee</td>
<td>$200 minimum*</td>
</tr>
<tr>
<td>CODA Administrative Fund Fee (Annual Administrative Fee Per Program)</td>
<td>See above - $100 in 2021 (fee waived in 2021) ($25 in 2014; $35 in 2015-2020)</td>
</tr>
</tbody>
</table>

* Program directed to contact CODA for current fee.

**CODA International Accreditation Fees (predoctoral international programs)**

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee (see above)</td>
<td>$65,000 (2016); $67,600 (2017); $73,010 (2018 and 2019); $76,660 (2020 and 2021)</td>
</tr>
<tr>
<td>Annual Accreditation Fee (see above)</td>
<td>$15,000 (2016); $15,600 (2017); $16,850 (2018); $17,530 (2019); $19,283 (2020 and 2021)</td>
</tr>
<tr>
<td>Site Visit Fee (application and regular visit)</td>
<td>International program pays all site visit expenses (actual expenses) for all site visits during the application and regular site visit schedule. (2015, 2016, 2017, 2018, 2019, 2020 and 2021)</td>
</tr>
<tr>
<td>Site Visit Administrative Fee</td>
<td>International program pays an administrative fee of 25% of the total site visit cost for coordination of each site visit. (2015, 2016, 2017 2018, 2019, 2020 and 2021)</td>
</tr>
<tr>
<td>International Consultation</td>
<td>$5,000 consultation fee in 2018, 2019, 2020 and 2021 (outside of PACV process) and all expenses associated with the consultation visit ($10,000 in 2015, 2016 &amp; 2017)</td>
</tr>
</tbody>
</table>

* All international fees must be paid in advance in U.S. Dollars.
Note: Additional fees (noted above) also apply to accredited predoctoral international programs.
# TRENDS IN THE NUMBER OF ACCREDITED PROGRAMS*

<table>
<thead>
<tr>
<th>Year</th>
<th>Predoctoral</th>
<th>Advanced Dental</th>
<th>DH</th>
<th>DA</th>
<th>DLT</th>
<th>DTP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>56</td>
<td>708</td>
<td>286</td>
<td>268</td>
<td>20</td>
<td>NA</td>
<td>1,338</td>
</tr>
<tr>
<td>2007</td>
<td>56</td>
<td>713</td>
<td>293</td>
<td>275</td>
<td>20</td>
<td>NA</td>
<td>1,357</td>
</tr>
<tr>
<td>2008</td>
<td>57</td>
<td>723</td>
<td>301</td>
<td>274</td>
<td>20</td>
<td>NA</td>
<td>1,375</td>
</tr>
<tr>
<td>2009</td>
<td>58</td>
<td>726</td>
<td>310</td>
<td>277</td>
<td>20</td>
<td>NA</td>
<td>1,391</td>
</tr>
<tr>
<td>2010</td>
<td>61</td>
<td>721</td>
<td>325</td>
<td>285</td>
<td>20</td>
<td>NA</td>
<td>1,412</td>
</tr>
<tr>
<td>2011</td>
<td>62</td>
<td>748</td>
<td>331</td>
<td>289</td>
<td>20</td>
<td>NA</td>
<td>1,450</td>
</tr>
<tr>
<td>2012</td>
<td>62</td>
<td>739</td>
<td>329</td>
<td>291</td>
<td>20</td>
<td>NA</td>
<td>1,441</td>
</tr>
<tr>
<td>2013</td>
<td>61</td>
<td>739</td>
<td>329</td>
<td>291</td>
<td>20</td>
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<td>1,440</td>
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<tr>
<td>2014</td>
<td>65</td>
<td>763</td>
<td>335</td>
<td>273</td>
<td>19</td>
<td>NA</td>
<td>1,455</td>
</tr>
<tr>
<td>2015</td>
<td>65</td>
<td>770</td>
<td>335</td>
<td>265</td>
<td>17</td>
<td>NA</td>
<td>1,452</td>
</tr>
<tr>
<td>2016</td>
<td>66</td>
<td>776</td>
<td>334</td>
<td>259</td>
<td>17</td>
<td>NA</td>
<td>1,452</td>
</tr>
<tr>
<td>2017</td>
<td>66</td>
<td>773</td>
<td>336</td>
<td>258</td>
<td>16</td>
<td>NA</td>
<td>1,449</td>
</tr>
<tr>
<td>2018</td>
<td>66</td>
<td>767</td>
<td>332</td>
<td>258</td>
<td>14</td>
<td>1</td>
<td>1,438</td>
</tr>
<tr>
<td>2019</td>
<td>66</td>
<td>772</td>
<td>328</td>
<td>252</td>
<td>14</td>
<td>0</td>
<td>1,432</td>
</tr>
<tr>
<td>2020</td>
<td>66</td>
<td>772</td>
<td>328</td>
<td>250</td>
<td>14</td>
<td>1</td>
<td>1,431</td>
</tr>
<tr>
<td>2021</td>
<td>67</td>
<td>771</td>
<td>325</td>
<td>242</td>
<td>14</td>
<td>0</td>
<td>1,419</td>
</tr>
</tbody>
</table>

*Year-End Number of Programs; 2021 is a year start estimate.

*Black font represents actual; Red font represents program numbers used at the time of budget preparation.
# TRENDS IN CODA BUDGET

## Revenue:

1. Accreditation Fees

<table>
<thead>
<tr>
<th>Year</th>
<th>Predoctoral</th>
<th>Advanced Dental</th>
<th>DH</th>
<th>DA</th>
<th>DLT</th>
<th>DTP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>203,840</td>
<td>251,340</td>
<td>211,640</td>
<td>198,320</td>
<td>14,800</td>
<td>NA</td>
<td>879,940</td>
</tr>
<tr>
<td>2007</td>
<td>211,960</td>
<td>263,810</td>
<td>225,610</td>
<td>211,750</td>
<td>15,400</td>
<td>NA</td>
<td>928,530</td>
</tr>
<tr>
<td>2008</td>
<td>224,580</td>
<td>278,355</td>
<td>240,800</td>
<td>219,200</td>
<td>16,000</td>
<td>NA</td>
<td>978,935</td>
</tr>
<tr>
<td>2009</td>
<td>237,800</td>
<td>290,400</td>
<td>257,920</td>
<td>230,464</td>
<td>16,640</td>
<td>NA</td>
<td>1,033,224</td>
</tr>
<tr>
<td>2010</td>
<td>270,165</td>
<td>309,936</td>
<td>295,125</td>
<td>246,525</td>
<td>17,906</td>
<td>NA</td>
<td>1,139,657</td>
</tr>
<tr>
<td>2011</td>
<td>304,000</td>
<td>390,260</td>
<td>322,865</td>
<td>264,435</td>
<td>18,300</td>
<td>NA</td>
<td>1,299,860</td>
</tr>
<tr>
<td>2012</td>
<td>295,058</td>
<td>414,497</td>
<td>339,422</td>
<td>281,688</td>
<td>19,360</td>
<td>NA</td>
<td>1,350,025</td>
</tr>
<tr>
<td>2013</td>
<td>314,150</td>
<td>421,230</td>
<td>345,450</td>
<td>305,550</td>
<td>21,000</td>
<td>NA</td>
<td>1,407,380</td>
</tr>
<tr>
<td>2014*</td>
<td>390,000</td>
<td>763,000</td>
<td>502,500</td>
<td>409,500</td>
<td>19,950</td>
<td>NA</td>
<td>2,084,950</td>
</tr>
<tr>
<td>2015</td>
<td>421,200</td>
<td>1,247,400</td>
<td>542,700</td>
<td>429,300</td>
<td>19,380</td>
<td>NA</td>
<td>2,659,980</td>
</tr>
<tr>
<td>2016</td>
<td>444,840</td>
<td>1,307,560</td>
<td>562,790</td>
<td>436,415</td>
<td>20,162</td>
<td>NA</td>
<td>2,771,767</td>
</tr>
<tr>
<td>2017</td>
<td>462,660</td>
<td>1,352,750</td>
<td>588,000</td>
<td>451,500</td>
<td>19,760</td>
<td>NA</td>
<td>2,874,670</td>
</tr>
<tr>
<td>2018</td>
<td>500,280</td>
<td>1,449,630</td>
<td>627,480</td>
<td>487,620</td>
<td>18,760</td>
<td>1,890</td>
<td>3,085,660</td>
</tr>
<tr>
<td>2019</td>
<td>520,740</td>
<td>1,520,840</td>
<td>646,160</td>
<td>496,440</td>
<td>19,600</td>
<td>-</td>
<td>3,203,780</td>
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<tr>
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<td>541,860</td>
<td>1,582,600</td>
<td>672,400</td>
<td>512,500</td>
<td>20,440</td>
<td>2,050</td>
<td>3,331,850</td>
</tr>
<tr>
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<td>1,580,550</td>
<td>666,250</td>
<td>496,100</td>
<td>20,440</td>
<td>-</td>
<td>3,313,410</td>
</tr>
</tbody>
</table>

*Year 2014 onward, calculation does not include revenue from doubling of the fee in the year of site visit.

*Black font represents actual; Red font represents program numbers used at the time of budget preparation.
2. Initial Accreditation Application and Fees:

<table>
<thead>
<tr>
<th>Year</th>
<th>Budgeted</th>
<th>Actual</th>
<th>Fee</th>
<th>Total Revenue</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>28</td>
<td>$1,500</td>
<td>$42,000</td>
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<td></td>
</tr>
<tr>
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<td>34</td>
<td>$1,500</td>
<td>$51,000</td>
<td>OMR recognized</td>
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</tr>
<tr>
<td>2001</td>
<td>29</td>
<td>$1,500</td>
<td>$43,500</td>
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<td></td>
</tr>
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<td>2002</td>
<td>37</td>
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<td>$83,250</td>
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</tr>
<tr>
<td>2003</td>
<td>17</td>
<td>$2,250</td>
<td>$38,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>26</td>
<td>$2,400</td>
<td>$91,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>18</td>
<td>$2,475</td>
<td>$39,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>18</td>
<td>$2,575</td>
<td>$74,675</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>15</td>
<td>$2,675</td>
<td>$107,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>22</td>
<td>$2,785</td>
<td>$75,195</td>
<td>Anesthesia Accreditation; Oral Medicine Accreditation</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>30</td>
<td>$2,900</td>
<td>$101,500</td>
<td></td>
<td></td>
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<tr>
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<td>30</td>
<td>$4,550</td>
<td>$222,950</td>
<td>Oral Facial Pain Accreditation</td>
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</tr>
<tr>
<td>2011</td>
<td>30</td>
<td>$7,500</td>
<td>$255,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>30</td>
<td>$7,931</td>
<td>$237,930</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>20</td>
<td>$10,000</td>
<td>$150,000</td>
<td>Annualized as of October 2013 Accreditation</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>$50,000</td>
<td>$50,000</td>
<td>Predoc $50,000</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>15</td>
<td>$15,000</td>
<td>$225,000</td>
<td>Allied /Advance Application Fee</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>11</td>
<td>$15,000</td>
<td>$150,000</td>
<td>Allied /Advance Application Fee</td>
<td></td>
</tr>
<tr>
<td>2017</td>
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<td>$60,000</td>
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<td>Allied /Advance Application Fee</td>
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</tr>
<tr>
<td>2018</td>
<td>1</td>
<td>$67,600</td>
<td>$0</td>
<td>Predoc International</td>
<td></td>
</tr>
<tr>
<td>2019*</td>
<td>0</td>
<td>$73,010</td>
<td>$0</td>
<td>Predoc International</td>
<td></td>
</tr>
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<td>2020</td>
<td>1</td>
<td>$67,400</td>
<td>$67,400</td>
<td>Predoc</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>1</td>
<td>$16,850</td>
<td>$252,750</td>
<td>Allied /Advance Application Fee</td>
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</tr>
<tr>
<td>2021*</td>
<td>0</td>
<td>$16,850</td>
<td>$17,950</td>
<td>Allied /Advance Application Fee</td>
<td></td>
</tr>
</tbody>
</table>

3. Service Income-Other:
Includes database email/contact distribution list agreements, fee for non-compliance with CODA’s submission process related to Privacy and Data Security (HIPAA), and administration fee for focused site visits.
Expense:

1. Total Compensation:

- Irregular trend in the compensation is due to a number of vacant positions in 2011, 2012-2013, 2016, 2018-2020.
- For 2012, 15 total positions (7 exempt and 8 non-exempt); however, vacant Manager position and vacant Director position
- For 2013, 14 total positions (6 exempt and 8 non-exempt); however there was one vacant non-exempt position and two non-exempt positions that were staffed by temporary staff
- For 2014, 14 total positions (6 exempt and 8 non-exempt); there is one temporary staff position at this time.
- For 2015, 15 total positions (7 exempt and 8 non-exempt); there was one new hire
- For 2016, 15 total positions (7 exempt and 8 non-exempt)
- For 2017, 15 total positions (7 exempt and 8 non-exempt); one vacant coordinator position
- For 2018, 15 total positions (7 exempt and 8 non-exempt); two vacant manager positions and one vacant support staff position
- For 2019, 15 total positions (7 exempt and 8 non-exempt); two vacant manager positions for the year and one vacant manager position for half of the year
- For 2020, 15 total positions (7 exempt and 8 non-exempt); three vacant manager positions for the year, and one vacant coordinator and one vacant support staff position for half of the year
- For 2021, 15 total positions (7 exempt and 8 non-exempt); one vacant manager position

2. Total Program/Activity:

Variances in actual program/activity are the result of different numbers of programs being site visited each year, as well as different activities in any one year.

- Standing Committees: In-house vs. Conference Calls
- Review Committees: In-house vs. Conference Calls
- Requests for CODA staff attendance at COI meetings
- Ad hoc, sub-committee, and task force meetings, as needed

3. Shared Services (Indirect Expenses):

Services Agreement signed October 2018, expired January 1, 2020. CODA to compensate the ADA for shared services to include costs for human resources, conference services, finance and operations, information technology, legal and facilities. These expenses do not appear as line items in the CODA budget. Total $697,091 for 2020.
2022 CODA Budget Notes

1. Accreditation Site Visit Information:

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2017*</th>
<th>2018*</th>
<th>2019*</th>
<th>2020*</th>
<th>2021*</th>
<th>2022</th>
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<td>6</td>
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<td>9</td>
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<tr>
<td>Predoc IA and interim</td>
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<td>77</td>
<td>59</td>
<td>75</td>
<td>72</td>
<td>68</td>
<td>84</td>
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<tr>
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<td>61</td>
<td>72</td>
<td>73</td>
<td>78</td>
<td>70</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>151</td>
<td>138</td>
<td>157</td>
<td>159</td>
<td>147</td>
<td>157</td>
</tr>
</tbody>
</table>

* 2017, 2018, 2019, 2020, 2021 budgeted; 2022 estimated (additional application visits or off-campus focused site visits may be added/removed as a result of CODA actions).

Notes:
- 2020 – Due to COVID-19, all 2020 visits beginning mid-March 2020 through year-end were canceled
- 2021 – Site visits scheduled for 2020 that were canceled have been rescheduled to 2021
- 2022 – Site visits schedule for 2021 have been rescheduled to 2022, these numbers reflect the rescheduling of visits

2020 vs. 2021 Site Visits

<table>
<thead>
<tr>
<th>Site Visits</th>
<th>2021</th>
<th>2022</th>
<th>Difference</th>
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</thead>
<tbody>
<tr>
<td>Predoc</td>
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<td>9</td>
<td>0</td>
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<tr>
<td>Predoc IA and Interim</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Advanced Education</td>
<td>68</td>
<td>84</td>
<td>+16</td>
</tr>
<tr>
<td>Allied Education</td>
<td>70</td>
<td>64</td>
<td>-6</td>
</tr>
<tr>
<td>Total</td>
<td>147</td>
<td>157</td>
<td>-10</td>
</tr>
</tbody>
</table>

2. Other Budgeted Commission Meeting Expenses in 2022

a) Commission Meetings (2 meetings/year)
b) CODA Standing Committee and Ad Hoc Meetings (3-4 in-house meetings/year)
c) ADEA Annual Session (5 days with 7 CODA Staff)
d) ASPA Meeting (3 days with 1 CODA staff twice/year)
e) CHEA Meeting (5 days with 1 CODA staff every year)
f) CDAC Annual Meeting (3 days with 1 CODA staff every year)
g) CDAC Site Observation (4 days with 1 CODA staff every year)
h) Allied Dental Conference (3 days with 2 CODA staff every year)
i) Review Committee Meetings
   o 20 in-house (2 Predoc; 2 AGDOO; 11 Advanced Education; 2 DA; 2 DH; 1 DLT)
j) Site visitor training for 60-80 new site visitors (2 days)
k) New Commissioner/RC/Appeal Board Member training (Typically 4-8 Commissioner Trainees and Appeal Board for 2 nights; 20-30 Review Committee members for 1 night)
l) International Meetings (1-2 meetings, 4 days each, with 1 CODA Staff)

New 2022 Budget Items for Consideration by Finance Committee:
   a) Strategic planning activities (studies, international travel, etc.)
   b) Other needs based on resources

CONSIDERATIONS FOR 2022 BUDGET

CODA 2022 Budget (National):
   • Revenue is primarily generated by the Commission through Annual Accreditation Fees, Application Fees, and other fees assessed to educational programs. Revenue is primarily based on the number of accredited programs, and number of site visits conducted in a year (doubling annual fee).
   • Expenses are directly related to the cost of conducting the accreditation program. Program activity and travel expenses are increased from 2021 to 2022.
   • Ongoing site visitor training and webinars should be provided.
   • CODA expects to cover all direct costs and end the year with net revenue for direct expenses.

CODA 2022 Budget (International):
   • In January 2014, CODA directed that revenue and expenses be recorded as a separate program activity center related to international accreditation to ensure that CODA’s domestic activities are not compromised by the international activities.
   • The budget has been developed under the assumption that, by 2019, CODA may be accrediting predoctoral dental education programs internationally. In Summer 2019, the first international predoctoral dental education program was accredited by CODA.

CODA 2022 Budget (International PACV):
   • At the ADA 2015 House of Delegates, the House adopted Resolution 53, which sunset the Joint Advisory Committee on International Accreditation (JACIA) and supported CODA’s establishment of a Standing Committee on International Accreditation. In doing so, the operational budget of the JACIA was transferred to the Commission on Dental Accreditation.
   • This budget has been developed based upon assumptions of programs that may be interested in the PACV process for international predoctoral dental education programs.
## 2011-2022 Expenses and Revenue

### 2011-2022 Revenue and Expenses CODA

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Annual Accreditation Fees</td>
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<td>108,000</td>
<td>353,850</td>
<td>262,750</td>
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<td>158,830</td>
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<td>216,476</td>
<td>136,200</td>
<td>136,200</td>
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<td>-</td>
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<td>-</td>
<td>73,010</td>
<td>91,250</td>
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<td>73,010</td>
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<tr>
<td>International PACV</td>
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<td>28,143</td>
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<td>40,312</td>
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<td><strong>Total Revenue</strong></td>
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<td>4,195,707</td>
<td>4,219,296</td>
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<tr>
<td><strong>Expenses</strong></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<td><strong>Direct Expenses</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total Compensation</td>
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<td>1,568,393</td>
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<td>1,683,990</td>
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<td>Total Direct Expenses</td>
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<td>**Indirect Expenses *</td>
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<td>786,398</td>
<td>754,711</td>
<td>747,336</td>
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<td>793,873</td>
<td>697,091</td>
<td>698,486</td>
<td>699,683</td>
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<td>Revenue net of direct expenses</td>
<td>(476,567)</td>
<td>(708,040)</td>
<td>(1,016,050)</td>
<td>(119,508)</td>
<td>759,487</td>
<td>908,430</td>
<td>887,555</td>
<td>1,606,356</td>
<td>1,615,480</td>
<td>1,462,632</td>
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<td>Revenue net of total expenses</td>
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<td>(1,573,323)</td>
<td>(1,802,448)</td>
<td>(1,118,867)</td>
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<td>192,400</td>
<td>170,092</td>
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<td>61%</td>
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<td>124%</td>
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<td>125%</td>
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</tbody>
</table>

### Assumptions For 2022

**Revenue**

1. Increment in Accreditation fee is assumed at 0% over 2021, slight increment is assumed for programs increment.

**Expenses**

1. Compensation is adjusted inline with 2019 actuals

**Indirect Expenses**

1. Percentage of indirect expenses to direct expenses is recalculated, and is decreased from 37.5% to 28% (Actual based) from 2013 to 2017
2. 2018 onward indirect expenses based on ADA/CODA service agreement, and .2% increment thereof.
## ANNUAL FEES AND APPLICATION FEE FOR PROGRAMS

**ACTUAL 2019, 2020 and 2021 Fees and Proposed 2022***

<table>
<thead>
<tr>
<th>Discpline</th>
<th>Annual Fee</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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<td>Predoctoral (DDS/DMD) U.S Programs</td>
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<td>$8,210</td>
<td>$8,210</td>
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<td>Predoctoral (DDS/DMD) International</td>
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<td>$19,283</td>
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<td>Dental Public Health Programs</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontic Programs</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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<tr>
<td>Oral Pathology Program</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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</tr>
<tr>
<td>Oral &amp; Max. Radiology Programs</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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<tr>
<td>Oral &amp; Max. Surgery Programs</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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</tr>
<tr>
<td>OMS Clinical Fellowships</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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<tr>
<td>Orthodontic Programs</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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<td>Orthodontic Clinical Fellowships</td>
<td>$1,970</td>
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<td>$2,050</td>
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<tr>
<td>Pediatric Dentistry Programs</td>
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<td>$2,050</td>
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<tr>
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<tr>
<td>Prosthodontic Programs</td>
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<td>$2,050</td>
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<tr>
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<tr>
<td>Oral Medicine Programs</td>
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</tr>
<tr>
<td>Dental Anesthesiology Programs</td>
<td>$1,970</td>
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<td>$2,050</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Facial Pain Programs</td>
<td>$1,970</td>
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<td>$2,050</td>
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<tr>
<td>Dental Hygiene Programs</td>
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<tr>
<td>Dental Assisting Programs</td>
<td>$1,970</td>
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<tr>
<td>Dental Lab Tech Programs</td>
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<td>$1,460</td>
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</tr>
<tr>
<td>Dental Therapy Programs</td>
<td>$1,970</td>
<td>$2,050</td>
<td>$2,050</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predoctoral (DDS/DMD) Programs</td>
<td>$8,210</td>
<td>$8,380</td>
</tr>
<tr>
<td>Predoctoral (DDS/DMD) International</td>
<td>$19,283</td>
<td>$19,670</td>
</tr>
<tr>
<td>Dental Public Health Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Endodontic Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Oral Pathology Program</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Oral &amp; Max. Radiology Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Oral &amp; Max. Surgery Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>OMS Clinical Fellowships</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Orthodontic Programs</td>
<td>$2,050</td>
<td>$2,100</td>
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<tr>
<td>Orthodontic Clinical Fellowships</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Pediatric Dentistry Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Periodontic Programs</td>
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<td>$2,100</td>
</tr>
<tr>
<td>Prosthodontic Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Gen. Practice Residency Programs</td>
<td>$2,050</td>
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<td>Adv. General Dentistry Programs</td>
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<tr>
<td>Dental Anesthesiology Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Oral Facial Pain Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Dental Hygiene Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Dental Assisting Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
<tr>
<td>Dental Lab Tech Programs</td>
<td>$1,460</td>
<td>$1,490</td>
</tr>
<tr>
<td>Dental Therapy Programs</td>
<td>$2,050</td>
<td>$2,100</td>
</tr>
</tbody>
</table>

| Application Fee (Advance/Allied) | $16,850 | $17,500 | $17,500 |
| Application Fee (Predoc) | $67,400 | $70,000 | $70,000 |
| International Application Fee (Predoc) | $73,010 | $73,010 | $73,010 |

* For 2022 increment rate is proposed at 0% and 2%.
Predoctoral Dental Education International Consultation and Preliminary Accreditation Consultation Visit (PACV) Survey

INTERNATIONAL CONSULTATION AND ACCREDITATION FEES *

1. Payment/Check should be made out to the American Dental Association.
2. Drawn on a U.S. account in U.S. dollars.
3. Send to:
   The Commission on Dental Accreditation
   c/o Dr. Sherin Tooks, CODA Director
   211 E. Chicago Ave., Suite 1900
   Chicago, IL 60611

4. Fee Categories
   a. Application fee for PACV Survey - $10,000.00
   b. Focused Consultation Service:
      a. $12,500.00 Focused Consultation Fee
      b. Actual costs for Focused Consultation Visit, including travel, hotel, meals for 2 volunteers/staff for 7 days; estimated $12,500.00 to $15,000.00
   c. $5,400.00 Administrative Fee per Visit
   c. Preliminary Accreditation Consultation Site Visit (PACV):
      a. $50,000.00 Consultation Fee for submission of PACV self study
      b. Actual costs for Preliminary Accreditation Consultation Site Visit, including travel, hotel, meals for 4 volunteers/staff for 7 days, estimated $25,000.00 to $30,000.00
      c. $5,400.00 Administrative Fee per Visit

International programs undergoing the consultative process must pay upfront for all prepaid cost such as air fare.

5. Actual costs for Accreditation Site Visit, including travel, hotel, meals for 7 volunteers/staff for 7 days, estimated $44,300.00 to $47,000.00
   a. The application fee to the Commission is $73,010 (2018 & 2019); $76,660 (2020 & 2021)
   b. Annual Fees are $17,530 (2019) and $19,283 (2020 & 2021) (once accredited, programs must pay this fee every year)
   c. 25% Administrative Fee on total cost of Visit

* Fees are subject to change each year.
CODA Accreditation Fees for 2020 and 2021, and Proposed 2022

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2020* Annual Fee</th>
<th>2021* Annual Fee</th>
<th>2022* Annual Fee</th>
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</thead>
<tbody>
<tr>
<td>Predoctoral (DDS/DMD) U.S. Program</td>
<td>8,210</td>
<td>8,210</td>
<td>8,210</td>
</tr>
<tr>
<td>Predoctoral International Program</td>
<td>19,283**</td>
<td>19,283**</td>
<td>19,283**</td>
</tr>
<tr>
<td>Dental Public Health Programs</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Endodontic Programs</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral Pathology Program</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral &amp; Max. Radiology Programs</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Oral &amp; Max. Surgery Programs</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>OMS Clinical Fellowships</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Orthodontic Programs</td>
<td>2,050</td>
<td>2,050</td>
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</tr>
<tr>
<td>Ortho Clinical Fellowships</td>
<td>2,050</td>
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</tr>
<tr>
<td>Pediatric Dentistry Programs</td>
<td>2,050</td>
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</tr>
<tr>
<td>Periodontic Programs</td>
<td>2,050</td>
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<td>2,050</td>
</tr>
<tr>
<td>Prosthodontic Programs</td>
<td>2,050</td>
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</tr>
<tr>
<td>Gen. Practice Residency Programs</td>
<td>2,050</td>
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</tr>
<tr>
<td>Adv. General Dentistry Programs</td>
<td>2,050</td>
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<td>2,050</td>
</tr>
<tr>
<td>Oral Medicine Programs</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
<tr>
<td>Dental Anesthesiology Programs</td>
<td>2,050</td>
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<td>2,050</td>
</tr>
<tr>
<td>Oral Facial Pain Programs</td>
<td>2,050</td>
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<td>2,050</td>
</tr>
<tr>
<td>Dental Hygiene Programs</td>
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<tr>
<td>Dental Assisting Programs</td>
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<td>2,050</td>
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<tr>
<td>Dental Lab Tech Programs</td>
<td>1,460</td>
<td>1,460</td>
<td>1,460</td>
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<tr>
<td>Dental Therapy Programs</td>
<td>2,050</td>
<td>2,050</td>
<td>2,050</td>
</tr>
</tbody>
</table>

**CODA Administrative Fund Fee (Annual Administrative Fee Per Program)**

<table>
<thead>
<tr>
<th></th>
<th>2020* Annual Fee</th>
<th>2021* Annual Fee</th>
<th>2022* Annual Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>$35</td>
<td>$100***</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>

**Application Fee**

<table>
<thead>
<tr>
<th></th>
<th>2020* Annual Fee</th>
<th>2021* Annual Fee</th>
<th>2022* Annual Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied/Advanced Application Fee</td>
<td>16,850</td>
<td>16,850</td>
<td>16,850</td>
</tr>
<tr>
<td>Predoctoral Application Fee</td>
<td>67,400</td>
<td>67,400</td>
<td>67,400</td>
</tr>
<tr>
<td>Predoctoral International Application Fee</td>
<td>76,660</td>
<td>76,660</td>
<td>76,660</td>
</tr>
</tbody>
</table>

**Special Focused Site Visit Administrative Fee**

<table>
<thead>
<tr>
<th></th>
<th>2020* Annual Fee</th>
<th>2021* Annual Fee</th>
<th>2022* Annual Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
<td></td>
</tr>
</tbody>
</table>

*Beginning in 2014, during the year of a site visit the annual fee is doubled.

** Predoctoral International Program Fees are noted below, in lieu of doubling of annual fee during the year of a site visit.

***Administrative Fund Fee waived in 2021 (CODA, Summer 2020)
# Proposed 2022 Other Accreditation Fees

## Additional Fees Assessed by CODA 2014-2022

<table>
<thead>
<tr>
<th>Fee</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Accreditation Fee</td>
<td>See above</td>
</tr>
<tr>
<td>Application Fee</td>
<td>See above</td>
</tr>
<tr>
<td>Special Focused Site Visit Administrative Fee</td>
<td>$4,000 (2016 &amp; 2017); $4,320 (2018 &amp; 2019); $5,000 (2020, 2021, and 2022)</td>
</tr>
<tr>
<td>CODA Penalty for Non-compliance CODA Policy on HIPAA</td>
<td>$1,000 (2017); $4,000 per program per submission (2018, 2019, 2020, 2021 and 2022)</td>
</tr>
<tr>
<td>Email/Contact Distribution List Fee</td>
<td>$200 minimum*</td>
</tr>
<tr>
<td>CODA Administrative Fund Fee (Annual Administrative Fee Per Program)</td>
<td>See above - $25 (2022); $100 in 2021 (fee waived in 2021); $25 in 2014; $35 in 2015-2020</td>
</tr>
</tbody>
</table>

* Program directed to contact CODA for current fee.

## CODA International Accreditation Fees (predoctoral international programs)*

<table>
<thead>
<tr>
<th>Fee</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee (see above)</td>
<td>$65,000 (2016); $67,600 (2017); $73,010 (2018 and 2019); $76,660 (2020, 2021 and 2022)</td>
</tr>
<tr>
<td>Annual Accreditation Fee (see above)</td>
<td>$15,000 (2016); $15,600 (2017); $16,850 (2018); $17,530 (2019); $19,283 (2020, 2021 and 2022)</td>
</tr>
<tr>
<td>Site Visit Fee (application and regular visit)</td>
<td>International program pays all site visit expenses (actual expenses) for all site visits during the application and regular site visit schedule. (2015, 2016, 2017, 2018, 2019, 2020, 2021 and 2022)</td>
</tr>
<tr>
<td>Site Visit Administrative Fee</td>
<td>International program pays an administrative fee of 25% of the total site visit cost for coordination of each site visit. (2015, 2016, 2017, 2018, 2019, 2020, 2021 and 2022)</td>
</tr>
<tr>
<td>International Consultation</td>
<td>$5,000 consultation fee in 2018, 2019, 2020, 2021 and 2022 (outside of PACV process) and all expenses associated with the consultation visit ($10,000 in 2015, 2016 &amp; 2017)</td>
</tr>
</tbody>
</table>

* All international fees must be paid in advance in U.S. Dollars.

Note: Additional fees (noted above) also apply to accredited predoctoral international programs.
Pre-doctoral Dental Education International Consultation and Preliminary Accreditation
Consultation Visit (PACV) Survey

INTERNATIONAL CONSULTATION AND ACCREDITATION FEES *

1. Payment/Check should be made out to the American Dental Association.
2. Drawn on a U.S. account in U.S. dollars.
3. Send to:
   The Commission on Dental Accreditation
   c/o Dr. Sherin Tooks, CODA Director
   211 E. Chicago Ave., Suite 1900
   Chicago, IL 60611

4. Fee Categories
   a. Application fee for PACV Survey - $10,000.00
   b. Focused Consultation Service:
      a. $12,500.00 Focused Consultation Fee
      b. Actual costs for Focused Consultation Visit, including travel, hotel, meals for 2 volunteers/staff for 7 days; estimated $12,500.00 to $15,000.00
      c. $5,400.00 Administrative Fee per Visit
   c. Preliminary Accreditation Consultation Site Visit (PACV):
      a. $50,000.00 Consultation Fee for submission of PACV self study
      b. Actual costs for Preliminary Accreditation Consultation Site Visit, including travel, hotel, meals for 4 volunteers/staff for 7 days, estimated $25,000.00 to $30,000.00
      c. $5,400.00 Administrative Fee per Visit

International programs undergoing the consultative process must pay upfront for all prepaid cost such as air fare.

5. Actual costs for Accreditation Site Visit, including travel, hotel, meals for 7 volunteers/staff for 7 days, estimated $44,300.00 to $47,000.00
   a. The application fee to the Commission is $73,010 (2018 & 2019); $76,660 (2020, 2021 & 2022)
   b. Annual Fees are $17,530 (2019) and $19,283 (2020, 2021 & 2022) (once accredited, programs must pay this fee every year)
   c. 25% Administrative Fee on total cost of Visit

* Fees are subject to change each year.
CODA Fee-Related Policies

J. PROGRAM FEE POLICY

Programs accredited by the Commission pay an annual fee. The annual fee is doubled in the year of the program’s regular interval accreditation site visit. As there is some variation in fees for different disciplines based on actual accreditation costs, programs should contact the Commission office for specific information. Other than doubling of the annual fee during the site visit year, site visits are conducted without any additional charge to the institution and the Commission assumes all expenses incurred by its site visitors. However, accredited programs with multiple sites which must be site visited during a regular site visit and programs sponsored by the U.S. military in international locations are assessed a fee at the time of the site visit. The fee is established on a case-by-case basis, dependent upon the specific requirements to conduct the visit (e.g. additional site visitors, additional days, and additional travel time and expenses). Fees are also assessed to the program for the conduct of special focused site visits. (See Invoicing Process for Special Focused Site Visits in Policy on Special Site Visits). International dental education programs also pay an annual fee and site visit fees (See International Dental Education Site Visits). Expenses for representatives from the state board of dentistry or from other agencies, such as a regional accrediting agency, are not assessed by the Commission. Fee structures are evaluated annually by the Commission. The Commission office should be contacted for current information on fees.

An annual administrative fee is also applied to each program. Fees may also be associated with staff consulting services (See Staff Consulting Services, and International Policies and Procedures)-administrative fees related to the Commission policy on protected health information and personally identifiable information (See Policy and Procedures Related to Compliance with the Health Insurance Portability and Accountability Act).

All institutions offering programs accredited by the Commission on Dental Accreditation are expected to adhere to the due date for payment of all fees for each accredited program sponsored by the institution. Written requests for an extension must specify a payment date no later than thirty (30) days beyond the initial due date. Failure to pay fees by the designated deadline is viewed as an institutional decision to no longer participate in the Commission’s accreditation program. Following appropriate reminder notice(s), if payment or a request for extension is not received, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting. Programs which have been discontinued or had accreditation withdrawn will not be issued a refund of accreditation fees.

Revised: 1/20; 2/19; 2/15; 8/14; 8/13; 7/08; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01, 7/95
K. POLICY ON CODA ADMINISTRATIVE FUND

In 2020, the Commission on Dental Accreditation approved the reclassification of its Research and Development Fund (R&D Fund) to an Administrative Fund.

The Commission on Dental Accreditation Administrative Fund may include but is not limited to the following uses:

- Commission studies and activities related to quality assurance and strategic planning
- Conduct of business through newly formed ad hoc or sub-committees not previously budgeted; engagement of site visitors to gain unique expertise or to provide training
- Ongoing review and enhancement of business resources, human resources, and technology resources in various aspects of the CODA accreditation program
- Expenses related to Shared Services Agreement with the American Dental Association not previously budgeted
- Other business purposes as applicable to the work of the Commission on Dental Accreditation

Criteria Guideline for Distribution of Funds:

1. Funds $5,000 or less: Funds in this category are classified as discretionary funds that may be used by the CODA Director. A maximum of $5,000 per use is permissible, with a requirement for immediate reporting on the use of the funds, via email, to the Finance Committee for informational purposes. The discretionary funds do not require a formal request by a CODA committee, nor do they require prior approval for use by the Finance Committee or Commission.

2. Funds between $5,001 and $20,000: Projects which require this level of funding must be reviewed and approved by the Finance Committee prior to use. Approval by the Commission is not required.

3. Funds greater than $20,000: Projects which require funding in excess of $20,000 must be submitted for review and approval by the Commission upon recommendation of the Finance Committee.

All Funding Disbursements:

- The Finance Committee and Commission will review a full accounting of the Administrative Fund and uses of the fund at each finance committee and Commission meeting.
- Fund allocations requiring approval by the Finance Committee or the Commission require formal requests/proposals from the Commission’s review committees or standing committees; disbursement of funds within the Director’s discretionary allocation do not require formalized requests.

Adopted: 2/20
Appendix 8
Subpage 3
Finance Committee
Commission Only
Winter 2021

Compliance with Health Insurance Portability and Accountability Act (HIPAA). HIPAA is the federal law that governs how “Covered Entities” handle the privacy and security of patients’ protected health information (PHI). HIPAA Covered Entities include health care providers that send certain information electronically as well as certain health plans and clearinghouses. The Commission may be deemed a “Business Associate” of institutions that are HIPAA Covered Entities. A Business Associate is an individual or entity that performs a function or activity on behalf of a HIPAA Covered Entity involving the use or disclosure of individually identifiable health information. Business Associates must comply with certain HIPAA Security and Privacy rules provisions and implement training programs. The Commission “HIPAA Policy and Procedure Manual” is updated periodically. All Commission site visitors, Review Committee members, Commissioners, and staff are required to complete a CODA HIPAA training exercise on a yearly basis.

The program’s documentation for CODA must not contain any patient protected health information (PHI) or sensitive personally identifiable information (PII). If the program submits documentation that does not comply with the policy on PHI or PII, CODA will assess an administrative processing fee of $4,000 per program submission to the institution; a program’s resubmission that continues to contain PHI or PII will be assessed an additional $4,000 administrative processing fee.

Revised: 8/20; Adopted 1/20 (Formerly Policy on Electronic Submission of Accreditation Materials, Commission Policy and Procedure Related to Compliance with the Health Insurance Portability and Accountability Act [HIPAA] and Policy on Preparation and Submission of Reports to the Commission)

I. SITE VISITS (Excerpt)

Invoicing Process for Special Focused Site Visits
In advance of the special focused site visit, the program must remit payment for the Administrative Fee ($5,000 in 2020 and 2021) plus $1,500 per site visitor/staff attending visits up to two (2) days in length. Site visits that are three (3) or more days will be billed an additional $500 per site visitor/staff for each additional day; further, if additional airfare or transportation expenses are incurred, these will be assessed to the program. Failure to submit the special focused site visit fee in advance of the visit may result in a delay of the visit and additional rescheduling cost to the program, and may impact the program’s accreditation status. See Program Fee Policy.

Revised: 1/20; 8/19; 2/19; 2/18; 2/17; 8/16; 2/16; 8/14; 8/13; 1/00, 1/99, 1/98; Reaffirmed: 8/13; 8/10, 7/06;
Adopted: 7/96
BB. POLICY ON REQUESTS FOR CONTACT DISTRIBUTION LISTS

Periodically, the Commission receives requests for contact distribution lists from the communities of interest. The nature and scope of a request will determine whether the Commission will be able to comply with the request. For all types of requests, a “Contact Distribution List Request Form” must be submitted to the Director of the Commission, who will consult with CODA staff regarding the potential for supplying the requested lists based on staff workload capacity and the purpose for which the contact list is requested. This form is available upon request from the Commission office. Examples of potential requesting parties include member and non-member dentists; other dental professionals; deans, dental faculty and affiliates of dental education programs; non-profit dental organizations; researchers; and government officials (Federal and state). Contact distribution lists will not be supplied to commercial interests. A commercial interest is defined as an entity or corporation whose primary purpose for requesting the information is to sell a product or service. Granting the request is at the sole discretion of the Commission.

Additional requirements:
• Requests will be granted only in Excel format.
• The Commission office should be contacted for current fees and rates.
• A formal agreement specifying the permitted use of the data is required before the Commission will act on the request.

Revised: 8/20 8/15; 1/14; Adopted: 8/12

B. INTERNATIONAL PREDOCTORAL DENTAL EDUCATION SITE VISITS (Excerpt)

ACCREDITATION SITE VISIT: The Commission’s accreditation service for international dental education programs is the same as the process and procedures of the accreditation program for U.S.-based dental education programs. The application process for accreditation of fully-operational international programs will not be modified. For fully-operational programs, one site visit would occur upon application and, if successful, subsequent visits would occur on the usual seven-year cycle established for U.S. predoctoral dental education programs.

Programs that are successful in the PACV may submit an application for accreditation and an application fee for accreditation. The program will also be responsible for all site visit expenses (actual expenses) for all site visits during the application process and regular site visit schedule. International programs will pay an administrative fee of 25% of the total site visit cost to the program for coordination of each site visit. Accredited programs also pay an annual fee. All fees must be paid in advance in United States dollars. See CODA Policy on Fees and contact the Commission office for current fee schedule.
Commission site visitors will then be selected to evaluate the written application and determine whether the application is complete and the program is ready for an accreditation site visit. Once the Commission determines that the program has submitted sufficient information to determine the program’s potential for complying with the accreditation standards, a site visit will be scheduled.

A visiting committee consists of six (6) Commission trained volunteer site visitors and one Commission staff. The committee includes a chair, basic scientist, curriculum site visitor, clinical science site visitor, finance site visitor, and a national licensure site visitor.

The accreditation visit, following the process established for U.S.-based programs, will involve several interviews with the identified stakeholders of the international dental program and the institution’s administration. Interviews are conducted with the appropriate administrators, faculty, staff and students. The accreditation site visit committee also verifies that the written application accurately represents the program through multiple interviews, observations, on-site documentation review and facility inspection.

Following the site visit, the visiting committee writes a preliminary draft site visit report that will be considered by the Review Committee on Predoctoral Dental Education and the Commission. The Commission then determines whether to grant the program the appropriate accreditation status.

Revised: 8/16; 2/16; 8/14; 1/14; Reaffirmed: 8/10; Adopted: 7/06
REPORT OF THE STANDING COMMITTEE ON QUALITY ASSURANCE AND STRATEGIC PLANNING

**Background:** At its August 6, 2010 meeting, the Commission on Dental Accreditation (CODA) adopted a revised Standing Committee structure and charge for each committee. The Standing Committee on Quality Assurance and Strategic Planning (QASP) charge is to:

- Develop and implement an ongoing strategic planning process;
- Develop and implement a formal program of outcomes assessment tied to strategic planning;
- Use results of the assessment processes to evaluate the effectiveness of the Commission and make recommendations for appropriate changes, including the appropriateness of its structure;
- Monitor USDE, and other quality assurance organizations e.g. Council on Higher Education Accreditation (CHEA), American National Standards Institute/International Organization for Standardization (ANSI/ISO), and International Network for Quality Assurance Agencies in Higher Education (INQAAHE) for trends and changes in parameters of quality assurance; and
- Monitor and make recommendations to the Commission regarding changes that may affect its operations, including expansion of scope and international issues.

**January 19, 2021 Meeting of the QASP:** The QASP conducted a virtual meeting on January 19, 2021, which included the following committee members: Dr. Linda Casser, Dr. Maxine Feinberg, Dr. Jeffery Hicks (Committee and CODA Chair), Dr. Susan Kass, Dr. James Katancik, Dr. Sanjay Mallya, Dr. Timmothy Schwartz, and Dr. Lawrence Wolinsky. Dr. Bruce Rotter, vice chair, CODA, *ex-officio* was in attendance. Dr. Sherin Tooks, director, CODA, Ms. Dawn Herman, Mr. Gregg Marquardt, Ms. Kirsten Nadler, Ms. Michelle Smith, Ms. Jennifer Snow, Ms. Peggy Soeldner, CODA managers, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, were in attendance.

The QASP initiated its meeting with a review of the charge to the standing committee. Discussion was focused on review of the 2017-2021 CODA Strategic Plan and Operational Effectiveness Tracking to complement the strategic plan. The Committee also discussed ongoing quality assurance and strategic planning activities, and additional items of interest to CODA related to strategic planning and operational effectiveness. Below is a summary of QASP discussions and recommendations.

**Consideration of 2017-2021 CODA Strategic Plan Tracking Sheet and Operational Effectiveness Tracking Sheet:** The Standing Committee on Quality Assurance and Strategic Planning (QASP) reviewed the 2017-2021 CODA Strategic Plan, which was adopted by the Commission in Summer 2016 and implemented January 1, 2017 (*Appendix 1*). The QASP also reviewed a strategic plan progress tracking sheet, which included updates through December 2020 to document activities related to the strategic plan, and CODA’s success in achieving the goals, objectives, and action items associated with the strategic plan (*Appendix 2*). Additionally, the QASP reviewed the Commission’s operational effectiveness tracking sheet, which was approved by CODA in Summer 2017, with updates through December 2020 as presented in *Appendix 3*. 
**Quality Assurance and Strategic Planning Committee Recommendation:** This report is informational in nature and no action is required.

**Consideration of Ongoing Quality Assurance and Strategic Planning Activities**

**Discussion on CODA Administrative Fund:** The QASP discussed its Winter and Summer 2020 recommendations to CODA and the Commission’s actions in Winter 2020 to modify its Research and Development Fund to the CODA Administrative Fund. The Committee discussed the history of the Fund, noting that prior to April 2020 the fund was uncapped. The Standing Committee also noted the Commission’s letter of inquiry to the ADA following the Summer 2020 Commission meeting, which to date had not garnered a response (Appendix 4, Commission Members Only). The QASP members continued to inquire as to the rationale used by the ADA Board of Trustees in developing the cap limit of $300,000.00. Again, QASP members believed the Commission should work with the ADA-CODA Relationship Workgroup and ADA, through its President, to express the Commission’s continued concerns related to the CODA Administrative Fund cap. The Standing Committee also recommended that discussion among CODA and the appropriate ADA members include, but not be limited to, negotiation of a greater cap.

**Quality Assurance and Strategic Planning Committee Recommendation:** It is recommended that the Commission on Dental Accreditation inform the ADA-CODA Relationship Workgroup of the Commission’s concerns related to the $300,000.00 cap applied to the Commission’s Administrative Fund in order to effect meaningful dialogue and discussion of the terms of the Fund.

It is further recommended that the Commission on Dental Accreditation direct a letter to the ADA President, to express the Commission’s concerns related to the cap placed on CODA’s Administrative Fund, and request further review and discussion by the ADA-CODA Relationship Workgroup to include but not be limited to negotiation of a greater cap.

**Discussion on Shared Services Agreement between the Commission on Dental Accreditation and the American Dental Association:** The QASP members discussed the ADA-CODA Shared Services Agreement, noting that the agreement expired on January 1, 2020. Most recently, the Commission signed the ADA’s proposed agreement with a strikethrough on the language related to capping CODA’s Administrative Fund. The Commission did not receive a countersigned agreement and believes that there is no current agreement in place, though the spirit of the agreement carries on with regard to CODA’s annual reimbursement of the services provided by the ADA. The Standing Committee believed it would be of benefit to inquire about the shared services agreement as the Commission engages with the ADA-CODA Workgroup regarding the CODA Administrative Fund. Once the Commission’s concerns related to the Administrative Fund cap are resolved, the Standing Committee believed that the Commission and ADA should reinstate the services agreement.
Quality Assurance and Strategic Planning Committee Recommendation: This report is informational in nature and no action is required.

Additional Quality Assurance and Strategic Planning Items for Discussion

Discussion on 2022-2026 Strategic Planning Process: The QASP members reviewed a proposed strategic plan development process and deliverables for the Commission’s upcoming 2022-2026 Strategic Plan (Appendix 5). The Committee noted CODA’s directive to conduct a Mega Issue Discussion on the strategic plan during its Summer 2021 meeting.

Quality Assurance and Strategic Planning Committee Recommendation: This report is informational in nature and no action is required.

Discussion on Trends in Dental Education, Practice, Research and Higher Education (Update on Ad Hoc Committees): The QASP members received oral updates on the Commission’s three Ad Hoc Committees; these are the Ad Hoc Committee to Study the Commission’s Structure and Function, the Ad Hoc Committee to Study Educational Activity Sites, and the Ad Hoc Committee to Study Alternative Site Visit Methods. It was noted that all ad hoc committees will provide reports and recommendations to the Commission at its Winter 2021 meeting.

Quality Assurance and Strategic Planning Committee Recommendation: This report is informational in nature and no action is required.

Update on United States Department of Education, General Accreditation Matters, and CODA Timeline for Re-Rcognition: The Standing Committee noted that CODA submitted its petition for re-recognition in September 2020. The Committee also reviewed recent issues related to United States Department of Education (USDE) recognition of accrediting agencies. The Committee noted that currently the Commission is not required to report on criteria §602.14 (b-e) Separate and Independent/Joint Use, although the current Accreditation Handbook (for petitions submitted after July 1, 2020) published by the USDE on December 22, 2020 indicates “This requirement is subject to further guidance after a final decision by the Secretary.”

Quality Assurance and Strategic Planning Committee Recommendation: This report is informational in nature and no action is required.

Commission Actions:

Prepared by: Dr. Sherin Tooks
Background: Noting that the 2012-2016 strategic plan was nearing its termination, in Winter 2016, the Commission on Dental Accreditation (CODA) directed that CODA’s Standing Committee on Quality Assurance and Strategic Planning (QASP) work with CODA staff to identify a strategic planning facilitator and initiate the Commission’s strategic planning process. The Commission also directed a Mega Issue discussion prior to the Summer 2016 CODA meeting to finalize CODA’s strategic plan.

Following the May 2, 2016 mail ballot approval to expend Research and Development Funds for the strategic planning activities, the Commission obtained the services of Ms. Elise Scanlon Esq., of the Elise Scanlon Law Group, to facilitate the strategic planning process. The Standing Committee on Quality Assurance and Strategic Planning met on June 13-14, 2016 and developed a draft mission statement, vision statement, values statements, and a draft strategic plan. Prior to the Summer CODA meeting, the draft plan was circulated to the Board of Commissioners for input. Following the Commissioner comment period, the QASP considered all input received on the draft document and finalized the document for discussion at the Summer 2016 Commission meeting. The Commission discussed the draft mission statement, vision statement, values statements, and strategic plan during a Mega Issue Discussion on August 3, 2016, and adopted the final plan at its meeting on August 5, 2016.
MISSION

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.

VISION

The Commission on Dental Accreditation is a globally recognized leader for accrediting educational programs in the dental professions.

VALUES

The Commission is committed to:

**Integrity:** The quality of being honest, accountable, and principled.

**Collegiality:** Working respectfully and collaboratively toward a common purpose.

**Transparency:** Being open about the process by which accreditation standards and policies are developed and implemented.

**Consistency:** Fairness, objectivity, and the reliability of outcomes.
CODA Strategic Plan 2017-2021

**Goal 1:** The Commission on Dental Accreditation will be a leader in accreditation of dental education programs by recognizing the emerging areas of dental education, practice, research, and trends in higher education.

**Objective 1:** Anticipate and address changes in models of practice and research, and their impact on dental education recognizing the input of diverse constituents.

**Action Items:**
- Periodically engage with and review reports from dental-related organizations (e.g., ADA and its Health Policy Institute, ADEA, AADB, AADR/IADR and the sponsoring organizations of dental disciplines) to identify changes in foundational knowledge and dental practice that may be of interest to the Commission.

**Objective 2:** Continuously review and identify trends in higher education policy and regulation.

**Action Items:**
- Continuously monitor trends in higher education practices and USDE regulations that have the potential to impact CODA, and alert the Commission semi-annually of actions of interest and changes in best practices of accreditation.
- Maintain continuous communication with USDE, ASPA, CHEA and the accreditation community to stay current on regulatory changes and trends required regulations.
- On an on-going basis, review, revise and/or develop policies, procedures and/or standards consistent with trends in higher education and accreditation regulations.
- Maintain compliance with USDE recognition criteria, including filing reports as required and the petition for re-recognition.
- Continue to engage and participate in meetings of accrediting organizations.

**Objective 3:** Identify trends in scope of practice and monitor the impact on program accreditation.

**Action Items:**
- At least annually engage with dental-related organizations (e.g., ADA, ADEA, and AADB, state dental boards /regulatory bodies and other professional organizations) and review reports to identify trends in scope of practice that may be of interest to the Commission.
- On an on-going basis, review, revise or develop policies, procedures and/or standards consistent with trends in scope of practice.
**Objective 4:** Create technology strategies to improve accreditation program efficiency and effectiveness.

**Action Items:**
- By winter 2018 secure funding and conduct a formal technology audit to identify current and future technology needs to administer the accreditation program.
- By winter 2018 identify existing internal and external resources to assist in advancing technological strategies to ensure best accreditation practices.
- By summer 2018 develop a technology strategy and plan, to improve accreditation program efficiencies and effectiveness together with budgetary considerations for implementation.

**Objective 5:** Create a comprehensive communication plan to enhance CODA’s visibility.

**Action Items:**
- By summer of 2017, CODA will conduct a follow-up survey of the 2012 Communication Survey to its communities of interest to assess its progress toward enhanced communication and report the results to the Commission.
- By winter of 2018, CODA will research methods to reach and communicate information to its varied communities of interest in association with review and revision of its communication plan.
- By summer 2018, CODA will review and revise its communication plan and strategies to address findings of the Communication Survey and identified best practices of communication with its stakeholders.
- Every 3-5 years, or as the need arises, and following development of the communication plan and strategies, survey CODA’s communities of interest to assess its effectiveness in responding to and communicating with stakeholders.

**Goal 2:** The Commission on Dental Accreditation will be a leader in the field in accreditation of dental education programs by ensuring long term sustainability in governance and autonomy, resources, best practices in higher education accreditation, and building relationship, partnerships and collaboration.

**Objective 1:** CODA will realize a greater level of autonomy in its governance and finances.

**Action Items:**
- By winter 2018 CODA will define its short-term and long-term goals for greater autonomy in financial position and governance autonomy.
- Annually, CODA will engage with the ADA Board of Trustees to develop support for changes it will submit to the ADA House of Delegates.
Annually, CODA will submit to the ADA House of Delegates, proposed incremental changes to the ADA Bylaws and other ADA governance documents to enhance CODA’s autonomy in governance and financial position.

Objective 2: CODA will realize greater autonomy in resource management.

Action Items:
- By winter 2018, CODA will assess its financial stability over the past 3-5 years (i.e., trends in revenue, expenses, and surplus) and prepare projections for the next 3-5 years (through 2021), including identifying indirect and direct expenses, with a report to the Commission.
- By summer 2017, CODA will submit a proposal to the ADA for calculation of shared services based on an assessment of trends in indirect expenses (shared services).
- By summer 2017, CODA will submit a resolution to the ADA Board of Trustees and/or House of Delegates (as appropriate) to grant CODA autonomy in setting and managing its annual budget.
- When CODA is in a position to fund all of its expenses (direct and indirect) for two years, CODA will submit a resolution to the ADA Board of Trustees and/or House of Delegates (as appropriate) to grant CODA the authority to retain its annual surplus in the CODA operational budget.

Objective 3: Build and strengthen relationships by enhanced communication with CODA’s communities of interest.

Action Items:
- In accordance with the Communication Plan, develop communication and marketing tools to provide more information about CODA accreditation to CODA’s communities of interest, including its mission, vision, values, plans (including plans to enhance communication) and benefits.
- On a continuing basis, CODA staff will provide workshops and host hearings at national meetings (e.g., ADEA, ADA, other dental meetings) to foster relationships and provide current information about CODA, its mission, the benefit of accreditation and CODA’s activities.
- Annually, CODA will develop and/or update 2-3 webinars and/or reports on contemporary topics and will create and maintain a library that is accessible to CODA’s volunteers, program directors, and communities of interest.
Goal 3: The Commission on Dental Accreditation will establish a global reputation as a leader in dental accreditation by creating and maintaining international alliances.

Objective 1: Establish and foster relationships with global accreditation bodies and international educational institutions

Action Items:
- CODA will investigate ongoing opportunities for involvement with international groups in dental education and higher education accreditation (e.g., International Society of Dental Regulators, International Federation of Dental Educators and Associations, and Council on Higher Education Accreditation International Quality Group).
- CODA will support attendance, presentations and professional memberships in international groups in dental education and higher education accreditation.
- CODA will continue to offer consulting services to international educational programs and regulatory bodies.
- CODA will, as appropriate, consider establishment of reciprocal accreditation arrangements between the Commission and international accrediting agencies.

Objective 2: CODA shall continue to develop and expand its scope of accreditation services to international programs.

Action Items:
- After the Commission has accredited international predoctoral dental education programs for 4 years, the Commission will assess outcomes regarding expansion of international accreditation services, needed resources and financial implications.
- Monitor and study trends in international dental education to identify the need for further expansion of international accreditation.
- Continue to develop policies and procedures for accreditation of internationally-based predoctoral dental education programs.
- Study the feasibility of developing policies and procedures for accreditation of all disciplines of internationally-based programs, to include advanced and allied dental education.

Objective 3: CODA shall consider accreditation of international sites where educational activity occurs used by CODA accredited dental programs

Action Items:
- Monitor and study trends in international dental education to identify the need for expansion of international accreditation.
- Study the feasibility of developing policies and procedures for accreditation of U.S.-based programs offering education internationally.
## COMMISSION ON DENTAL ACCREDITATION
### Strategic Plan - 2017-2021

<table>
<thead>
<tr>
<th>MISSION</th>
<th>VISION</th>
<th>VALUES</th>
<th>GOALS</th>
<th>OBJECTIVES</th>
</tr>
</thead>
</table>
| 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. | The Commission on Dental Accreditation is a globally recognized leader for accrediting educational programs in the dental professions. | The Commission is committed to:  
**Integrity:** The quality of being honest, accountable, and principled.  
**Collegiality:** Working respectfully and collaboratively toward a common purpose.  
**Transparency:** Being open about the process by which accreditation standards and policies are developed and implemented.  
**Consistency:** Fairness, objectivity, and the reliability of outcomes. | 1. The Commission on Dental Accreditation will be a leader in accreditation of dental education programs by recognizing the emerging areas of dental education, practice, research, and trends in higher education.  
• Anticipate and address changes in models of practice and research, and their impact on dental education recognizing the input of diverse constituents.  
• Continuously review and identify trends in higher education policy and regulation.  
• Identify trends in scope of practice and monitor the impact on program accreditation.  
• Create technology strategies to improve accreditation program efficiency and effectiveness.  
• Create a comprehensive communication plan to enhance CODA’s visibility. | |
| | | | 2. The Commission on Dental Accreditation will be a leader in the field in accreditation of dental education programs by ensuring long term sustainability in governance and autonomy, resources, best practices in higher education accreditation, and building relationship, partnerships and collaboration. | |  
• CODA will realize a greater level of autonomy in its governance and finances.  
• CODA will realize greater autonomy in resource management.  
• Build and strengthen relationships by enhanced communication with CODA’s communities of interest. | |
| | | | 3. The Commission on Dental Accreditation will establish a global reputation as a leader in dental accreditation by creating and maintaining international alliances. | |  
• Establish and foster relationships with global accreditation bodies and international educational institutions  
• CODA shall continue to develop and expand its scope of accreditation services to international programs.  
• CODA shall consider accreditation of international sites where educational activity occurs used by CODA accredited dental programs | |
COMMISSION ON DENTAL ACCREDITATION
Strategic Plan – 2017-2021

GOAL 1: The Commission on Dental Accreditation will be a leader in accreditation of dental education programs by recognizing the emerging areas of dental education, practice, research, and trends in higher education.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
</table>
| 1. Anticipate and address changes in models of practice and research, and their impact on dental education recognizing the input of diverse constituents. | Periodically engage with and review reports from dental-related organizations (e.g., ADA and its Health Policy Institute, ADEA, AADB, AADR/IADR and the sponsoring organizations of dental disciplines) to identify changes in foundational knowledge and dental practice that may be of interest to the Commission. | A number of 2020 national meetings were canceled due to the COVID-19 pandemic, including the ADEA spring meeting and June ADEA Allied Director’s meeting. CODA staff virtually attended and presented at the NADL Educators meeting, ADEA Fall meeting and ADEA Dean’s Meeting, and staff virtually attended the ADA Annual Meeting.

The Ad Hoc Committee on CODA Structure and Function and the Ad Hoc Committee on Educational Activity Sites, which were to submit reports to CODA in Summer 2020, were granted additional time to submit reports, with a due date of Winter 2021, due to the COVID-19 pandemic. Additionally, in Summer 2020, CODA directed that The American Academy of Oral Medicine’s request for a separate Review Committee be considered by the existing Ad Hoc Committee on CODA Structure and Function. The Mega Issue related to the Ad Hoc Committee on Educational Activity Sites scheduled for Summer 2020 was canceled.

The Commission, in Summer 2020, directed the formation of an Ad Hoc Committee on Alternative Site Visit Methods, to investigate and develop policies and procedures, as needed, for alternative site visit methods, with a report to CODA in Winter 2021 |
| 2. Continuously review and identify trends in higher education policy and regulation. | Continuously monitor trends in higher education practices and USDE regulations that have the potential to impact CODA, and alert the Commission semi-annually of actions of interest and changes in best practices of accreditation. | Ongoing monitoring of higher education news sources and USDE publications. The revised USDE Criteria for Recognition became effective July 1, 2020. |
## COMMISSION ON DENTAL ACCREDITATION
### Strategic Plan – 2017-2021

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>QASP and CODA were alerted to the upcoming CODA review cycle for re-recognition that will take place in 2022. CODA awaited publication of the final USDE Criteria for Recognition in order to prepare its petition to the USDE, which CODA staff submitted on September 18, 2020.</td>
<td>Maintain continuous communication with USDE, ASPA, CHEA and the accreditation community to stay current on regulatory changes and trends required regulations.</td>
</tr>
<tr>
<td>Continue to report to USDE following each CODA meeting, per recognition criteria. Continue to update USDE database with accreditation status of programs under CODA’s purview.</td>
<td>Maintain compliance with USDE recognition criteria, including filing reports as required and the petition for re-recognition.</td>
</tr>
<tr>
<td>Submitted CODA petition for recognition by the USDE through the USDE’s electronic portal on September 18, 2020.</td>
<td>No action required at this time.</td>
</tr>
<tr>
<td>Attended spring and fall 2020 ASPA meetings, virtually. Director continues to be involved as a member of the ASPA Education Policy Committee.</td>
<td>On September 20, 2017, CODA received official notification of its continued recognition by the USDE for the full scope of five (5) years with no further reporting required. CODA continues to comply with criteria through submission of action reports following each CODA meeting.</td>
</tr>
<tr>
<td>Monitoring USDE actions related to other accrediting agencies, particularly regarding interpretation of the Separate and Independent criteria for recognition.</td>
<td>CODA modified a number of policies and procedures based upon the recommendations of the Standing Committee on Documentation and Policy Review. These are reflected in detail within CODA’s Winter and Summer 2020 Summary of Major Actions.</td>
</tr>
<tr>
<td>Attended numerous ASPA member sessions and a CHEA session related to the COVID-19 impact on accreditation.</td>
<td>On an on-going basis, review, revise and/or develop policies, procedures and/or standards consistent with trends in higher education and accreditation regulations.</td>
</tr>
<tr>
<td><strong>3. Identify trends in scope of practice and monitor the impact on program accreditation.</strong></td>
<td>CODA Staff submitted its petition for recognition by the USDE through the USDE’s electronic portal on September 18, 2020, related to CODA’s next petition for re-recognition in 2022.</td>
</tr>
<tr>
<td>Continue to engage and participate in meetings of accrediting organizations.</td>
<td>Ongoing, see above. CODA Director continues to serve on ASPA Education Policy Committee.</td>
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<td></td>
<td>CODA Staff attended virtual meetings of ASPA, the Chicago Area Accreditors group, and CHEA.</td>
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<td></td>
<td>CODA continues to be a member of and contribute to requests for comment from the Health Professions Accreditors Collaborative (HPAC) of which CODA is a member.</td>
</tr>
</tbody>
</table>

|  | Monitoring state legislative updates from ADEA and ADA. |
| At least annually engage with dental-related organizations (e.g., ADA, ADEA, and AADB, state dental boards /regulatory bodies and other professional organizations) and review reports to identify trends in scope of practice that may be of interest to the Commission. | In 2018, the CODA Director was invited to join the National Academy of Medicine (NAM) Action Collaborative, Education and Training Workgroup, for countering the opioid epidemic. The collaborative workgroup includes educators, practitioners, professional organizations and accrediting agencies in the health fields. Within the NAM Education and Training Workgroup, dental education is represented by CODA and ADEA. This organization’s work continued in 2020. |
| On an on-going basis, review, revise or develop policies, procedures and/or standards consistent with trends in scope of practice. | A number of standards were considered for revision in 2020. |
| 4. Create technology strategies to improve accreditation program efficiency and effectiveness. | By winter 2018 secure funding and conduct a formal technology audit to identify current and future technology needs to administer the accreditation program. | CODA continues to work with ADA Enterprise Solutions on the development of an electronic accreditation platform. The replacement of the former CODA DSA database occurred in August 2019. In 2020, CODA worked with ADA Enterprise Solutions on Phase II of the electronic accreditation tool, which will serve as the external web-based accreditation tool, including internal and external user acceptance testing. As a result of the COVID-19 pandemic, CODA directed that the electronic portal be developed and that all materials from programs be submitted electronically, only. In Summer 2018, CODA staff prepared and presented to CODA a technology needs assessment and strategy. |


Documentation and Policy Committee conducts ongoing review and revision of policy; see elsewhere in tracking document.

CODA developed temporary flexibility for the Class of 2020 in April 2020, and for the Class of 2021 in October 2020, as a result of the COVID-19 pandemic. Guidelines for submission of interruption of education reports were developed and all 1,400+ CODA-accredited educational programs were required to submit reports for the Class of 2020. CODA directed that reports for the Class of 2021 will be due on March 19, 2021 and submitted no earlier than March 1, 2021. An instructional video was also prepared and posted on CODA’s website.

See elsewhere related to other COVID-19 activities.
COMMISSION ON DENTAL ACCREDITATION  
Strategic Plan – 2017-2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer 2018</td>
<td>By summer 2018 develop a technology strategy and plan, to improve accreditation program efficiencies and effectiveness together with budgetary considerations for implementation.</td>
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<td></td>
<td>As a result of COVID-19, staff have increased the use of Skype for Business. Additionally, CODA has utilized Zoom for all Review Committees, ad hoc committees, standing committees, and other communications since March 2020. Hearings on Proposed Accreditation Standards and presentations at national meetings have occurred virtually. CODA is also working on the electronic accreditation portal. Additionally, CODA uses voice over IP to access business phone lines.</td>
</tr>
<tr>
<td>5.</td>
<td>Create a comprehensive communication plan to enhance CODA’s visibility.</td>
</tr>
<tr>
<td>2017</td>
<td>By summer of 2017, CODA will conduct a follow-up survey of the 2012 Communication Survey to its communities of interest to assess its progress toward enhanced communication and report the results to the Commission.</td>
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<tr>
<td></td>
<td>The Communication and Technology Committee report for CODA’s Summer 2017 meeting included a summary of the communication survey results.</td>
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<tr>
<td></td>
<td>The Communication and Technology Committee was unable to meet prior to CODA’s summer 2018 meeting; however, CODA staff prepared and presented to CODA a 2019-2023 Communication Plan, which was approved by the Commission.</td>
</tr>
<tr>
<td>Winter 2018</td>
<td>By winter of 2018, CODA will research methods to reach and communicate information to its varied communities of interest in association with review and revision of its communication plan.</td>
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<td></td>
<td>Communication survey data suggests that communities of interest (COI) prefer email as a communication channel, with CODA’s website as a second choice. The COI also prefer webinars as a means to gain information, and there is no strong preference to CODA’s use of videos or social media tools. CODA Personas were developed as were the communication objectives, high-level deliverables, and metrics.</td>
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<td>CODA has increased branding of many of its documents.</td>
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<td></td>
<td>The Commission’s second Annual Report was distributed in December 2020.</td>
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<tr>
<td></td>
<td>CODA provided several webinars and produced a recorded tutorial for submission of the interruption of education reports required by the Commission.</td>
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</table>
## COMMISSION ON DENTAL ACCREDITATION
### Strategic Plan – 2017-2021

<table>
<thead>
<tr>
<th>By summer 2018, CODA will review and revise its communication plan and strategies to address findings of the Communication Survey and identified best practices of communication with its stakeholders.</th>
<th>The Communication and Technology Committee met in spring 2020 and provided a report for the Commission’s Summer 2020 meeting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every 3-5 years, or as the need arises, and following development of the communication plan and strategies, survey CODA’s communities of interest to assess its effectiveness in responding to and communicating with stakeholders.</td>
<td>Initial communication survey conducted 2012. Follow-up survey distributed April 2017. Next survey should occur during time frame of 2021-2023.</td>
</tr>
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</table>

## GOAL 2: The Commission on Dental Accreditation will be a leader in the field in accreditation of dental education programs by ensuring long term sustainability in governance and autonomy, resources, best practices in higher education accreditation, and building relationship, partnerships and collaboration.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CODA will realize a greater level of autonomy in its governance and finances.</td>
<td>By winter 2018 CODA will define its short-term and long-term goals for greater autonomy in financial position and governance autonomy.</td>
<td>Following the Commission’s Winter 2020 meeting, CODA informed the ADA Board of Trustees that it had modified its Research and Development Fund to the CODA Administrative Fund. Subsequently, in April 2020, the ADA Board of Trustees imposed a $300,000 cap on the CODA Administrative Fund, which had been previously uncapped. Additionally, CODA proposed revisions to the CODA-ADA Shared Services Agreement, which expired on January 1, 2020. In July, CODA expressed concern that the Agreement, and did so again in August 2020 following the Commission’s Summer meeting. The ADA-CODA Workgroup met on February 17, 2020. The ADA-CODA Workgroup’s August 12, 2020 meeting was canceled. Continued review and progress is needed related to: 1) CODA’s request for a mechanism to establish a reserve fund, and 2) CODA’s desire to have sole authority to determine and manage its annual operating budget.</td>
</tr>
</tbody>
</table>
| **COMMISSION ON DENTAL ACCREDITATION**  
| Strategic Plan – 2017-2021 |
|---|---|
| **Annually, CODA will engage with the ADA Board of Trustees to develop support for changes it will submit to the ADA House of Delegates.** | See above. The ADA-CODA Relationship Workgroup met in 2020 and focused their discussions on CODA’s request for a mechanism to establish a reserve fund and the Shared Services Agreement. |
| **Annually, CODA will submit to the ADA House of Delegates, proposed incremental changes to the ADA Bylaws and other ADA governance documents to enhance CODA’s autonomy in governance and financial position.** | The Commission submitted letters to the ADA Board of Trustees and ADA President on July 10, 2020 and August 19, 2020, expressing concern related to ADA actions on the CODA Administrative Fund and the CODA-ADA Shared Services Agreement. |

### 2. CODA will realize greater autonomy in resource management.

| By winter 2018, CODA will assess its financial stability over the past 3-5 years (i.e., trends in revenue, expenses, and surplus) and prepare projections for the next 3-5 years (through 2021), including identifying indirect and direct expenses, with a report to the Commission. | Completed Summer 2017; the Finance Committee completed this action item and reported to the Commission in Summer 2017. The review of CODA’s 5 year retrospective and prospective financial plan was the basis for CODA’s resolutions noted above. |

| By summer 2017, CODA will submit a proposal to the ADA for calculation of shared services based on an assessment of trends in indirect expenses (shared services). | Completed October 2018; See B-91/substituted with B-108 (comments above). Shared services agreement was signed by CODA and ADA in October 2018. CODA will monitor services and fees on an annual basis. Shared services agreement is effective for a period of two years. |

| By summer 2017, CODA will submit a resolution to the ADA Board of Trustees and/or House of Delegates (as appropriate) to grant CODA autonomy in setting and managing its annual budget. | Postponed until 2022. At its Winter 2020 meeting, the Commission directed a delay of two (2) additional years, until 2022, of its plan to obtain sole authority to set and administer its annual operating budget. |

| When CODA is in a position to fund all of its expenses (direct and indirect) for two years, CODA will submit a resolution to the ADA Board of Trustees and/or House of Delegates (as appropriate) to grant CODA the authority to retain its annual surplus in the CODA operational budget. | See comments above. The Finance and QASP Committees may consider this item further. |

### 3. Build and strengthen relationships by enhanced communication with CODA’s communities of interest.

| In accordance with the Communication Plan, develop communication and marketing tools to provide more information about CODA accreditation to CODA’s communities of interest, including its mission, vision, values, plans (including plans to enhance communication) and benefits. | See above, comments on CODA Communication Plan. |

| On a continuing basis, CODA staff will provide workshops and host hearings at national meetings (e.g., ADEA, ADA, other dental meetings) to foster relationships and provide current information about CODA, its mission, the benefit of accreditation and CODA’s activities. | Conducted virtual hearings on standards to obtain community of interest input related to the following meetings, which were either canceled or conducted |
**COMMISSION ON DENTAL ACCREDITATION**  
**Strategic Plan – 2017-2021**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish and foster relationships with global accreditation bodies and CODA will investigate ongoing opportunities for involvement with international groups in dental education and higher education accreditation (e.g., International Society of Dental Regulators, International Federation)</td>
<td>CODA staff continues to monitor activities of international dental organizations, including the Council on Higher Education Accreditation International Quality Group (CHEA-CIQG).</td>
<td></td>
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</table>

**GOAL 3: Commission on Dental Accreditation will establish a global reputation as a leader in dental accreditation by creating and maintaining international alliances.**

Conducted virtual site visitor training in June 2020. Provided updates to the ADEA Dean’s group on multiple occasions. Provided an update at the ADEA Fall meeting. Presented at the ADEA Dean’s meeting on the topic of CODA/Accreditation after COVID-19. Provided webinars for programs preparing interruption of education reports for the Class of 2020. Produced and published a video to assist programs in preparing interruption of education reports for the Class of 2021.

Fostered ongoing communication through the formation of the CODA-ADEA COVID-19 Workgroup during the early part of 2020.

Annually, CODA will develop and/or update 2-3 webinars and/or reports on contemporary topics and will create and maintain a library that is accessible to CODA’s volunteers, program directors, and communities of interest.

Annual mandatory site visitor training program developed in 2019, along with a mandatory quiz. The second year of the training program was deployed in December 2020 for the 2020/2021 site visitor appointment cycle. In 2020, rather than one training module, the modules were customized for predoctoral/dental therapy, allied, and advanced dental education site visitors.

Annual updates, new content and new assessments will be developed for subsequent years, including potential for development of discipline-specific modules.
### COMMISSION ON DENTAL ACCREDITATION
#### Strategic Plan – 2017-2021

<table>
<thead>
<tr>
<th>International Educational Institutions</th>
<th>Objectives</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODA will support attendance, presentations and professional memberships in international groups in dental education and higher education accreditation.</td>
<td>CODA will continue to monitor. Currently, CHEA-CIQG provides updates on activities via its website.</td>
<td></td>
</tr>
<tr>
<td>CODA will continue to offer consulting services to international educational programs and regulatory bodies.</td>
<td>On November 5, 2020, staff attended an International Dental Regulators Meeting on Response to COVID-19. On November 16, 2020, the Korean Institute of Dental Education and Evaluations (KIDEE) inquired about CODA’s availability to present at a virtual meeting in mid-December. Due to the timing, CODA was unable to participate but has informed KIDEE that a future request with sufficient notice would be considered.</td>
<td></td>
</tr>
<tr>
<td>CODA will, as appropriate, consider establishment of reciprocal accreditation arrangements between the Commission and international accrediting agencies.</td>
<td>The Commission has received a request from the Commission on Dental Accreditation of Canada (CDAC) to review the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine for the potential inclusion in the Agreement of Reciprocity between CODA and the CDAC. The Commission will consider this request in Winter 2021.</td>
<td></td>
</tr>
</tbody>
</table>

2. CODA shall continue to develop and expand its scope of accreditation services to international programs.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Implementation Details</th>
</tr>
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<tbody>
<tr>
<td>After the Commission has accredited international predoctoral dental education programs for 4 years, the Commission will assess outcomes regarding expansion of international accreditation services, needed resources and financial implications.</td>
<td>In Summer 2019, the Commission granted accreditation to the first international dental education program at King Abdulaziz University, Jeddah, Saudi Arabia. CODA will monitor international accreditation activities and assess outcomes regarding expansion and needed resources, including financial implications, in 2023.</td>
</tr>
<tr>
<td>Monitor and study trends in international dental education to identify the need for further expansion of international accreditation.</td>
<td>TBD</td>
</tr>
<tr>
<td>Continue to develop policies and procedures for accreditation of internationally-based predoctoral dental education programs.</td>
<td>Policies and procedures continue to be developed as necessary.</td>
</tr>
<tr>
<td>Study the feasibility of developing policies and procedures for accreditation of all disciplines of internationally-based programs, to include advanced and allied dental education.</td>
<td>In Summer 2019, CODA directed the formation of an Ad Hoc Committee to study sites where educational activity occurs (domestic and international) for all programs under CODA’s purview. The Ad Hoc Committee will submit a report to CODA in Winter 2021.</td>
</tr>
<tr>
<td>3. CODA shall consider accreditation of international sites where educational activity occurs used by CODA accredited dental programs</td>
<td>Monitor and study trends in international dental education to identify the need for expansion of international accreditation.</td>
</tr>
<tr>
<td>Study the feasibility of developing policies and procedures for accreditation of U.S.-based programs offering education internationally.</td>
<td>TBD, See above related to Ad Hoc Committee to study sites where educational activity occurs</td>
</tr>
</tbody>
</table>
**Goal 1:** The Commission on Dental Accreditation will be a leader in accreditation of dental education programs by recognizing the emerging areas of dental education, practice, research, and trends in higher education.

**Objectives:**
- Anticipate and address changes in models of practice and research, and their impact on dental education recognizing the input of diverse constituents.
- Continuously review and identify trends in higher education policy and regulation.
- Identify trends in scope of practice and monitor the impact on program accreditation.
- Create technology strategies to improve accreditation program efficiency and effectiveness.
- Create a comprehensive communication plan to enhance CODA’s visibility.

<table>
<thead>
<tr>
<th>Action Items</th>
<th>Monitoring Mechanism</th>
<th>Evaluation Mechanism</th>
<th>When Evaluated</th>
<th>Who Collects Data</th>
<th>Who Assesses Data</th>
<th>Results</th>
<th>Resulting Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipate and address changes in models of practice and research, and their impact on dental education recognizing the input of diverse constituents.</td>
<td>Review proposed Standards revision(s) to ensure experimentation and innovation are permitted.</td>
<td>Circulate proposed standards revisions to appropriate Review Committee and CODA</td>
<td>Periodically</td>
<td>Director/Managers</td>
<td>RC/QASP/CODA</td>
<td>Proposed revisions to standards have been circulated to appropriate RCs and CODA. Standards have been circulated for public comment within an appropriate time frame. When questions arise, CODA has communicated with groups proposing</td>
<td>Ongoing - CODA circulated proposed revision and adopted proposed revisions to Accreditation Standards.</td>
</tr>
<tr>
<td>Conduct validity and reliability of Accreditation Standards</td>
<td>As required by policy, conduct validity and reliability study of Accreditation Standards</td>
<td>Periodically based on review cycle</td>
<td>Director/Managers</td>
<td>RC/QASP/CODA</td>
<td>2020: Validity and Reliability Studies for Predoctoral Dental Education and Oral and Maxillofacial Pathology were postponed due to COVID-19. These two disciplines’ Standards along with Dental Anesthesiology will be studied in 2021. Ad Hoc committees to study the V&amp;R results continued for OMS, ORTHO, and PERIO.</td>
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<tr>
<td>Continuously review and identify trends in higher education policy and regulation.</td>
<td>Develop and distribute site visitor training materials within specified timeframes</td>
<td>Number of site visitors trained annually, completion of training program</td>
<td>Annual</td>
<td>Director/Managers</td>
<td>QASP/CODA</td>
<td>Provided New Site Visitor Training program for new site visitors virtually, due to</td>
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<td></td>
<td>Results achieved, continue as planned.</td>
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<tr>
<td>Continue the development of online and web-based training materials</td>
<td>Number of site visitors trained annually, completion of training program</td>
<td>Annual</td>
<td>Director/Managers</td>
<td>QASP/CODA</td>
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<td>COVID-19 (117 attendees)</td>
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<td>For the second year, implemented mandatory site visitor training program module and quiz, which was distributed in December 2020. This year, three (3) custom modules were developed (advanced, allied, and predoctoral and dental therapy)</td>
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<td>Mandatory annual web-based site visitor training program disseminated in December 2020.</td>
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<td>Results achieved, continue as planned.</td>
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<tr>
<td>Task Description</td>
<td>Ongoing</td>
<td>Responsible Party</td>
<td>Task Details/Notes</td>
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<tr>
<td>Maintain recognition by USDE</td>
<td>Ongoing</td>
<td>Director</td>
<td>CODA submitted petition for re-recognition by the USDE on September 18, 2020. CODA reports activities to USDE in accordance with recognition criteria following each CODA meeting. Results achieved, continue as planned. Ongoing monitoring of Recognition Criteria for Accrediting Agencies and other issues related to USDE and accreditation.</td>
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<tr>
<td>Communicate with other accrediting agencies to stay current on regulatory changes and trends</td>
<td>Ongoing</td>
<td>Director/Managers</td>
<td>CODA interacts with ASPA (attended spring and fall 2020 virtual meetings) and numerous accreditor sessions related to COVID-19. Results achieved, continue as planned. CODA staff will attend ASPA and Chicago Area Accreditors meetings in 2021.</td>
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<tr>
<td>Identify trends in scope of practice and monitor the impact on program accreditation.</td>
<td>Facilitate participation of state dental licensing boards on site visits, as appropriate</td>
<td>Log of State Board participation</td>
<td>Annual</td>
<td>Director/Managers</td>
<td>QASP/CODA</td>
<td>CODA staff continues to foster enhanced communication with state dental boards for board participation on site visits, as invited by educational programs. Beginning mid-March 2020, site visits were canceled through CODA.</td>
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</table>

Results cannot be assessed as a majority of site visits were canceled in 2020. Continue to enhance communication and tracking of state board participation on site visits.
Eighteen (18) visits were conducted prior to mid-March, for allied, advanced and predoctoral dental education.

One (1) state board member accepted an invitation to attend a site visit.

State Boards declined to accept the invitation of five (5) programs.

Further, 12 programs chose not to invite the state board to attend their site visit.

<table>
<thead>
<tr>
<th>Receive and act on reports and publications on</th>
<th>Reports and publications received and evaluated.</th>
<th>As necessary</th>
<th>Director/Managers</th>
<th>QASP/CODA monitoring.</th>
<th>CODA monitoring.</th>
<th>QASP reviews</th>
<th>Results achieved, continue as planned.</th>
</tr>
</thead>
</table>

the remainder of the year due to COVID-19.
<p>| Create technology strategies to improve accreditation program efficiency and effectiveness. | Encourage use of information technologies that reduce administrative costs to the | Monitor and log technology advancements to enhance effectiveness of | Periodically | Director/Managers | ComTech/QASP/CODA | Since August 2017, CODA staff has participated in ongoing meetings with | In 2021, continue development of Phase II, related to external facing electronic |
|---|---|---|---|---|---|---|---|---|
| trends and changes. | reports and publications and trends as available. | CODA developed two ad hoc committees in 2019. One to address CODA structure and function and another to address educational activity sites. Work of these committees continued in 2020. | An additional ad hoc committee was established in 2020 to address alternative site visit methods. |</p>
<table>
<thead>
<tr>
<th>CODA and sponsoring institutions.</th>
<th>CODA business processes</th>
<th>ADA Enterprise Solutions team regarding CODA’s electronic accreditation platform.</th>
<th>accreditation platform.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODA staff completed UAT of database replacement, which was subsequently launched in July 2019.</td>
<td>CODA will continue to develop an electronic accreditation tool as Phase II of project.</td>
<td>In 2020 CODA directed an electronic portal for application upload be developed.</td>
<td></td>
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<tr>
<td>Create a comprehensive communication</td>
<td>Create a comprehensive communication plan that log communication activities that support timely</td>
<td>Periodically</td>
<td>Director/Managers</td>
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<tr>
<td>CODA 2017-2021 Outcomes Assessment Tracking</td>
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<td>ComTech/QASP/CODA</td>
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<td>2019-2023 Communication Plan presented to and approved by</td>
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<td>CODA staff implementing communication plan.</td>
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</tbody>
</table>
Goal 2: The Commission on Dental Accreditation will be a leader in the field in accreditation of dental education programs by ensuring long term sustainability in governance and autonomy, resources, best practices in higher education accreditation, and building relationship, partnerships and collaboration.

Objectives:
- CODA will realize a greater level of autonomy in its governance and finances.
- CODA will realize greater autonomy in resource management.
- Build and strengthen relationships by enhanced communication with CODA’s communities of interest.

<table>
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<tr>
<th>Action Items</th>
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</tr>
</thead>
<tbody>
<tr>
<td>CODA will realize a greater level of autonomy in its governance and finances.</td>
<td>Ensure ongoing financial stability of CODA</td>
<td>Establish and monitor CODA short- and long-term financial planning</td>
<td>Ongoing</td>
<td>Director/Managers</td>
<td>Finance/ QASP/ CODA</td>
<td>Shared Services Agreement signed by CODA and ADA in October 2018. The Agreement expired January 1, 2020.</td>
<td>Continue to monitor CODA finances to ensure long-term financial stability and future request for sole authority to determine and manage annual CODA budget.</td>
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<tr>
<td>CODA will realize greater autonomy in resource management.</td>
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<td>CODA may consider next steps regarding Shared Services Agreement and</td>
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</table>
CODA established Administrative Fund (in lieu of Research and Development Fund) in Winter 2020 and communicated this to ADA Board of Trustees.

August 2020, CODA directed a letter to ADA to express concerns related to a cap that was placed on Administrative Fund and wording included in Shared Services Agreement regarding this topic.

CODA directed that it postpone request to obtain Administrative Fund.

CODA to monitor resources for ongoing development of electronic accreditation tool.
<table>
<thead>
<tr>
<th>Engagement Area</th>
<th>Responsibility</th>
<th>Frequency</th>
<th>Authority</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage with ADA to initiate Bylaws changes in support of CODA governance and financial autonomy</td>
<td>Assess activity of ADA/CODA Relationship Workgroup and submit Resolutions to ADA House</td>
<td>Annually</td>
<td>Director</td>
<td>QASP/CODA</td>
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<tr>
<td>Build and strengthen relationships by enhanced communication with CODA’s communities of interest.</td>
<td>Routinely distribute current accreditation status information to communities of interest.</td>
<td>Semi-annual</td>
<td>Director/Managers</td>
<td>QASP/CODA</td>
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<tr>
<td></td>
<td>Publish and distribute accreditation status within 30 days of Commission meeting.</td>
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<tr>
<td>Update the CODA website within 30 days of the Commission meeting</td>
<td>Report on completion of update and number of website visits</td>
<td>Semi-annual</td>
<td>Director/Managers</td>
<td>QASP/CODA</td>
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<tr>
<td>CODA staff also updates USDE database in accordance with actions taken by CODA following each meeting.</td>
<td>CODA website updated within 30 days of CODA meeting.</td>
<td>CODA website monitored for ongoing dissemination of accurate information.</td>
<td>Communication and Technology Committee monitors CODA website activity; increased access to website occurs following CODA meetings related to Major Actions Report.</td>
<td>CODA published additional information on</td>
</tr>
<tr>
<td>Task</td>
<td>Status</td>
<td>Responsible Party</td>
<td>Notes</td>
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<tr>
<td>Publish newsletter, alerts, and other communication tools and maintain up-to-date web-page to inform community of interest</td>
<td>Ongoing</td>
<td>Director/Managers ComTech/QASP/CODA</td>
<td>CODA disseminated approximately 49 communications to inform various community of interest members of CODA newsletter, reminders, deadlines, training.</td>
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<tr>
<td>Report dates of completion and distribution.</td>
<td></td>
<td></td>
<td>Results achieved, continue as planned. Annual report distributed to all communities of interest in December 2020. COVID-19 webpage developed as a resource to</td>
<td></td>
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</tbody>
</table>
In 2020, due to COVID-19, the Commission created a special webpage to provide communities of interest with ongoing information. The Commission published 21 communications to this webpage.

The second annual report was published in December 2020.

<table>
<thead>
<tr>
<th>Engage with other organizations within CODA’s community of interest to provide current information about CODA and foster relationships</th>
<th>Report dates and type of activity</th>
<th>Ongoing and as requested</th>
<th>Director/Managers</th>
<th>QASP/CODA</th>
<th>Ongoing</th>
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<tr>
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<td>Attended the following 2020 meetings: NADL; and virtually attended the ADEA Fall meeting, ADEA Dean’s Meeting, ADA meeting, CDAC meeting,</td>
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</tbody>
</table>
**Goal 3:** The Commission on Dental Accreditation will establish a global reputation as a leader in dental accreditation by creating and maintaining international alliances.

**Objectives:**
- Establish and foster relationships with global accreditation bodies and international educational institutions
- CODA shall continue to develop and expand its scope of accreditation services to international programs.
- CODA shall consider accreditation of international sites where educational activity occurs used by CODA accredited dental programs

<table>
<thead>
<tr>
<th>Action Items</th>
<th>Monitoring Mechanism</th>
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<th>Who Assesses Data</th>
<th>Results</th>
<th>Resulting Action</th>
</tr>
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<tbody>
<tr>
<td>Establish and foster relationships with global accreditation bodies and international educational institutions.</td>
<td>Engage with International groups in dental and higher education</td>
<td>Log of organizations with which CODA has engaged</td>
<td>Annually</td>
<td>Director</td>
<td>QASP/CODA</td>
<td>Engaged with CDAC</td>
<td>Continue to monitor and seek opportunities to further engage with international groups</td>
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<tr>
<td>Attain membership in and actively participate in international organizations</td>
<td>Log of organizations with which CODA has engaged</td>
<td>Annually</td>
<td>Director</td>
<td>QASP/CODA</td>
<td>CODA directed that, if beneficial, CODA should join groups such as Council on Higher Education Accreditation International</td>
<td>Under continued review, no memberships have been obtained at this time.</td>
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<tr>
<td>Provide consultation services internationally</td>
<td>Log of consultation requests and follow-up</td>
<td>Annually</td>
<td>Director/Managers</td>
<td>QASP/CODA</td>
<td>Quality Group (CHEA-CIQG).</td>
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<td>2020: CODA invited to speak at international dental regulators meeting on COVID-19 activities. CODA also invited to speak at Korean Institute of Dental Education and Evaluations (KIDEE) meeting.</td>
<td>Timing of KIDEE conference and invitation did not permit CODA participation this year.</td>
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<td>Continue to monitor and offer serves as available.</td>
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<tr>
<th>Maintain reciprocal agreement with Commission on Dental Accreditation of Canada</th>
<th>Review and comment on proposed CDAC revisions; encourage site visit observation and meeting attendance among CDAC and CODA</th>
<th>Ongoing</th>
<th>Director</th>
<th>QASP/CODA</th>
<th>Results achieved, continue as planned.</th>
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<td></td>
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<td>Attended CDAC meeting in November 2020. Like CODA, CDAC canceled site visits due to COVID-19. CDAC did not attend any CODA visits in 2020. Plans underway to observe a</td>
<td>Plans underway to observe a</td>
</tr>
<tr>
<td>CODA shall continue to develop and expand its scope of accreditation services to international programs.</td>
<td>Monitor trends in international dental education and need for expansion of international accreditation to disciplines under CODA purview</td>
<td>Monitor international environment</td>
<td>Annual</td>
<td>Director</td>
<td>QASP/CODA</td>
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<tr>
<td>CODA shall consider accreditation of international sites where educational activity occurs used by CODA accredited dental programs.</td>
<td>Further develop policies and procedures related to international accreditation</td>
<td>Log international policies and procedures adopted by CODA</td>
<td>Semi-annual</td>
<td>Director/Managers</td>
<td>DocPol/QASP/CODA</td>
</tr>
<tr>
<td>Monitor reciprocal agreements established by international accreditors and potential impact to CODA, including reciprocity requests submitted to CODA</td>
<td>Log reciprocal agreements</td>
<td>Annual</td>
<td>Director</td>
<td>QASP/CODA</td>
<td>In December 2020, CDAC submitted request to review Standards for potential reciprocity for Oral Medicine, to be considered by CODA in Winter 2021.</td>
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</table>
PROPOSED CODA 2022-2026 STRATEGIC PLANNING ACTIVITY DELIVERABLES

Proposed Deliverables:

- SWOT Analysis, Environmental Scan, and Development of Draft Strategic Plan and Outcomes Assessment Plan (1 to 1.5 day virtual meeting with QASP, February-May 2021)
  - Conduct an environmental assessment of regulatory changes, changes in higher education, and changes in dental education that may affect CODA’s 2022-2026 strategic plan.
  - Conduct and develop a SWOT analysis with QASP members and CODA staff.
  - Facilitate meeting of QASP and CODA Staff to develop 2022-2026 Strategic Plan, including mission, vision, values, strategic plan objectives and action steps for each objective and Outcomes Assessment Plan, including identification of outcomes measures by which CODA should self-assess.

- Conduct a virtual meeting (1-2 hours) to fine tune Strategic Plan and Outcomes Assessment Plan with QASP and CODA Staff. (May 2021)

- Review Commissioner feedback on draft Strategic Plan and Outcomes Assessment Plan and offer suggestions for enhancement to QASP (June 2021)
  - Conduct a virtual meeting (1-2 hours) to fine tune Strategic Plan and Outcomes Assessment Plan with QASP and CODA Staff, following Commissioner feedback. (July 2021)

- Conduct a virtual meeting (1-2 hours) to review final draft of Strategic Plan and Outcomes Assessment Plan with QASP and CODA Staff prior to summer Mega Issue with full Commission and make final adjustments (July 2021, prior to August 4, 2021)

- Facilitate Mega Issue for full Commission to finalize Strategic Plan and Outcomes Assessment Plan for approval at Summer CODA meeting (Tentatively in-person meeting or by virtual meeting, August 4, 2021, afternoon)

  *Final Action by CODA on Strategic Plan and Outcomes Assessment Plan (August 6, 2021)*
REPORT OF THE STANDING COMMITTEE ON DOCUMENTATION AND POLICY REVIEW

Background: The Standing Committee on Documentation and Policy Review met via virtual meetings on January 20, 2021 and January 27, 2021. Committee members in attendance at both meetings included: Dr. Scott DeVito (chair), Dr. Joel Berg, Dr. John Hellstein, Dr. Susan Kass, Dr. Timmothy Schwartz, Dr. Marshall Titus, and Dr. Lawrence Wolinsky. Dr. Garry Myers attended the January 20, 2021 meeting and a portion of the January 27, 2021 meeting. Dr. Jeffery L. Hicks, chair, and Dr. Bruce Rotter, vice chair, Commission on Dental Accreditation (CODA), ex-officio, also attended both meetings. Dr. Sherin Tooks, director, and Ms. Dawn Herman, Mr. Gregg Marquardt, Ms. Kirsten Nadler, Ms. Michelle Smith, Ms. Jennifer Snow, Ms. Peggy Soeldner, managers, CODA, were in attendance at both meetings. Ms. Cathryn Albrecht, senior associate general counsel, attended the January 27, 2021 meeting.

At these meetings, the Standing Committee discussed the criteria for appointment as Commissioners and Review Committee members; miscellaneous policies identified for review and possible revision outside of their regular review cycle; and recent changes to the United States Department of Education (USDE) criteria for recognition and potential impact to the Commission.

Criteria for Appointment of Commissioners and Review Committee Members: The Standing Committee engaged in a lengthy discussion on the criteria for appointment to serve in the roles of Commissioner and Review Committee member within the Commission on Dental Accreditation. The Standing Committee noted the ongoing difficulty in finding volunteers in various roles on the Commission and, in particular, its Review Committees, resulting from the requirement to hold ADA membership as a condition for appointment. The Committee further noted that changes in membership criteria would result in revisions to CODA policies, the oversight of which is one of the charges of the Standing Committee.

The Standing Committee reviewed the CODA Rules and ADA governance documents (Bylaws and Governance and Organizational Manual) and learned that if CODA pursues changes to the ADA membership requirement for Commissioners who are dentists, a resolution to the House of Delegates (HOD) would be required. Additionally, in CODA leadership roles, the ADA Governance and Organizational Manual mentions the Chair, only; however, the Manual notes that in the event of a vacancy in the Chair of a Commission, the Vice Chair shall serve as ad interim Chair pending selection of a Chair, which suggests that both roles require ADA membership. The Committee also noted that Commission Rules require both the CODA Chair and CODA Vice Chair to be an ADA member.

The Standing Committee also noted that the CODA Rules indicate Appeal Board Members must be members of their appointing organization, but membership in the ADA is not required except for the ADA appointee on the Appeal Board.
The Standing Committee discussed the Review Committee nomination criteria, which by CODA’s own regulations mandates that Review Committee members who are eligible also be members of the ADA. It was noted that the requirement for Review Committee members may be changed solely at the Commission’s discretion.

Following considerable discussion, the Committee concluded that a change in the ADA membership requirement for Commissioners should not be pursued by the Commission at this time. Recommendations related to the Commission’s criteria for Review Committee members is noted elsewhere in this report.

**Consideration of Proposed Revisions to Miscellaneous Policies:** The Standing Committee considered policies that may warrant revision to ensure they are current, relevant, and align with Commission protocol and practices. Policies reviewed at this time included: Review Committees and Review Committee Meetings, Commission and Commission Meetings, Conflict of Interest Policy, Application for Accreditation for Fully Operational Programs With Enrollment and Without Accreditation, Application for Initial Accreditation for Developing Programs, Site Visitors, Reporting Program Changes in Accredited Programs, Policy on Non-Enrollment of First Year Students/Residents, Policy on Reprints, and Policy and Procedure Regarding Investigation of Complaint Against Educational Programs, section on Anonymous Comments/Complaints. The Committee also discussed report deadlines and whether the deadline should be changed.

**Review Committees and Review Committee Meetings:** The Standing Committee reviewed the Review Committees and Review Committee Meetings policy, specifically the section related to the process for receiving nominations for Review Committee members from sponsoring organizations and certifying boards. The Committee learned of two (2) recent incidents, and others in the past, where Review Committee appointments were delayed because sponsoring organizations/certifying boards did not provide the minimum number of qualified nominees, as required by the Commission. The Committee discussed possible solutions, including whether CODA should assume responsibility for identifying nominees when the sponsoring organization/certifying board does not comply with CODA’s request, and whether the vacant position on a Review Committee should remain vacant until the nominating organization provides the minimum number of qualified nominees. The Committee discussed the ramifications of changing the process, including the challenge CODA could face in identifying qualified nominees and the hardship to the affected Review Committee in conducting its business if a position remains vacant. Following discussion, the Committee determined that the sponsoring organization/certifying board from which the nominations are to be submitted has access to the largest group of potential nominees and should continue to be responsible for submitting a minimum of two (2) qualified nominations to the Commission. Accordingly, the policy should not be changed at this time and the situation should be monitored and revisited in the future if there continues to be delays in qualified nominations to the Commission for vacancies on Review Committees.
In discussion of Review Committee nominations criteria and requirements, specifically related to the ADA membership requirement for Review Committee members, the Committee noted the requirement that Review Committee members be ADA members and learned that, in the recent past, it has been a barrier to receiving nominations from otherwise interested and qualified nominees. This has created a hardship in filling Review Committee openings, particularly for smaller Review Committees. Therefore, the Committee believed the ADA membership requirement should be removed from the Review Committee nominations criteria, found in the Review Committees and Review Committee Meetings policy, and as noted in Appendix 1.

In addition, the Standing Committee also reviewed the section entitled Nomination Criteria to provide guidance in interpreting the criteria for public, higher education and hospital administrators on Review Committees, specifically related to being a “Member of” or “Member of or employee” of any professional/trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission, as well as the prohibition of any spouse, parent, child or sibling of an individual identified in the prior role. The Committee considered whether current membership or eligibility of membership should be the limiting criteria, and noted that the USDE regulations currently state “Member of” as the limitation. It was also noted that requiring eligibility for membership as a limitation further narrows the pool upon which CODA can draw nominees in these categories. The Committee believed the intent is to prohibit appointment of individuals with current knowledge of dentistry through membership in an organization affiliated or associated with CODA, or being the spouse, parent, child or sibling of an individual identified in the prior role. To that end, the Standing Committee believed the criteria is appropriately worded and revision is not warranted at this time.

Commission and Commission Meetings policy: The Standing Committee learned that the Composition portion of the Commission and Commission Meetings policy was not completely revised at the time of a major revision to the Board of Commissioners, Composition, within the CODA Rules at the Winter 2020 meeting of the Commission. Therefore, the Committee determined the revisions to the Composition portion of the Commission and Commission Meetings policy and presented in Appendix 1 are editorial in nature and should be made in the EOPP as indicated.

Conflict of Interest Policy: The Standing Committee reviewed the Conflict of Interest Policy, specifically the conflict of serving on the site visit to a program in the same state in which the site visitor is affiliated with an institution/program. The Committee learned, at times, it is difficult to secure site visitors due to the increased use of sites where educational activity occurs which are in locations outside of the state that is the program’s primary location and may be in the same state as a potential site visitor even though the potential site visitor has no knowledge of or conflict with the program and no relationship with the educational activity site in their own state. Following discussion, the Committee believed a conflict exists if the site visitor is affiliated with an institution/program in the same state as the program’s primary location or any of the
program’s educational activity sites, or if other conflicts exist, and that the policy should be revised to reflect this clarification.

The Standing Committee also discussed the conflict related to serving on the site visit to a program in the same state where the site visitor “owns property” but that is not the site visitor’s primary residence. Following deliberation, the Committee noted that the recent addition of this clause as a conflict has created an additional challenge in identifying site visitors to serve on site visit teams. The Committee believed owning property in the same state as a program being visited appears to be unrelated to accreditation and may be overly restrictive, particularly where the property is not the site visitor’s primary residence and the site visitor has no knowledge of the program. Therefore, the Standing Committee believed that owning property in the same state as a program being site visited should not be considered a conflict of interest and should be removed from the policy.

The Standing Committee also learned that the conflict identified in policy related to serving on the program’s visiting committee within the last ten (10) years, is also presenting increased challenges in identifying site visitors, and, of late, in making Review Committee assignments. The Committee discussed the risks in assigning site visitors to the same program, including bias based on previous site visit findings, both positive and negative. The Committee also discussed the likelihood that programs would be different than when previously visited based on CODA’s site visit interval of seven (7) years for all disciplines except oral and maxillofacial surgery, which is on a five (5) year visitation schedule. Through further deliberations, the Committee discussed the number of years between serving on a site visit team to the same institution, and believed seven (7) years is appropriate. Therefore, the Committee believed the policy should be revised to reflect the change in the amount of time between serving on a site visit team to the same institution, with the intent being that a site visitor must not have served on the program’s last comprehensive site visit or any visit from that time to the present. Following the discussion of this policy, the Standing Committee recommended approving the revisions to the Conflict of Interest Policy found in Appendix 1.

**Application for Accreditation for Fully Operational Programs With Enrollment and Without Accreditation and Application for Initial Accreditation for Developing Programs**: The Standing Committee reviewed the policies related to application for accreditation of fully operational and developing programs, specifically the steps for accreditation found in both. The Committee noted the steps in policy clearly identify that the first opportunity for the Commission to consider a program, if the application is in order, is 12 to 18 months following the application submission date. However, the Committee learned that procedurally, due to the amount of time required to process applications, including receipt of the application fee and initiation of the application review process, clarification of the point at which the 12 to 18 month period begins may be warranted. Following discussion, the Standing Committee believed that the policy should be revised to clarify that the 12 to 18 months timeframe for CODA consideration of an applicant program begins following Commission’s acknowledgement of the application through
a formal letter to the program as the first step in the application review process, and recommended the revisions to the policies found in Appendix 1 be approved.

**Site Visitors:** The Standing Committee reviewed the Site Visitors policy, specifically related to the criteria for selection of dental therapy site visitors. The Committee noted the criteria for the selection of dental therapy site visitors includes a temporary waiver of some criteria for the dental therapist educator position until after CODA accredits dental therapy programs; currently CODA accredits one (1) dental therapy program. Noting ongoing difficulty in finding dental therapist educators, the Committee believed the criteria should be revised to set a threshold number of dental therapy programs that must be accredited in order to terminate the waiver of certain criteria for the dental therapist educator position on a site visit team and believed the threshold should be a minimum of three (3) dental therapy programs. The Committee also believed the addition of the dental therapy site visit team composition should be added to policy and recommended approval of the revisions to the Site Visitor policy found in Appendix 1.

**Reporting Program Changes in Accredited Programs:** The Standing Committee reviewed the Reporting Program Changes in Accredited Programs policy, specifically the section related to the addition of educational tracks. Through discussion, the Committee learned that the addition of different types of educational tracks, such as part-time tracks, are not always reported by programs prior to implementation and that the addition of this program option to policy may be warranted. The Committee believed the addition of this, and other track offerings, are significant and could affect the ability of the program to continue to meet the Accreditation Standards. Therefore, the Committee recommended the addition of a part-time, multi-degree or other track offerings to the Reporting Program Changes policy as a program change that requires review by the appropriate Review Committee and approval by the Commission prior to implementation, as noted in Appendix 1.

**Policy on Non-Enrollment of First Year Students/Residents:** The Standing Committee discussed the Policy on Non-Enrollment of First Year Students/Residents specifically related to the opportunity for a third year of non-enrollment only for programs with the status of “approval without reporting requirements.” The Committee discussed the policy and believed the opportunity to request the extension of accreditation should be available for programs with any accreditation status, particularly since the program must provide a formal request stating the reasons why the accreditation of the program should not be discontinued. Therefore, the Committee believes the proposed revision in Appendix 1 should be approved.

**Policy on Reprints:** The Standing Committee discussed the Policy on Reprints and learned that the word “reprint” may require additional definition to ensure it is understood that “reprint” includes reproducing materials in any paper or electronic format or media. Following discussion, the Committee believed the proposed revision in Appendix 1 provides appropriate clarification and recommended it be approved.
Policy and Procedure Regarding Investigation of Complaints Against Educational Programs; Anonymous Comments/Complaints: The Standing Committee learned that, on occasion, CODA receives complaints identified as “anonymous” which are received via email and identify the sender in the email address. Through discussion, the Committee confirmed that complaints received in this manner are no longer “anonymous” since the identity of the sender is provided within the communication to the Commission, and should be reviewed as a “formal” complaint. Therefore, the Committee determined that the proposed revision found in Appendix 1 provides appropriate clarification and recommended its approval.

Deadlines for Submission of Reports to CODA: The Standing Committee discussed the deadline dates for submission of reports for consideration by the Commission. The Committee learned that receipt of program reports by the deadline of December 1 and June 1 continues to be a problem and can create a challenge in preparing reports for review by the Review Committees and Commission in a timely manner, particularly if follow-up with programs is required. The Committee discussed the possibility of moving the deadlines for all reports to November 15 and May 15 to allow additional time to follow-up with programs and provide sufficient time for review of reports by the Review Committees. Following discussion, the Committee believed changing the deadlines may be viewed as a penalty to compliant programs by requiring reports earlier than has been CODA’s general practice. The Committee noted that policies regarding failure to submit requested information and missed deadlines may be referenced when communicating with programs that do not adhere to CODA’s prescribed reporting deadlines. Therefore, the Standing Committee believed the deadlines for submitting reports to CODA should not be changed at this time.

Standing Committee Recommendation: It is recommended that the Commission on Dental Accreditation adopt and implement immediately the proposed revisions to policies found in Appendix 1, including the revision of policies in the Commission’s EOPP and in all appropriate Commission documents.

Consideration of Proposed Revisions to Miscellaneous Policies Due to Changes in United States Department of Education (USDE) Recognition Criteria: Through preparation of the Commission’s re-recognition petition to the USDE, Commission staff noted some USDE regulations have changed and warrant careful review and possible revision to related CODA Accreditation Standards and policies. To that end, the Standing Committee reviewed the specific language and regulations, and related CODA policies, as identified by CODA staff. Proposed revisions to policies are provided in Appendix 2. The USDE definitions and regulations reviewed are provided in Appendix 3.

USDE Language Change from “Regional Accreditation” to “Institutional Accreditation”: The Standing Committee learned that the language used by the USDE related to a parent institution’s accreditation has changed from “regional” accreditation to “institutional” accreditation, as noted in regulation §602.3 (Definitions). The Committee also learned that the predoctoral, dental therapy, dental hygiene, dental assisting, and dental laboratory technology Accreditation...
Standards use the term “regional” accreditation. Therefore, the Committee believed the Predoctoral, Dental Hygiene, Dental Assisting, and Dental Laboratory Technology Review Committees should review the Accreditation Standards under their purview and consider possible revisions to align with the language now used in USDE regulations.

In addition, the Standing Committee learned the USDE’s sole reference to “institutional accreditation” could create confusion when identifying the institutional accreditors that have USDE recognition authority to oversee institutions at the post-secondary, doctoral, and post-doctoral levels. For example, dental education programs must be sponsored by institutions accredited with the ability to award doctoral degrees. Post-doctoral dental education programs must be sponsored by institutions with the ability to award post-doctoral certificates and/or degrees. Allied dental education programs must be sponsored by institutions with the ability to award post-secondary certificates and degrees. The concern is that the change in USDE language could result in questions regarding the level of degree-granting authority that the institution has and its institutional accredditor’s USDE recognition. Given the scope of impact across all disciplines under CODA’s purview, the Committee believed each Review Committee should consider the discipline-specific Accreditation Standards under its purview for potential revision to address changes in reference to institutional accreditation and ensure the CODA Standards clearly identify the type of institutional accreditor required to serve as sponsors of CODA-accredited dental education programs.

**Standing Committee Recommendation:** It is recommended that the Commission on Dental Accreditation direct all Review Committees to review and revise their Accreditation Standards, as applicable, to align with USDE terminology related to “institutional accreditation” and to ensure the Accreditation Standards clearly document the appropriate type of accreditor for the discipline, with a report to the Summer 2021 meeting of the Commission.

**Consideration of Modifications to CODA Policies Related to USDE Recognition Criteria:** The Standing Committee reviewed the following USDE recognition criteria and related CODA policies: §602.16 Accreditation and preaccreditation standards, §602.18 Ensuring consistency in decision-making, §602.20 Enforcement of standards, §602.25 Due process, §602.26 Notification of accrediting decisions; and §602.28 Regard for decisions of States and other accrediting agencies.

§602.16 Accreditation and preaccreditation standards. The Standing Committee reviewed this regulation specifically related to Distance Education and noted no changes to warrant revision to CODA’s Policy on Distance Education at this time. The Committee believed CODA staff should continue to monitor this regulation for changes.

§602.18 Ensuring consistency in decision-making and §602.20 Enforcement of standards. The Standing Committee reviewed these regulations and the related CODA Accreditation Status Definitions. Through review, the Committee learned that the change in language of §602.18
specifically relates to the amount of time a program has to demonstrate compliance with deficiencies, noting the regulation allows an amount of time not to exceed three (3) years unless the agency determines there is good cause to extend the period of time. Further, regulation §602.20 indicates the agency’s timeline for a program to reach full compliance “must not exceed the lesser of four years or 150 percent of the length of the program in the case of a programmatic accrediting agency;” CODA is a programmatic accrediting agency. Through review of CODA policy, the Committee noted the CODA Accreditation Status Definitions states: “Evidence of compliance with the cited standards or policies must be demonstrated within a timeframe not to exceed eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause.” Following deliberation, the Committee questioned whether it would be responsible, as an accrediting agency of health profession disciplines, to lengthen the amount of time to reach compliance to no more than three (3) years as noted in the revised USDE regulations. The Committee believed CODA policy currently allows sufficient time for a program to come into compliance and, when necessary and appropriate, the flexibility for extending the period of achieving compliance for good cause. The Committee concluded that revision to Accreditation Status Definitions, particularly the timeline to reach full compliance, is not warranted at this time.

§602.25 Due process. The Standing Committee reviewed the USDE’s revisions to its criteria for recognition, along with CODA policies Due Process Related to Withdrawal of Accreditation and the Function and Procedures of the Appeal Board. Through review of the USDE criteria, the Committee believed the related CODA policy on Due Process Related to Withdrawal of Accreditation sufficiently addresses the requirements and revision is not warranted at this time. However, through review of the regulation related to Appeal Board decisions, the Committee noted the USDE revision includes removal of the Appeal Board’s authority to “reverse” decisions made by a decision-making body, which is currently noted in CODA’s Function and Procedures of the Appeal Board. Therefore, the Committee believed the revisions to this policy found in Appendix 2 should be approved to ensure consistency between the USDE criteria for Appeal Board authority and CODA policy and procedures.

§602.26 Notification of accrediting decisions. In conjunction with review of this criteria, the Standing Committee reviewed the Commission’s policies Voluntary Discontinuance of Accreditation and Due Process Related to Withdrawal of Accreditation as well as suggested revisions due to changes in the recognition criteria.

Through review of the USDE criteria related to voluntary discontinuance of accreditation, the Committee noted the timeframe to notify the USDE and appropriate licensing bodies and accrediting agencies was changed to ten (10) business days. Therefore, the Committee recommended the Voluntary Discontinuance of Accreditation policy, found in Appendix 2, be revised to ensure consistency and continued compliance with USDE recognition criteria.
The Standing Committee also reviewed the USDE criteria related to Due Process Related to Withdrawal of Accreditation, as well as suggested revisions. The Committee noted that accrediting agencies must provide written notice of the *initiation* of an adverse action and the *final decision* on an adverse action within seven (7) business days to the USDE, appropriate state licensing or authorizing agencies, appropriate institutional accrediting agencies, and the public. Further, programs are also required to inform all current and prospective students/residents/fellows of the Commission’s notice of any *initiated* or *final decision* on an adverse action within seven (7) business days of the program’s receipt of CODA’s notice. To ensure CODA policies appropriately reflect current USDE criteria, the Committee recommended the revisions noted in Appendix 2 be approved.

§602.28 Regard for decisions of States and other accrediting agencies. The Standing Committee also reviewed §602.28 and related CODA Policy on Regard for Decisions of States and Other Accrediting Agencies. Following review of the criteria for recognition and CODA policy, the Committee determined revisions are warranted to ensure CODA policy is appropriately aligned with revised USDE criteria, and recommended the revisions found in Appendix 2 be approved.

**Standing Committee Recommendation:** It is recommended that the Commission on Dental Accreditation adopt and implement immediately the proposed revisions to policies found in Appendix 2, including the revision of policies in the Commission’s EOPP and in all appropriate Commission documents.

**Commission Action:**

Prepared by: Ms. Peggy Soeldner
MISCELLANEOUS POLICY REVISIONS FOR CONSIDERATION

Underline indicates addition; Strikethrough indicates deletion

REVIEW COMMITTEES AND REVIEW COMMITTEE MEETINGS

1. Structure: The chair of each Review Committee will be the appointed Commissioner from the relevant discipline.
   i. The Commission will appoint all Review Committee members.
      a. Review Committee positions not designated as discipline-specific will be appointed from the Commission where feasible, e.g. a public representative on the Commission could be appointed to serve as the public member on the Dental Laboratory Technology Review Committee; an ADA appointee to the Commission could be appointed to the Dental Assisting Review Committee as the general dentist practitioner.
      b. Discipline-specific positions on Review Committees will be filled by appointment by the Commission of an individual from a small group of qualified nominees (at least two) submitted by the relevant national organization, discipline-specific sponsoring organization or certifying board. Nominating organizations may elect to rank their nominees, if they so choose. If fewer than two (2) qualified nominees are submitted, the appointment process will be delayed until such time as the minimum number of required qualified nominations is received.
   ii. Consensus is the method used for decision making; however if consensus cannot be reached and a vote is required, then the Chair may only vote in the case of a tie (American Institute of Parliamentarians Standard Code of Parliamentary Procedures).
   iii. Member terms will be staggered, four year appointments; multiple terms may be served on the same or a different committee, with a one-year waiting period between terms. A maximum of two (2) terms may be served in total. The one-year waiting period between terms does not apply to public members.
   iv. One public member will be appointed to each committee.
   v. The size of each Review Committee will be determined by the committee’s workload.
   vi. As a committee’s workload increases, additional members will be appointed while maintaining the balance between the number of content experts and non-content experts. Committees may formally request an additional member through New Business at Review Committee/Commission meetings. If an additional member is approved, this member must be a joint nomination from the professional organization and certifying board, as applicable.
   vii. Conflict of interest policies and procedures are applicable to all Review Committee members.
   viii. Review Committee members who have not had not been on a site visit within the last two (2) years prior to their appointment on a Review Committee should observe at least one site visit within their first year of service on the Review Committee.
   ix. In the event that fewer than 50% of discipline-specific experts are present for any one discipline, the decision by a quorum of the Review Committee shall be acceptable. In the case of less than 50% of discipline-specific experts, including the Chair, available for a review committee meeting, for specified agenda items or for the entire meeting, the Review Committee Chair may temporarily appoint an additional discipline-specific expert(s) with the approval of the CODA Director. The substitute should be a previous Review Committee member or an individual approved by both the Review Committee Chair and the CODA Director. The substitute would
have the privileges of speaking, making motions and voting.

x. Consent agendas may be used by Review Committees, when appropriate, and may be approved by a quorum of the Review Committee present at the meeting.

Revised: 8/20; 1/20; 8/18; 8/17; 2/15; 1/14, 2/13, 8/10, 7/09; 7/08; 7/07; Adopted: 1/06

2. Composition

Predoctoral Education Review Committee (9 members)
1 discipline-specific Commissioner appointed by American Dental Education Association
1 public member
3 dental educators who are involved with a predoctoral dental education program (two must be general dentists)
1 general dentist (One of whom is a practitioner
1 non-general* dentist) (dentist and the other an educator)
1 dental assistant, dental hygienist, dental therapist or dental laboratory technology professional educator
1 dental therapist educator
*a dentist who has completed an advanced dental education program in dental anesthesiology, dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthodontics.

Three (3) Advanced Dental Education Review Committees (DPH, OMP, OMR - 5 members each. At least one member must be a dental educator.)
1 discipline-specific Commissioner appointed by the discipline-specific sponsoring organization
1 public member
1 dentist nominated by the discipline-specific sponsoring organization
1 dentist nominated by the discipline-specific certifying board
1 general dentist

Six (6) Advanced Dental Education Review Committees (ENDO, OMS, ORTHO, PERIO, PED, PROS - 6 members each. At least one member must be a dental educator.)
1 discipline-specific Commissioner appointed by the discipline-specific sponsoring organization
1 public member
1 dentist nominated by the discipline-specific sponsoring organization
1 dentist nominated by the discipline-specific certifying board
1 dentist nominated by the discipline-specific certifying board and discipline-specific sponsoring organization
1 general dentist

Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Review Committee (12 members)
1 discipline-specific Commissioner, jointly appointed by American Dental Education Association (ADEA), the Special Care Dentistry Association (SCDA), the American Society of Dentist Anesthesiologists (ASDA), the American Academy of Oral Medicine (AAOM), and the American Academy of Orofacial Pain (AAOP)
1 public member
2 current General Practice Residency (GPR) educators nominated by the SCDA
2 current Advanced Education in General Dentistry (AEGD) educators nominated by ADEA
1 oral medicine educator nominated by the American Academy of Oral Medicine
1 dental anesthesiology educator nominated by the American Society of Dentist Anesthesiologists
1 orofacial pain educator nominated by the American Academy of Orofacial Pain
1 general dentist graduate of a GPR or AEGD
1 non-general* dentist
1 higher education or hospital administrator with past or present experience in administration in a teaching institution
*a dentist who has completed an advanced dental education program in dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthodontics.

Dental Assisting Education Review Committee (10 members)
1 discipline-specific Commissioner appointed by American Dental Assistants Association
1 public member
2 general dentists (practitioner or educator)
5 dental assisting educators
1 dental assisting practitioner who is a graduate of a Commission accredited program

Dental Hygiene Education Review Committee (11 members)
1 discipline-specific Commissioner appointed by American Dental Hygienists’ Association
1 public member
4 dental hygienist educators
2 dental hygienist practitioners
1 dentist practitioner
1 dentist educator
1 higher education administrator

Dental Laboratory Technology Education Review Committee (5 members)
1 discipline-specific Commissioner appointed by National Association of Dental Laboratories
1 public member
1 general dentist
1 dental laboratory technology educator
1 dental laboratory owner nominated by National Association of Dental Laboratories

Revised: 8/18; 2/16; 2/15; 8/14; 2/13, 7/09, 7/08, 1/08; Reaffirmed: 8/17; 8/10; Adopted: 1/06

3. Nomination Criteria: The following criteria are requirements for nominating members to serve on the Review Committees. Rules related to the appointment term on Review Committees apply.

All Nominees:
• Ability to commit to one (1) four (4) year term;
• Willingness to commit ten (10) to twenty (20) days per year to Review Committee activities, including training, comprehensive review of print and electronically delivered materials and travel to Commission headquarters;
• Ability to evaluate an educational program objectively in terms of such broad areas as curriculum,
faculty, facilities, student evaluation and outcomes assessment;

- Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of
Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; HIPAA
Training, Licensure Attestation, and Professional Conduct Policy and Prohibition Against
Harassment);
- Ability to conduct business through electronic means (email, Commission Web Sites); and
- Active, life or retired member of the American Dental Association, where applicable.

**Educator Nominees:**
- Commitment to predoctoral, advanced, and/or allied dental education;
- Active involvement in an accredited predoctoral, advanced, or allied dental education program as a
full- or part-time faculty member;
- Subject matter experts with formal education and credentialed in the applicable discipline; and
- Prior or current experience as a Commission site visitor.

**Practitioner Nominees:**
- Commitment to predoctoral, advanced, and/or allied dental education;
- Majority of current work effort as a practitioner; and
- Formal education and credential in the applicable discipline.

**Public/Consumer Nominees:**
- A commitment to bring the public/consumer perspective to Review Committee deliberations. The
nominee should not have any formal or informal connection to the profession of dentistry; also, the
nominee should have an interest in, or knowledge of, health-related and accreditation issues. In order
to serve, the nominee must not be a:
  a. Dentist or member of an allied dental discipline;
  b. Member of a predoctoral, advanced, or allied dental education program faculty;
  c. Employee, member of the governing board, owner, or shareholder of, or independent consultant
to, a predoctoral, advanced, or allied dental education program that is accredited by the
Commission on Dental Accreditation, has applied for initial accreditation or is not-accredited;
  d. Member or employee of any professional/trade association, licensing/regulatory agency or
membership organization related to, affiliated with or associated with the Commission, dental
education or dentistry; and
  e. Spouse, parent, child or sibling of an individual identified above (a through d).

**Higher Education Administrator:**
- A commitment to bring the higher education administrator perspective to the Review Committee
deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related
to, affiliated with or associated with the Commission; and
  b. Spouse, parent, child or sibling of an individual identified above.

**Hospital Administrator:**
- A commitment to bring the hospital administrator perspective to Review Committee deliberations. In
order to serve, the nominee must not be a:
a. Member of any trade association, licensing/regulatory agency or membership organization related
to, affiliated with or associated with the Commission; and
b. Spouse, parent, child or sibling of an individual identified above.

Revised: 2/21; 8/18; 8/17; 8/14; 8/10; Adopted: 07/08

COMMISSION AND COMMISSION MEETINGS

The Commission and its Review Committees meet twice each year to consider site visit reports
and institutional responses, progress reports, information from annual surveys, applications for
initial accreditation, and policies related to accreditation. These meetings are held in the winter
and the summer.

Reports from site visits conducted less than 90 days prior to a Commission meeting are usually
defered and considered at the next Commission meeting. Commission staff can provide
information about the specific dates for consideration of a particular report.

The Commission has established policy and procedures for due process which are detailed in the
Due Process section of this manual.

Revised: 8/17; 8/14; 7/06, 7/96; Reaffirmed: 8/10; Adopted: 7/96

1. Composition and Criteria

Composition

The Board of Commissioners shall consist of:

1. Four (4) members shall be selected from nominations open to all trustee districts from the active,
life or retired members of this association, no one of whom shall be a faculty member working
more than one day per week of a school of dentistry or a member of a state board of dental
examiners or jurisdictional dental licensing agency. These members shall be nominated by the
Board of Trustees and elected by the American Dental Association House of Delegates.

2. Four (4) members who are active, life or retired members of the American Dental Association
shall be selected by the American Association of Dental Boards from the active membership of
that body, no one of whom shall be a member of a faculty of a school of dentistry.

3. Four (4) members who are active, life or retired members of the American Dental Association
shall be selected by the American Dental Education Association from its active membership.
These members shall hold positions of professorial rank in dental schools accredited by the
Commission on Dental Accreditation and shall not be members of any state board of dental
examiners.

4. Four (4) members who shall be appointed by the Board of Trustees from the names of active, life
or retired members of this Association. None of the appointees shall be a faculty member of any
dental education program working more than one day per week or a member of a state board of
dental examiners or jurisdictional dental licensing agency.

Four (4) members who are active, life or retired members of this Association and also active
members of the American Association of Dental Boards shall be selected by the American
Association of Dental Boards. None of these members shall be a faculty member of any dental
education program.

Four (4) members who are active, life or retired members of this Association and also active
members of the American Dental Education Association shall be selected by the American
Dental Education Association. None of these members shall be a member of any state board of
dental examiners or jurisdictional dental licensing agency.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant
selected by the American Dental Assistants Association from its active or life membership, one
(1) licensed dental hygienist selected by the American Dental Hygienists’ Association, one (1)
certified dental laboratory technician selected by the National Association of Dental
Laboratories, one (1) student selected jointly by the American Student Dental Association and the
Council of Students, Residents and Fellows of the American Dental Education Association, one
(1) dentist who is board certified in the respective discipline-specific area of practice and is
selected by each of the following organizations: American Academy of Oral and Maxillofacial
Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of
Pediatric Dentistry, American Academy of Periodontology, American Association of
Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association
of Orthodontists, American Association of Public Health Dentistry, American College of
Prosthodontists; one (1) dentist who is jointly appointed by the American Dental Education
Association, the Special Care Dentistry Association, the American Society of Dentist
Anesthesiologists, the American Academy of Oral Medicine, and the American Academy of
Orofacial Pain and four (4) consumers members of the public who are neither dentists nor allied
dental personnel nor teaching in a dental or allied dental education institution and who are
selected by the Commission, based on established and publicized criteria. In the event a
Commission member sponsoring organization fails to select a Commissioner, it shall be the
responsibility of the Commission to select an appropriate representative to serve as a
Commissioner. A member of the Standing Committee on the New Dentist (when assigned by
the ADA Board of Trustees) and the Director of the Commission shall be an ex-officio
members of the Board without the right to vote.

Criteria (All Appointees)
• Ability to commit to one (1) four (4) year term;
• Willingness to commit ten (10) to twenty (20) days per year to activities, including training,
  comprehensive review of print and electronically delivered materials, and travel to
  Commission headquarters;
Evaluation policies and procedures used in the accreditation process provide a system of checks and balances regarding the fairness and impartiality in all aspects of the accreditation process. Central to the fairness of the procedural aspects of the Commission’s operations and the impartiality of its decision making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one’s duty to make decisions in the public’s interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be: 1) any relationship with an institution or program, or 2) a partiality or bias, either of which might interfere with objectivity in the accreditation review process. Procedures for selection of representatives of the Commission who participate in the evaluation process reinforce impartiality. These representatives include: Commissioners, Review Committee members, site visitors, and Commission staff.

In addition, procedures for institutional due process, as well as strict guidelines for all written documents and accreditation decisions, further reinforce adherence to fair accreditation practices. Every effort is made to avoid conflict of interest, either from the point of view of an institution/program being reviewed or from the point of view of any person representing the Commission.

On occasion, current and former volunteers involved in the Commission’s accreditation process (site visitors, review committee members, commissioners) are requested to make presentations related to the Commission and its accreditation process at various meetings. In these cases, the volunteer must make it clear that the services are neither supported nor endorsed by the Commission on Dental Accreditation. Further, it must be made clear that the information provided is based only on experiences of the individual and not being provided on behalf of the Commission.

Revised: 8/15; 8/14; Reaffirmed: 8/18; 2/18; 8/12, 8/10
1. Visiting Committee Members: Conflicts of interest may be identified by either an institution/program, Commissioner, site visitor or Commission staff. An institution/program has the right to reject the assignment of any Commissioner, site visitor or Commission staff because of a possible or perceived conflict of interest. The Commission expects all programs, Commissioners and/or site visitors to notify the Commission office immediately if, for any reason, there may be a conflict of interest or the appearance of such a conflict.

All active site visitors who independently consult with educational programs accredited by CODA or applying for accreditation must identify all consulting roles to the Commission and must file with the Commission a letter of conflict acknowledgement signed by themselves and the institution/program with whom they consulted. All conflict of interest policies as noted elsewhere in this document apply. Contact the CODA office for the appropriate conflict of interest declaration form.

Conflicts of interest include, but are not limited to, a site visitor who:

- is a graduate of a program at the institution;
- has served on the program’s visiting committee within the last ten (10) seven (7) years;
- has served as an independent consultant, employee or appointee of the institution;
- has a family member who is employed or affiliated with the institution;
- has a close professional or personal relationship with the institution/program or key personnel in the institution/program which would, from the standpoint of a reasonable person, create the appearance of a conflict;
- manifests a partiality that prevents objective consideration of a program for accreditation;
- is a former employee of the institution or program;
- previously applied for a position at the institution within the last five (5) years;
- is affiliated with an institution/program in the same state as the program’s primary location;
- is a resident of or owns property in the state; and/or
- is in the process of considering, interviewing and/or hiring key personnel at the institution.

Note: Because of the nature of their positions, a state board representative will be a resident of the state in which a program is located and may be a graduate of the institution/program being visited. These components of the policy do not apply for state board representatives, although the program retains the right to reject an individual’s assignment for other reasons.

If an institutional administrator, faculty member or site visitor has doubt as to whether or not a conflict of interest could exist, Commission staff should be consulted prior to the site visit. The Chair, Vice-Chair and a public member of the Commission, in consultation with Commission staff and legal counsel, may make a final determination about such conflicts.

Revised: 2/21; 8/18; 2/18; 2/16; 8/14; 1/14; 2/13; 8/10; Reaffirmed: 8/12
2. Commissioners, Review Committee Members And Members Of The Appeal Board: The Commission firmly believes that conflict of interest or the appearance of a conflict of interest must be avoided in all situations in which accreditation recommendations or decisions are being made by Commissioners, Review Committee members, or members of the Appeal Board. No Commissioner, Review Committee member, or member of the Appeal Board should participate in any way in accrediting decisions in which he or she has a financial or personal interest or, because of an institutional or program association, has divided loyalties and/or has a conflict of interest on the outcome of the decision.

During the term of service as a Review Committee member, these individuals should not serve as site visitors for an actual accreditation site visit to an accredited or developing program, unless deemed necessary. Two instances when a review committee member could serve on a site visit include: 1) an inability to find a site visitor from the comprehensive site visitor list, or 2) when the review committee believes a member should attend a visit for consistency in the review process. This applies only to site visits that would be considered by the same review committee on which the site visitor is serving. Review committee members may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, review committee members may not serve as a site visitor for mock accreditation purposes. These policies help avoid conflict of interest in the decision making process and minimize the need for recusals.

During the term of service as a commissioner or appeal board member, these individuals may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, Commissioners or appeal board may not serve on a site visit team during their terms.

Areas of conflict of interest for Commissioners, Review Committee members and/or members of the Appeal Board include, but are not limited to:

- close professional or personal relationships or affiliation with the institution/program or key personnel in the institution/program which may create the appearance of a conflict;
- serving as an independent consultant or mock site visitor to the institution/program;
- being a graduate of the institution/program;
- being a current employee or appointee of the institution/program;
- previously applied for a position at the institution within the last five (5) years;
- being a current student at the institution/program;
- having a family member who is employed by or affiliated with the institution;
- manifesting a professional or personal interest at odds with the institution or program;
- key personnel of the institution/program having graduated from the program of the Commissioner, Review Committee member, or member of the Appeal Board;
- having served on the program’s visiting committee within the last ten (10) seven (7) years;
and/or

• no longer a current employee of the institution or program but having been employed there within the past ten (10) years.

To safeguard the objectivity of the Review Committees, conflict of interest determinations shall be made by the Chair of the Review Committee. If the Chair, in consultation with a public member, staff and legal counsel, determines that a Review Committee member has a conflict of interest in connection with a particular program, the Review Committee member will be instructed to not access the report either in advance of or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any committee member who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Commission, conflict of interest determinations shall be made by the Chair of the Commission. If the Chair, in consultation with a public member, staff and legal counsel, determines that a Commissioner has a conflict of interest in connection with a particular program, the Commissioner will be instructed to not access the report either in advance of or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any Commissioner who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Appeal Board, any member who has a conflict of interest in connection with a program filing an appeal must inform the Director of the Commission. The Appeal Board member will be instructed to not access the report for that program either in advance of or at the time of the meeting, and the individual must leave the room when the program is being discussed. If necessary, the respective representative organization will be contacted to identify a temporary replacement Appeal Board member.

Conflicts of interest for Commissioners, Review Committee members and members of the Appeal Board may also include being from the same state, but not the same program. The Commission is aware that being from the same state may not itself be a conflict; however, when residence within the same state is in addition to any of the items listed above, a conflict would exist.

This provision refers to the concept of conflict of interest in the context of accreditation decisions. The prohibitions and limitations are not intended to exclude participation and decision-making in other areas, such as policy development and standard setting.
Commissioners are expected to evaluate each accreditation action, policy decision or standard adoption for the overall good of the public. The American Dental Association (ADA) Constitution and Bylaws limits the involvement of the members of the ADA, the American Dental Education Association and the American Association of Dental Boards in areas beyond the organization that appointed them. Although Commissioners are appointed by designated communities of interest, their duty of loyalty is first and foremost to the Commission. A conflict of interest exists when a Commissioner holds appointment as an officer in another organization within the Commission’s communities of interest. Therefore, a conflict of interest exists when a Commissioner or a Commissioner-designee provides simultaneous service to the Commission and an organization within the communities of interest. (Refer to Policy on Simultaneous Service)

Revised: 2/21; 8/16; 2/16; 2/15; 8/14; 1/14, 8/10; Reaffirmed: 8/18; 8/12

3. Commission Staff Members: Although Commission on Dental Accreditation staff does not participate directly in decisions by volunteers regarding accreditation, they are in a position to influence the outcomes of the process. On the other hand, staff provides equity and consistency among site visits and guidance interpreting the Commission’s policies and procedures.

For these reasons, Commission staff adheres to the guidelines for site visitors, within the time limitations listed and with the exception of the state residency, including:

- graduation from a program at the institution within the last five years;
- service as a site visitor, employee or appointee of the institution within the last five years;
- and/or
- close personal or familial relationships with key personnel in the institution/program.

Revised: 8/14; 8/10, 7/09, 7/07, 7/00, 7/96, 1/95, 12/92; Reaffirmed: 8/18; 8/12, 1/03; Adopted: 1982

APPLICATION FOR ACCREDITATION FOR FULLY OPERATIONAL PROGRAMS WITH ENROLLMENT AND WITHOUT ACCREDITATION

Those programs that have graduated at least one class of students/residents and are enrolling students/residents in every year of the program are considered fully operational. These programs will complete the self-study document and will be considered for the accreditation status of “approval with reporting requirements” or “approval without reporting requirements” following a comprehensive site visit (Please see procedures for the conduct of a comprehensive site visit). Students/Residents who are enrolled in the program at the time accreditation is granted, and who successfully complete the program, will be considered graduates of an accredited program. Students/Residents who graduated from the program prior to the granting of accreditation will not be considered graduates of an accredited program.
Because accreditation is voluntary, a program may withdraw its application for accreditation at any time prior to the Commission taking action regarding an accreditation status. When an accreditation status has been granted, the program has the right to ask that the status be discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of programs, application forms, deadlines for submission and accreditation standards. Program administrators and faculty are encouraged to consult with Commission staff during this initial process.

An application fee must be submitted with a program’s application for accreditation. Programs should contact the Commission office for the current fee schedule.

The following steps apply:

1. An application for accreditation is completed by the program and submitted to the Commission on Dental Accreditation, along with appropriate documentation and application fee. The first opportunity for the Commission to consider the program, provided that the application is in order, is generally could be 12 to 18 months following the Commission’s formal acknowledgment of receipt of the application and initiation of the review process. the application submission date.

2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet minimum requirements. The application is considered complete when the Criteria for Granting Accreditation have been addressed as part of the application process.

3. If it is determined that the Criteria for Granting Accreditation have been addressed, a site visit is scheduled four (4) to seven (7) months following completion of the application review.

4. If changes occur within the program between the date of submission of the application and scheduled site visit, the site visit may be delayed.

5. After the site visit has been conducted, the visiting committee submits a draft report to the Commission office.

6. Within four (4) to six (6) weeks following the site visit, the preliminary draft of the site visit report is transmitted to the institution for consideration and comment prior to review by the discipline-specific Review Committee and the Commission.

7. The visiting committee’s report and the institution’s response to the preliminary report are transmitted to the discipline-specific Review Committee for consideration at its meeting prior to the Commission meeting.

8. The Commission then considers the Review Committee’s report and takes action on the accreditation status.

9. The Commission’s action regarding accreditation status and the final site visit report are transmitted to the institution within thirty (30) days of the Commission’s meeting.
Time Limitation for Review of Applications: The review of an application will be terminated if an institution fails to respond to the Commission’s requests for information for a period of six (6) months. In this case, the institution will be notified that the application process has been terminated. If the institution wishes to begin the process again, a new application and application fee must be submitted.

Revised: 2/21; 8/16; 2/16; 8/13; 7/08; Reaffirmed: 8/18; 8/13; 8/10; Adopted: 8/02

APPLICATION FOR INITIAL ACCREDITATION FOR DEVELOPING PROGRAMS

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 “developing.” The same review steps that apply for Application for Accreditation for Fully Operational Programs with Enrollment and Without Accreditation apply to Application for Initial Accreditation for Developing Programs.

The developing program must not enroll students/residents until initial accreditation status has been obtained. Once a program is granted “initial accreditation” status, a site visit will be conducted in the second year of programs that are four or more years in duration and again prior to the first class of students/residents graduating. Programs that are less than four (4) years in duration will be site visited again prior to the first class of students/residents graduating.

An institution which has made the decision to initiate and seek accreditation for a program that falls within the Commission on Dental Accreditation’s purview is required to submit an application for accreditation. “Initial accreditation” status may then be granted to programs which are developing, according to the accreditation standards.

Because accreditation is voluntary, a program may withdraw its application for accreditation at any time prior to the Commission taking action regarding an accreditation status. The initial accreditation status is granted based upon one or more site evaluation visit(s) and until the program is fully operational. When an accreditation status has been granted, the program has the right to ask that the status be discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of programs, application forms, deadlines for submission and accreditation standards. Program administrators and faculty are encouraged to consult with Commission staff during this initial process.

An application fee must be submitted with a program’s application for initial accreditation. Programs should contact the Commission office for the current fee schedule.

The following steps apply:

1. An application for accreditation is completed by the program and submitted to the
Commission on Dental Accreditation, along with appropriate documentation and application fee. The first opportunity for the Commission to consider the program, provided that the application is in order, is generally could be 12 to 18 months following the Commission’s formal acknowledgment of receipt of the application and initiation of the review process. The application submission date.

2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet minimum requirements. The application is considered complete when the Criteria for Granting Accreditation have been addressed as part of the application process.

3. If it is determined that the Criteria for Granting Accreditation have been addressed, a site visit is scheduled four (4) to seven (7) months following completion of the application review.

4. If changes occur within the program between the date of submission of the application and scheduled site visit, the site visit may be delayed.

5. After the site visit has been conducted, the visiting committee submits a draft report to the Commission office.

6. Within four (4) to six (6) weeks following the site visit, the preliminary draft of the site visit report is transmitted to the institution for consideration and comment prior to review by the discipline-specific Review Committee and the Commission.

7. The visiting committee’s report and the institution’s response to the preliminary report are transmitted to the discipline-specific Review Committee for consideration at its meeting prior to the Commission meeting.

8. The Commission then considers the Review Committee’s report and takes action on the accreditation status.

9. The Commission’s action regarding accreditation status and the final site visit report are transmitted to the institution within thirty (30) days of the Commission’s meeting.

Revised: 2/21; 8/16; 2/16; 8/13; 7/08, 8/02, 7/01; Reaffirmed: 8/18; 8/13; 8/11, 8/10

SITE VISITORS

The Commission uses site visitors with education and practice expertise in the discipline or areas being evaluated to conduct its accreditation program. Nominations for site visitors are requested from national dental and dental-related organizations representing the areas affected by the accreditation process. Self-nominations are accepted. Site visitors are appointed by the Commission annually and may be re-appointed.

During the term of service as a Review Committee member, these individuals should not serve as site visitors for an actual accreditation site visit to an accredited or developing program, unless deemed necessary. Two instances when a review committee member could serve on a site visit include: 1) an inability to find a site visitor from the comprehensive site visitor list, or 2) when the review committee believes a member should attend a visit for consistency in the review.
process. This applies only to site visits that would be considered by the same review committee on which the site visitor is serving. Review committee members are prohibited from serving as independent consultants for mock accreditation purposes. These policies help avoid conflict of interest in the decision making process and minimize the need for recusals.

During the term of service as a commissioner, these individuals may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, site visitors serving on the Commission may not serve on a site visit team during their terms.

All other active site visitors who independently consult with educational programs accredited by CODA or applying for accreditation must identify all consulting roles to the Commission and must file with the Commission a letter of conflict acknowledgement signed by themselves and the institution/program with whom they consulted. All conflict of interest policies as noted elsewhere in this document apply. Contact the CODA office for the appropriate conflict of interest declaration form.

Prior to a site visit, a list of site visitors and other participants is reviewed by the institution/program for conflict of interest or any other potential problem. The program/institution being site visited will be permitted to remove individuals from the list if a conflict of interest, as described in the Commission’s Conflict of Interest Policy, can be demonstrated. Information concerning the conflict of interest must be provided in writing clearly stating the specifics of the conflict.

Site visitors are appointed by the Chair and approved by the institution’s administration, i.e. dental school dean or program director. The visiting committee conducts the site visit and prepares the report of the site visit findings for Commission action. The size and composition of a visiting committee varies with the number and kinds of educational programs offered by the institution. All visiting committees will include at least one person who is not a member of a Review Committee of the Commission or a Commission staff member. Two dental hygiene site visitors shall be assigned to dental school-sponsored dental hygiene site visits.

When appropriate, a generalist representative from a regional accrediting agency may be invited by the chief executive officer of an institution to participate in the site visit with the Commission’s visiting committee. A generalist advises, consults and participates fully in committee activities during a site visit. The generalist’s expenses are reimbursed by the institution. The generalist can help to ensure that the overall institutional perspective is considered while the specific programs are being reviewed.

The institution is encouraged to invite the state board of dentistry to send a current member to participate in the site visit. If invited, the current member of the state board receives the same background materials as other site visit committee members and participates in all site visit
conferences and executive sessions. The state board of dentistry reimburses its member for
expenses incurred during the site visit.

In addition to other participants, Commission staff member may participate on the visiting
committee for training purposes. It is emphasized that site visitors are fact-finders, who report
committee findings to the Commission. Only the Commission is authorized to take action
affecting the accreditation status.

Revised: 8/19; 2/16; 8/14; 1/03, 1/00, 7/97; Reaffirmed: 8/10, 7/09, 7/07, 7/06, 7/01;
CODA: 07/96:10, 12/83:4

1. **Appointments:** All site visitor appointments are made annually for one year terms for a
maximum of six consecutive years. Following the maximum appointment period of six
consecutive years, the site visitor may reapply for appointment after one year. In exceptional
circumstances the Review Committee may recommend that the Commission alter an individual’s
term limits. Site visitors assist the Commission in a number of ways, including: developing
accreditation standards, serving on special committees, and serving as site visitors on visits to
predoctoral, advanced dental and allied dental education programs.

The Commission reviews nominations received from its communities of interest, including
discipline-specific sponsoring organizations and certifying boards. Individuals may also self-
nominate. In addition to the mandatory subject expertise, the Commission always requests
nominations of potentially under-represented ethnic groups and women, and makes every effort to
achieve a pool of site visitors with broad geographic diversity to help reduce site visit travel
expenses.

Site visitors are appointed/reappointed annually and required to sign the Commission’s Conflict
of Interest Statement, the Agreement of Confidentiality, the Copyright Assignment, Licensure
Attestation, and the ADA’s Professional Conduct Policy and Prohibition Against Harassment.
Site visitors must also complete annual training and will receive periodic updates on the
Commission’s policies and procedures related to the Health Insurance Portability and
Accountability Act (HIPAA). The Commission office stores these forms for seven (7) years. In
addition, site visitors must comply with training requirements, the ADA’s travel policy and other
CODA Rules and Regulations. The Commission may remove a site visitor for failing to comply
with the Commission’s policies and procedures, continued, gross or willful neglect of the duties
of a site visitor, or other just cause as determined by the Commission.

Subsequent to appointment/reappointment by the Commission, site visitors receive an
appointment letter explaining the process for appointment, training, and scheduling of
Commission site visitors.

Revised: 8/19; 8/18; 8/14; 7/08; Reaffirmed: 8/10, 1/98, 8/02; CODA: 07/94:9, 01/95:10
2. Criteria For Nomination Of Site Visitors: For predoctoral dental education programs, the Commission solicits nominations for site visitors from the American Dental Education Association to serve in five of six roles on dental education program site visits. The site visitor roles are Chair, Basic Science, Clinical Science, Curriculum, and Finance. Nominations for the sixth role, national licensure site visitor, are solicited from the American Association of Dental Boards.

For advanced dental education programs, the Commission solicits nominations for site visitors from the discipline-specific sponsoring organizations and their certifying boards.

For allied dental education programs, the American Dental Education Association is an additional source of nominations that augments, not supersedes, the nominations from the Commission’s other participating organizations, American Dental Assistants Association (ADAA), American Dental Hygienists’ Association (ADHA) and National Association of Dental Laboratories (NADL).

Revised: 8/18; 8/15; 8/14; 8/12; Reaffirmed: 8/19; 8/10, 7/07, 7/01; CODA: 05/93:6-7

The Commission requests all agencies nominating site visitors to consider regional distribution, gender and minority representation and previous experience as a site visitor. Although site visitors are nominated by a variety of sources, the Commission carefully reviews the nominations and appoints site visitors on the basis of need in particular areas of expertise. The pool of site visitors is utilized for on-site evaluations, for special consultations and for special or Review Committees.

All site visitors are appointed for a one-year term and may be re-appointed annually for a total of six consecutive years. Appointments are made at the Winter (January/February) Commission meeting and become effective with the close of the ADA annual session in the Fall.

Revised: 1/20; 8/19; 8/18; 8/14; 8/12, 7/09, 7/07, 7/01; Reaffirmed: 8/10; Adopted: 7/98

A. Predoctoral Dental Education: The accreditation of predoctoral dental education programs is conducted through the mechanism of a visiting committee. Membership on such visiting committees is general dentistry oriented rather than discipline or subject matter area oriented. The composition of such committees shall be comprised, insofar as possible, of site visitors having broad expertise in dental curriculum, basic sciences, clinical sciences, finance, national licensure (practitioner) and one Commission staff member. The evaluation visit is oriented to an assessment of the educational program’s success in training competent general practitioners.

Although a basic science or clinical science site visitor may have training in a specific basic science or discipline-specific advanced dental education area, it is expected that when serving as a member of the core committee evaluating the predoctoral program, the site visitor serves as a general dentist. Further, it is expected that all findings, conclusions or recommendations that are to be included in the report must have the concurrence of the
visiting committee team members to ensure that the report reflects the judgment of the entire
visiting committee.

In appointing site visitors, the Commission takes into account a balance in geographic
distribution as well as representation of the various types of educational settings and
diversity. Because the Commission views the accreditation process as one of peer review,
predoctoral dental education site visitors, with the exception of the national licensure site
visitor, are affiliated with dental education programs.

The following are criteria for the six roles of predoctoral dental education site visitors:

Chair:
- Must be a current dean of a dental school or have served as dean within the previous three
  (3) years.
- Should have accreditation experience through an affiliation with a dental education
  program accredited by the Commission and as a previous site visitor.

Basic Science:
- Must be an individual who currently teaches one or more biomedical science courses to
dental education students or has done so within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education
  program accredited by the Commission or as a previous site visitor.

Clinical Science:
- Must be a current clinical dean or an individual with extensive knowledge of and
  experience with the quality assurance process and overall clinic operations.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education
  program accredited by the Commission or as a previous site visitor.

Curriculum:
- Must be a current academic affairs dean or an individual with extensive knowledge and
  experience in curriculum management.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education
  program accredited by the Commission or as a previous site visitor.

Finance:
- Must be a current financial officer of a dental school or an individual with extensive
  knowledge of and experience with the business, finance and administration of a dental
  school.
• Has served in the above capacity within the previous three (3) years.
• Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

National Licensure:
• Should be a current clinical board examiner or have served in that capacity within the previous three (3) years.
• Should have an interest in the accreditation process.

Revised: 8/18; 2/18; 2/16; 8/14; 1/99; Reaffirmed: 8/19; 8/10, 7/07, 7/01; CODA: 07/05, 05/77:

B. Advanced Dental Education: In the disciplines of dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics, sponsoring organizations are advised that candidates recommended to serve as site visitors be board certified and/or have completed or participated in a CODA-accredited advanced dental education program in the discipline and must have experience in advanced dental education as teachers or administrators. Each applicable Review Committee will determine if board certification is required. Some sponsoring organizations have established additional criteria for their nominations to the Commission.

C. Allied Dental Education in Dental Hygiene: In appointing site visitors, the Commission takes into account a balance in geographic distribution, representation of the various types of educational settings, and diversity. Because the Commission views the accreditation process as one of peer review, the dental hygiene education site visitors are affiliated with dental hygiene education programs.

The following are criteria for selection of dental hygiene site visitors:
• a full-time or part-time appointment with a dental hygiene program accredited by the Commission on Dental Accreditation;
• a baccalaureate or higher degree;
• background in educational methodology;
• accreditation experience through an affiliation with a dental hygiene education program that has completed a site visit; and
• accreditation experience within the previous three (3) years.

Revised: 8/18; 8/16; 8/14; Reaffirmed: 8/19; 8/10; adopted: 7/09

D. Allied Dental Education in Dental Assisting: The following are criteria for selection of dental assisting site visitors:
• certification by the Dental Assisting National Board as a dental assistant;
• full-time or part-time appointment with a dental assisting program accredited by the Commission on Dental Accreditation;
• equivalent of three (3) years full-time dental assisting teaching experience;
• baccalaureate or higher degree;
• demonstrated knowledge of accreditation; and
• current background in educational methodology.

Revised: 8/18; 8/16; 8/14; 2/13, 1/08, 1/98, 2/02; Reaffirmed: 8/19; 8/10, 7/08; CODA:

07/95:

E. Allied Dental Education in Dental Laboratory Technology: The following are criteria for
selection of dental laboratory technology site visitors:
• background in all five (5) dental laboratory technology specialty areas: complete
dentures, removable dentures, crown and bridge, dental ceramics, and orthodontics;
• background in educational methodology
• knowledge of the accreditation process and the Accreditation Standards for Dental
Laboratory Technology Education Programs;
• Certified Dental Technician (CDT) credential through the National Board of Certification
(NBC); and
• full or part-time appointment with a dental laboratory technology education program
accredited by the Commission on Dental Accreditation or previous experience as a
Commission on Dental Accreditation site visitor.

Revised: 8/18; 8/14; Reaffirmed: 8/19; 8/10; Adopted:

07/09

F. Allied Dental Education in Dental Therapy: The following are criteria for selection of dental
therapy site visitors:
• a full-time or part-time appointment with a predoctoral dental or allied dental education
program accredited by the Commission on Dental Accreditation or an accredited (or
recognized) dental therapy program;
• a baccalaureate or higher degree;
• background in educational methodology;
• accreditation experience through an affiliation with a dental therapy, allied, or predoctoral
dental program that has completed a site visit;*
• accreditation experience within the previous three (3) years;*
• must either be a licensed dentist educator (general dentist) or licensed dental therapist
educator; and
• the “licensed dentist educator” may be predoctoral dental educator site visitors (i.e., a general
dentist educator who serves as curriculum or clinical predoctoral site visitor) or allied dental
educator site visitors.
*temporarily waived for dental therapist educator position until after CODA accredits a
minimum of three (3) dental therapy education programs.

Dental therapy site visit team consist of three (3) members as follows: one (1) dental therapist
educator, one (1) predoctoral dentist educator (curriculum or clinical site visitor), and one (1)
additional site visitor that could be either a second dental therapist educator, second
predoctoral dentist educator, or an allied dentist educator. If needed due to lack of dental
therapy educator availability, such that if a dental therapy educator cannot be identified in
accordance with Commission policy then the three-person site visit team may be composed of
predoctoral educators and allied dentists, three (3) people total in any combination.

Revised: 2/21; 8/18; 8/16; Reaffirmed: 8/19; Adopted: 02/16

REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are
dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an
educational program. The Commission views change as part of a healthy educational process
and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes have a direct and
significant impact on the program’s potential ability to comply with the accreditation standards.
These changes tend to occur in the areas of finances, program administration, enrollment,
curriculum and clinical/laboratory facilities, but may also occur in other areas. All program
changes that could affect the ability of the program to comply with the Accreditation Standards
must be reported to the Commission. When a change is planned, Commission staff should be
consulted to determine reporting requirements. Reporting program changes in the Annual
Survey does not preclude the requirement to report changes directly to the Commission. Failure
to report and receive approval in advance of implementing the change, using the Guidelines for
Reporting Program Change, may result in review by the Commission, a special site visit, and
may jeopardize the program’s accreditation status.

Advanced dental education programs must adhere to the Policy on Enrollment Increases in
Advanced Dental Education Programs. In addition, programs adding off-campus sites must
adhere to the Policy on Reporting and Approval of Sites Where Educational Activity Occurs.
Guidelines for Reporting and Approval of Sites where Educational Activity Occurs are available
from the Commission office. Guidelines for Requesting an Increase in Enrollment in a
Predoctoral Dental Education Program and Guidelines for Reporting Enrollment Increases in
Advanced Dental Education Programs are available from the Commission office.

On occasion, the Commission may learn of program changes which may impact the program’s
ability to comply with accreditation standards or policy. In these situations, CODA will contact
the sponsoring institution and program to determine whether reporting may be necessary.
Failure to report and receive approval prior to the program change may result in further review
by the Commission and/or a special site visit, and may jeopardize the program’s accreditation
status.
The Commission’s Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breach of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

A Report of Program Change must document how the program will continue to meet accreditation standards. The Commission’s Guidelines for Reporting Program Changes are available on the Commission’s website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported by June 1 or December 1 and must be reviewed by the appropriate Review Committee and approved by the Commission prior to the implementation to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites not owned by the sponsoring institution used to meet accreditation standards or program requirements (See Guidelines on Reporting and Approval of Sites Where Educational Activity Occurs);
- Changes to Off-Campus Sites not owned by the sponsoring institution that impacts the use of the site (e.g. minor site to major site, or termination of enrollment at or discontinued use of major site);
- Transfer of sponsorship from one institution to another;
- Moving a program from one geographic site to another, including but not limited to geographic moves within the same institution;
- Program director qualifications not in compliance with the standards. In lieu of a CV, a copy of the new or acting program director’s completed BioSketch must be provided to Commission staff. Contact Commission Staff for the BioSketch template.
- Substantial increase in program enrollment as determined by preliminary review by the discipline-specific Review Committee Chair.
  - Requests for retroactive permanent increases in enrollment will not be considered. Requests for retroactive temporary increases in enrollment may be considered due to special circumstances on a case-by-case basis. Programs are reminded that resources must be maintained even when the full complement of students/residents is not enrolled in the program. (see Policy on Enrollment Increases In Advanced Dental Education Programs and Predoctoral programs see Guidelines for Requesting an Increase in Enrollment in a Predoctoral Dental Education Program);
- Change in the nature of the program’s financial support that could affect the ability of the program to meet the standards;
- Curriculum changes that could affect the ability of the program to meet the standards;
- Reduction in faculty or support staff time commitment that could affect the ability of the program to meet the standards;
• Change in the required length of the program;
• Reduction of program dental facilities that could affect the ability of the program to meet the standards;
• Addition of advanced standing opportunity, part-time track or multi-degree track, or other track offerings; and/or
• Expansion of a developing dental hygiene or assisting program which will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

The Commission recognizes that unexpected changes may occur. If an unexpected change occurs, it must be reported no more than 30 days following the occurrence. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster (See Policy/Guidelines on Interruption of Education). Failure to proactively plan for change will not be considered an unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that must be reported in writing at least thirty (30) days prior to the anticipated implementation of the change and are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:

• Establishment of Off-Campus Sites owned by the sponsoring institution used to meet accreditation standards or program requirements;
• Expansion or relocation of dental facilities within the same building;
• Change in program director. In lieu of a CV, a copy of the new or acting program director’s completed BioSketch must be provided to Commission staff. Contact Commission Staff for the BioSketch template.
• First-year non-enrollment. See Policy on Non Enrollment of First Year Students/Residents.
• Addition of distance education methods (see reporting requirements found in the Policy on Distance Education).

The Commission uses the following process when considering reports of program changes. Program administrators have the option of consulting with Commission staff at any time during this process.

1. A program administrator submits the report by June 1 or December 1.
2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by the Commission.
3. Receipt of the report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review Committee and by the Commission at their next regularly scheduled meeting. Additional information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next site visit.

4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of program changes received from accredited educational programs.

- **Approve the report of program change**: If the Review Committee or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change(s) have been noted and will be reviewed at the next regularly-scheduled site visit to the program.

- **Approve the report of program change and request additional information**: If the Review Committees or Commission does not identify any concerns regarding the program’s compliance with the accreditation standards, but believes follow up reporting is required to ensure continued compliance with accreditation standards, additional information will be requested for review by the Commission. Additional information could occur through a supplemental report or a focused site visit,

- **Postpone action and continue the program’s accreditation status, but request additional information**: The transmittal letter will inform the institution that the report of program change has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request.

- **Postpone action and continue the program’s accreditation status pending conduct of a special site visit**: If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.

- **Deny the request**: If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for a program change. The institution will be advised that they may re-submit the request of program change with additional information if they choose. If the program change was
submitted retroactively, and non-compliance is identified, the program’s accreditation status will be changed. The transmittal letter will inform the institution that the report of program change has been considered, but an area of non-compliance with the accreditation standards has been identified. The program’s accreditation status is changed and additional specific information regarding the identified area(s) of non-compliance will be requested for review by the Commission.

Revised: 2/21; 8/20; 1/20; 8/18; 2/18; 8/17; 8/16; 2/16; 8/15; 2/15; 8/13 2/12; 8/11, 8/10, 7/09, 7/07, 8/02, 7/97; Reaffirmed: 7/07, 7/01, 5/90; CODA: 05/91:11

POLICY ON NON-ENROLLMENT OF FIRST YEAR STUDENTS/RESIDENTS

First-year non-enrollment must be reported to the Commission. The accreditation status of programs within the purview of the Commission on Dental Accreditation will be discontinued when all first-year positions remain vacant for two (2) consecutive years. Exceptions to this policy may be made by the Commission for programs with “approval without reporting requirements” status upon receipt of a formal request from the institution stating reasons why the accreditation of the program should not be discontinued. Exceptions to this policy may also be made by the Commission for programs in Oral and Maxillofacial Pathology with “initial accreditation” status upon receipt of a formal request from the institution stating reasons why the accreditation of the program should not be discontinued. If the Commission grants an institution’s request to continue the accreditation of a program, the continuation of accreditation is effective for one (1) year. Only one (1) request for continued accreditation will be granted for a total of three (3) consecutive years of non-enrollment. See the Commission’s policies related to Reporting Program Changes in Accredited Programs, Initial Accreditation, Intent to Withdraw Accreditation, Voluntary Discontinuance, and Discontinuance or Closure of Educational Programs Accredited by The Commission and Teach-Out Plans for additional information.

Revised: 2/21; 8/20; 8/16; 2/15; Reaffirmed: 8/15; 8/10, 7/07, 7/01, 7/99, 12/87, 4/83, 12/76

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Revised: 2/21; 1/20; Reaffirmed: 8/20; Adopted: 8/18

POLICY AND PROCEDURE REGARDING INVESTIGATION OF COMPLAINTS AGAINST EDUCATIONAL PROGRAMS

Anonymous Comments/Complaints

An “anonymous comment/complaint” is defined as an unsigned comment/complaint submitted to the Commission. Any submitted information that identifies the complainant renders this submission a formal complaint and will be reviewed as such (e.g. inclusion of a complainant’s name within an email or submitted documentation).

All anonymous complaints will be reviewed by Commission staff to determine linkage to Accreditation Standards or CODA policy and procedures. If linkage to Accreditation Standards or CODA policy is identified, legal counsel, the Chair or the appropriate Review Committee, and the applicable Review Committee members may be consulted to assist in determining whether there is sufficient evidence of probable cause of noncompliance with the standard(s) or required accreditation policy(ies), or procedure(s) to proceed with an investigation. The initial screening is usually completed within thirty (30) days. If further investigation is warranted, the anonymous complaint will be handled as a formal complaint (See Formal Complaints); however, due to the anonymous nature of the submission, the Commission will not correspond with the complainant.

Anonymous comments/complaints determined to be unrelated to an Accreditation Standard or CODA policies and procedures, or those that do not provide sufficient evidence of probable cause
of noncompliance with the standard(s) or required accreditation policy(ies), or procedure(s) to proceed, will be added to the respective program’s file for evaluation during the program’s next scheduled accreditation site visit. At the time of the site visit, the program and site visit team will be informed of the anonymous comment/complaint. The program will have an opportunity to respond to the anonymous comment/complaint; the response will be considered during the site visit evaluation. Anonymous comments/complaints will be assessed to determine trends in compliance with Commission standards, policies, and procedures. The assessment of findings related to the anonymous comments/complaint will be documented in the site visit report.

Revised: 2/21; Adopted: 8/17
CONSIDERATION OF POLICY REVISIONS RELATED TO CHANGES IN THE USDE
REGULATIONS FOR RECOGNITION OF ACCREDITING AGENCIES

Underline indicates addition; Strikethrough indicates deletion

FUNCTION AND PROCEDURES OF THE APPEAL BOARD

The principal function of the Appeal Board is to determine whether the Commission on Dental Accreditation, in arriving at a decision regarding the withdrawal or denial of accreditation for a given program, has properly applied the facts presented to it. In addition, the Commission’s Rules stipulate that the Appeal Board shall provide the educational program filing the appeal the opportunity to be represented by legal counsel and shall give the program the opportunity to offer evidence and argument in writing and/or orally to try to refute or overcome the findings and decision of the Commission.

Reaffirmed: 8/16; 8/10

1. Appeal Board: The four (4) permanent members of the Appeal Board include: one (1) representative selected by the American Dental Association, one (1) representative selected by the American Association of Dental Boards, one (1) representative selected by the American Dental Education Association and one (1) consumer representative selected by the Commission on Dental Accreditation. Representatives from allied or advanced dental education areas would also be included on the Appeal Board, depending on the nature of the appeal. Appeal Board members do not concurrently serve on the Commission. (See Rules of the Commission, Article III, Section 2. Appeal Board Composition, p. 5)

The Appeal Board is an autonomous body, separate from the Commission. Costs related to appeal procedures will be underwritten, whenever possible, by the institution and the Commission on an equally shared cost basis.

Revised: 8/18; 8/16; Reaffirmed: 8/10

2. Selection Criteria For Appeal Board Members: The Appeal Board Member shall not be:

- a current member of a dental or allied dental faculty*;
- an employee, member of the governing board, owner, shareholder of, or independent consultant to, a program that either is accredited by the Commission on Dental Accreditation or has applied for initial accreditation*; and
- spouse, parent, child, or sibling of an individual identified above;
- current member of the Commission; and/or
- an individual who has participated in any step of the process leading up to the decision that is being appealed (e.g. member of the visiting committee, member of Review Committee, etc.).

The Appeal Board Member shall:

- be willing to participate as a member of the appellate body should it be convened; and
be willing to comply with all Commission policies and procedures (e.g., Agreement of Confidentiality; Conflict of Interest Policy; and Professional Conduct Policy and Prohibition Against Harassment).

*Discipline-specific representatives from allied or advanced dental education areas and the ADEA representative can be a program director, faculty member or practitioner.

Revised: 8/18; 2/16; 8/14; 2/13; Reaffirmed: 8/16; 8/10

3. **Appeal Procedures:** If a program has been denied accreditation or if its accreditation has been withdrawn, the following appeal procedures are followed:

1. Within fourteen (14) days after the institution’s receipt of notification of the Commission on Dental Accreditation’s decision to deny or withdraw accreditation, the program may file a written request of appeal to the Director of the Commission. If a request of appeal is not made, the Commission’s proposed decision will automatically become final and the appropriate announcement will be made.

2. If a request of appeal is received, the Director of the Commission shall acknowledge receipt of the request and notify the program of the date of the appeal hearing. The appeal date shall be within sixty (60) days after the appeal has been filed.

3. The program filing the appeal may be represented by legal counsel in addition to the program administrator and other program representatives and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. The educational program need not appear in person or by its representative at the appellate hearing.

4. Legal counsel of the American Dental Association will be available to members of the Appeal Board upon request.

5. No new information regarding correction of the deficiencies may be presented with the exception of review of new financial information if all of the following conditions are met: (i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made. (ii) The financial information is significant and bears materially on the financial deficiencies identified by the Commission. The criteria of significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution’s or program’s failure to meet the Commission’s standard pertaining to finances. An institution or program may seek the review of new financial information described in this section only once and any determination by the Commission made with respect to that review does not provide a basis for an appeal.

6. The Appeal Board may make the following decisions: to affirm, amend, or remand or reverse the adverse actions of the Commission. A decision to affirm, or amend or reverse the adverse action is implemented by the Commission. In a decision to remand the adverse action for further consideration, the Appeal Board will identify specific issues that the Commission must address. The Commission must act in a manner consistent with the Appeal
Board’s decisions or instructions.

7. No change in the accreditation status of the program will occur pending disposition of the appeal.

8. Within ten (10) days of the hearing, the applicant shall be notified by tracked mail of the Appeal Board’s decision. The decision may be to sustain the decision of the Commission or to remand the matter back to the Commission for reconsideration. Notice shall include a statement of the specifics on which the decision is based.

9. The decision rendered by the Appeal Board shall be final and binding.

10. In the event the educational program does not file a timely appeal of the Board of Commissioner’s findings and decisions, the Board of Commissioner’s decision shall become final.

In accord with due process measures, the Appeal Board will, when appropriate, review substantive procedural issues raised by the appellants. To this end, the Appeal Board is limited in its inquiry to the factual determinations up to the time of the Commission on Dental Accreditation’s decision regarding the status of the program at issue.

It is not proper for the Appeal Board to either receive or consider facts not previously presented to the Commission on Dental Accreditation since it does not sit as an initial reviewing body. Similarly, it is not the function of the Appeal Board to determine whether the facts, singularly or cumulatively, justify the decision of the Commission on Dental Accreditation unless it can be shown that the Commission’s decision was clearly against the manifest weight of the evidence. Further, the Appeal Board will not hear testimony relative to the reasonableness of previously determined requirements for accreditation since this is clearly outside the scope of authority of this reviewing body.

Revised: 2/21; 8/18; 8/16; 8/11, 1/03; Reaffirmed: 8/10

4. Mechanism For The Conduct Of The Appeal Hearing:

1. A brief opening statement may be made by the Commission of Dental Accreditation for the purpose of establishing the Commission’s finding and the reasons therefore.

2. The Appellant will then present its argument to the Board.

3. The Commission may then present its rebuttal of the Appellant’s argument.

4. After hearing the evidence, the Appeal Board shall meet in executive session to discuss the appeal and make its decision. The Appeal Board’s decision may be to sustain the decision of the Commission, or remand the matter to the Commission for reconsideration. The decision shall be based on a majority vote of the members of the Appeal Board with the Chair voting only to break a tie vote.

5. The Appellant shall be notified by tracked mail of the decision of the Appeal Board, including a statement of specifics, within ten (10) days following the hearing.

Revised: 8/16; 7/07, 7/06, 7/00, 12/88, 1978; Reaffirmed: 8/11, 8/10; Adopted: 12/77
VOLUNTARY DISCONTINUANCE OF ACCREDITATION

The Commission may become aware of an accredited program’s decision to voluntarily discontinue its participation in the accreditation program when it receives official notification from the sponsoring institution’s chief executive officer. When the Commission becomes aware of the program’s intent to discontinue accreditation, it takes the following steps:

1. Commission staff verifies that both the program and institution understand the impact of this intended action and informs the institution and program of the specific audiences that will be notified of their decision to let accreditation lapse (the USDE Secretary, the appropriate accrediting agency and state licensing agency). If students/residents who matriculated prior to the program’s reported discontinuance effective date are enrolled in any year of the program, the program must submit a Teach-Out Plan until all of these students/residents have graduated. (See Policy on Discontinuance or Closure of Educational Programs Accredited by the Commission and Teach-Out Plans)

2. Within ten (10) business days thirty (30) days, Commission staff contacts the institution’s chief executive officer and program director and acknowledges the date when accreditation will lapse (i.e. program’s discontinuance effective date) and the date by which the program will no longer be listed in the Commission's lists of accredited programs (i.e. date of CODA meeting or mail ballot). The USDE Secretary and the state licensing or accrediting agency are copied on this letter. Commission staff will inform the program that any classes enrolled on or after the program’s reported date of discontinuance must be advised that they will not graduate from a CODA-accredited program. (See Policy on Discontinuance or Closure of Educational Programs Accredited by the Commission and Teach-Out Plans)

3. At its next meeting, or by mail ballot if waiting until the next meeting would preclude a timely review, the Commission will take action to affirm the program’s decision to let accreditation lapse, either through a Discontinuance or Teach-Out (See Other Accreditation Action Definitions). The USDE Secretary and appropriate state licensing or accrediting agency are copied on any follow-up correspondence to the institution/program that may occur after this meeting.

Revised: 2/21; 2/16; 8/15; 7/06, 7/00; Reaffirmed: 8/20; 8/10

DUE PROCESS RELATED TO WITHDRAWAL OF ACCREDITATION

An institution/program may request a special appearance (hearing) before the appropriate Review Committee in order to supplement the written information about the program which has already been provided to the Review Committee. (See Due Process Related to Review Committee Special Appearance)
If the Review Committee’s recommendation to the Commission is to withdraw accreditation, the Commission will notify the institution of the proposed action and the date of the Commission meeting at which the Review Committee’s recommendation will be considered. This notification will advise the institution of its right to provide additional information for the Commission to consider prior to reaching a decision on the proposed action. Any additional information must be submitted in writing at least one (1) week prior to the meeting, absent documented extraordinary circumstances, and should include any reasons why the institution believes that the withdrawal of accreditation is unjustified.

If the Commission determines that accreditation should be withdrawn, the program will be notified within fourteen (14) days and the notification is sent by tracked mail. The program is also notified of its right to appeal this decision to the Appeal Board. The filing of an appeal shall automatically stay the final decision of the Commission.

Adverse actions, or those that may be appealed, are defined as those related to denial or withdrawal of accreditation. Such decisions become final fourteen (14) days after the date on the transmittal letter or when any appeal has been resolved. The Commission has procedures in place to provide notice of the reasons for taking an adverse accreditation action. Such procedures are required in order for accrediting agencies to comply with U.S. Department of Education’s Criteria and Procedures for Recognition of Accrediting Agencies.

Revised: 2/19; 8/18; 2/18; 8/16; Reaffirmed: 8/10

12. Notice Of Reasons For Adverse Actions: Accrediting agencies recognized by the Secretary of the USDE, including the Commission, are required to report any adverse accreditation action (defined as an action to deny or withdraw accreditation). Accordingly, when the Commission makes a final decision to deny or withdraw a program’s accreditation, a brief statement summarizing the reasons for the Commission’s decision and the official comments that the affected program may make with regard to that decision, is made available to the USDE Secretary, the appropriate state licensing or authorizing agency and the public. The Commission’s final decision; the statement summarizing the reasons for the Commission’s decision; and the program’s official comments will be posted on the Commission’s website no later than sixty (60) days after the decision is final.

The Commission’s Notice of Reasons for Adverse Action Disclosure Statement includes the following information about the program’s accreditation history, past problems, current problems, specific reasons why action to deny or withdraw accreditation was taken and what future option are available to the program.

To illustrate the scope of the statement and the level of reasons reported, a sample announcement follows:

Disclosure Statement: Dental Assisting Program
Pick Your State Community College

The Commission on Dental Accreditation, the only nationally-recognized accrediting agency for predoctoral, advanced, and allied dental education programs, reviewed an application for initial accreditation of the new dental assisting program offered by Pick-Your-State Community College. On the basis of information provided in the application, the Commission was unable to grant “initial accreditation” status to the program.

The Commission determined, at its (date) meeting, that the application did not provide sufficient information and assurances that the proposed program meets the intent of the Accreditation Standards for Dental Assisting Education Programs. Specific concerns in compliance with the standards were noted in the following areas:

- Financial Support (adequacy of resources);
- Curriculum (adequacy of knowledge and skills offered, scope and depth of instruction in required areas, and documentation of student competence);
- Admissions (documentation that written criteria, procedures, and policies are used);
- Faculty (adequacy of teaching and supervision of students);
- Facilities (insufficient documentation of adequacy of physical facilities and equipment).

The Commission informed the program and sponsoring institution that these specific concerns would need to be addressed before the institution reapplied for “initial accreditation” status of the dental assisting program.

______________________________
CEO, Sponsoring Institution (date)

______________________________
Chair, Commission on Dental Accreditation (date)

Revised: 8/17; 5/12; Reaffirmed: 8/14; 8/10

13. Procedure For Disclosure Notice Of Adverse Actions: The following procedure is used when an adverse action (to deny or withdraw accreditation) is taken. Applicants, when they inquire about initial accreditation, are to be notified by Commission staff that the Notice of Reasons for Adverse Actions statement will be prepared and distributed should accreditation be denied.

1. The Commission sends notice of any adverse action in a transmittal letter to the appropriate institutional executives no later than fourteen (14) days after the Commission meeting. This letter is sent by certified/tracked mail, (including email), and includes the reasons for any adverse action to deny or withdraw accreditation. All current and prospective students/residents/fellows must be informed of the Commission’s notice of any adverse
action within seven (7) business days of the program’s receipt of the notice. The USDE Secretary, the appropriate state entities, and any appropriate institutional accrediting agency are notified at this time, usually by a letter to the Secretary with copies to the other entities and the institution.

2. A statement of the reasons for any adverse action is developed and available for distribution within sixty (60) days. This new statement will include the same information that has been contained in the transmittal letter. For this reason, the statement will be drafted and the draft will be sent to the institution/program for review at the same time as the transmittal letter. As needed, the draft statement will be reviewed by legal counsel prior to being sent.

3. The institution must notify the Commission within fourteen (14) days if it wishes to indicate an intent to appeal an adverse action. If an intent to appeal is received, the usual appeal procedures are followed according to the Commission policy on Due Process Related to Appeal of Accreditation Actions.

4. If an intent to appeal is not received by the fourteen (14) day deadline specified, the adverse action is considered final and the USDE Secretary, the appropriate state entities, and any appropriate institutional accrediting agency are notified at this time, usually by a letter to the Secretary with copies to the other entities and the institution.

5. During the same fourteen (14) days, the institution/program will be asked to review the draft statement and:
   a. indicate agreement with the statement; and/or,
   b. make official comments with regard to the decision, or state that the affected institution has been offered the opportunity to provide official comment.

6. When the final statement (or statement and response) has been developed and signed by both parties, it will be distributed as required in the regulations to the USDE Secretary, to the appropriate state licensing or authorizing agency, to any appropriate institutional accrediting agency, and to the public. All current and prospective students/residents/fellows must be informed of the Commission’s final decision within seven (7) business days of the program’s receipt of the notice.

7. The Commission’s final decision; the statement summarizing the reasons for the Commission’s decision; and the program’s official comments will be posted on the Commission’s website no later than sixty (60) days after the decision is final.

When there are no differences of opinion regarding the statement, it may be possible to send it to the Secretary along with the letter in step #4 above, along with posting the final decision and reasons on the Commission’s website.

Revised: 2/21; 8/17; 5/12; 7/06; Reaffirmed: 8/14; 8/10; Adopted: 7/00; CODA: 07/94:6

POLICY ON REGARD FOR DECISIONS OF STATES AND OTHER ACCREDITING AGENCIES

The Commission takes into account decisions made by other recognized accrediting or state agencies. If the Commission determines that an institution sponsoring an accredited program or
a program seeking accreditation is the subject of an interim action or threatened loss of
accreditation or legal authority to provide postsecondary education, the Commission will act as
follows.

If a recognized institutional accrediting agency takes adverse action with respect to the
institution offering the program or places the institution on public probationary status, the
Commission will promptly review its accreditation of the program to determine if it should take
adverse action against the program.

The Commission does not renew the accreditation status of a program during any period in
which the institution offering the program:

• Is the subject of an interim action or final decision by a recognized institutional accrediting
agency potentially leading to the suspension, revocation, withdrawal, or termination of
accreditation or pre-accreditation;
• Is the subject of a decision by a recognized institutional accrediting agency to deny
accreditation or pre-accreditation;
• Is the subject of a pending or final interim action by a state agency potentially leading to
the suspension, revocation, withdrawal or termination of the institution's legal authority to
provide postsecondary education;
• Has been notified of probation or an equivalent status, or a threatened loss of accreditation,
and the due process procedures required by the action have not been completed; and/or
• Has been notified of a threatened suspension, revocation, or termination by a state of the
institution's legal authority to provide postsecondary education, and the due process
procedures required by the action have not been completed.

In considering whether to grant initial accreditation to a program, the Commission takes into
account actions by:

• Recognized institutional accrediting agencies that have denied accreditation or pre-
accreditation to the institution offering the program, placed the institution on public
probationary status, or revoked the accreditation or pre-accreditation of the institution; and
• State agency that has suspended, revoked, or terminated the institution's legal authority to
provide postsecondary education.

If the Commission grants accreditation to a program notwithstanding its actions described above,
the Commission will provide to the USDE Secretary, within 30 days of granting initial or
continued accreditation, a thorough and reasonable explanation, consistent with the accreditation
standards, why the previous action by a recognized institutional accrediting agency or the state
does not preclude the Commission's grant of accreditation. The Commission’s review and
explanation will consider each of the findings of the other agency in light of its own standards.

Upon formal request, the Commission will share with other appropriate USDE-recognized
accrediting agencies and USDE-recognized State approval agencies information about the
accreditation status of a program and any adverse actions it has taken against an accredited program.

Revised: 2/21; 5/12; Reaffirmed: 8/20; 8/15; 8/10, 7/07, 7/01; Revised: 7/96; 12/88
§602.16 Accreditation and preaccreditation standards.
(a) The agency must demonstrate that it has standards for accreditation, and preaccreditation, if offered, that are sufficiently rigorous to ensure that the agency is a reliable authority regarding the quality of the education or training provided by the institutions or programs it accredits. The agency meets this requirement if the following conditions are met:
(1) The agency’s accreditation standards must set forth clear expectations for the institutions or programs it accredits in the following areas:
   (i) Success with respect to student achievement in relation to the institution's mission, which may include different standards for different institutions or programs, as established by the institution, including, as appropriate, consideration of State licensing examinations, course completion, and job placement rates.
   (ii) Curricula.
   (iii) Faculty.
   (iv) Facilities, equipment, and supplies.
   (v) Fiscal and administrative capacity as appropriate to the specified scale of operations.
   (vi) Student support services.
   (vii) Recruiting and admissions practices, academic calendars, catalogs, publications, grading, and advertising.
   (viii) Measures of program length and the objectives of the degrees or credentials offered.
   (ix) Record of student complaints received by, or available to, the agency.
   (x) Record of compliance with the institution's program responsibilities under title IV of the Act, based on the most recent student loan default rate data provided by the Secretary, the results of financial or compliance audits, program reviews, and any other information that the Secretary may provide to the agency; and
(2) The agency's preaccreditation standards, if offered, must--
   (i) Be appropriately related to the agency's accreditation standards; and
   (ii) Not permit the institution or program to hold preaccreditation status for more than five years before a final accrediting action is made.
(b) Agencies are not required to apply the standards described in paragraph (a)(1)(x) of this section to institutions that do not participate in title IV, HEA programs. Under such circumstance, the agency’s grant of accreditation or preaccreditation must specify that the grant, by request of the institution, does not include participation by the institution in title IV, HEA programs.
(c) If the agency only accredits programs and does not serve as an institutional accrediting agency for any of those programs, its accreditation standards must address the areas in paragraph (a)(1) of this section in terms of the type and level of the program rather than in terms of the institution.
(d)
(1) If the agency has or seeks to include within its scope of recognition the evaluation of the quality of institutions or programs offering distance education, correspondence courses, or direct assessment education, the agency's standards must effectively address the quality of an institution's distance education, correspondence courses, or direct assessment education in the areas identified in paragraph (a)(1) of this section.

(2) The agency is not required to have separate standards, procedures, or policies for the evaluation of distance education or correspondence courses.

(e) If none of the institutions an agency accredits participates in any title IV, HEA program, or if the agency only accredits programs within institutions that are accredited by a nationally recognized institutional accrediting agency, the agency is not required to have the accreditation standards described in paragraphs (a)(1)(viii) and (a)(1)(x) of this section.

(f) An agency that has established and applies the standards in paragraph (a) of this section may establish any additional accreditation standards it deems appropriate.

(g) Nothing in paragraph (a) of this section restricts—

(1) An accrediting agency from setting, with the involvement of its members, and applying accreditation standards for or to institutions or programs that seek review by the agency;

(2) An institution from developing and using institutional standards to show its success with respect to student achievement, which achievement may be considered as part of any accreditation review; or

(3) Agencies from having separate standards regarding an institution's or a program's process for approving curriculum to enable programs to more effectively meet the recommendations of—

(i) Industry advisory boards that include employers who hire program graduates;

(ii) Widely recognized industry standards and organizations;

(iii) Credentialing or other occupational registration or licensure; or

(iv) Employers in a given field or occupation, in making hiring decisions.

(4) Agencies from having separate faculty standards for instructors teaching courses within a dual or concurrent enrollment program, as defined in 20 U.S.C. 7801, or career and technical education courses, as long as the instructors, in the agency's judgment, are qualified by education or work experience for that role.

Note: On August 31, 2020, the Department rescinded Dear Colleague Letter 06-17 (the “DCL”), which was issued in September 2006, and had been interpreted to mean that, if an institution does not offer more than 50% of an educational program via distance education, the institution’s accrediting agency is not required to expand its scope of recognition to include distance education. Agencies should be aware that, pursuant to 34 C.F.R. § 668.8(m), a distance education program is not eligible for Title IV participation unless the institution has been evaluated and accredited to offer distance education programs by a recognized accrediting agency that has distance education within its scope of recognition. This requirement applies to the offering of any portion of a distance education program. Accrediting agencies should work with institutions they accredit or plan to accredit to communicate the agency’s requirements for evaluating whether the institution is capable of effective delivery of distance education programs. Further, if distance education in a program offered by an institution or at the institution as a whole exceeds 50%, accreditors must approve this as a substantive change.
pursuant to 34 C.F.R. § 602.22(a)(1)(ii)(C). Pursuant to 34 C.F.R. § 602.27(a)(4), the addition of distance education to an agency's scope of recognition requires only written notification to the Department. The Department is waiving, through the end of the term that begins after the date on which the Federally-declared national emergency related to COVID-19 is rescinded, the requirement that institutions must have obtained accreditation to offer distance education programs. The Department recognizes that it may take additional time for accreditors and institutions to implement the changes necessary to come into compliance with 34 C.F.R. § 668.8(m) beyond the expiration of the waiver period because of the uncertainty of at what point in a term the national emergency will end. Accordingly, the Department may issue further guidance and that guidance may also allow additional time following the end of the national emergency for accrediting agencies and institutions to come into compliance with the requirements of 34 C.F.R. § 668.8(m).

§602.18 Ensuring consistency in decision-making.
(a)The agency must consistently apply and enforce standards that respect the stated mission of the institution, including religious mission, and that ensure that the education or training offered by an institution or program, including any offered through distance education, correspondence courses, or direct assessment education is of sufficient quality to achieve its stated objective for the duration of any accreditation or preaccreditation period.
(b)The agency meets the requirement in paragraph (a) of this section if the agency—
(1)Has written specification of the requirements for accreditation and preaccreditation that include clear standards for an institution or program to be accredited or preaccredited;
(2)Has effective controls against the inconsistent application of the agency's standards;
(3)Bases decisions regarding accreditation and preaccreditation on the agency's published standards and does not use as a negative factor the institution's religious mission-based policies, decisions, and practices in the areas covered by § 602.16(a)(1)(ii), (iii), (iv), (vi), and (vii) provided, however, that the agency may require that the institution's or program's curricula include all core components required by the agency;
(4)Has a reasonable basis for determining that the information the agency relies on for making accrediting decisions is accurate;
(5)Provides the institution or program with a detailed written report that clearly identifies any deficiencies in the institution's or program's compliance with the agency's standards; and
(6)Publishes any policies for retroactive application of an accreditation decision, which must not provide for an effective date that predates either—
(i) An earlier denial by the agency of accreditation or preaccreditation to the institution or program; or
(ii) The agency's formal approval of the institution or program for consideration in the agency's accreditation or preaccreditation process.
(c)Nothing in this part prohibits an agency, when special circumstances exist, to include innovative program delivery approaches or, when an undue hardship on students occurs, from applying equivalent written standards, policies, and procedures that provide alternative means of satisfying one or more of the requirements set forth in 34 CFR 602.16, 602.17, 602.19, 602.20,
602.22, and 602.24, as compared with written standards, policies, and procedures the agency ordinarily applies, if—

(1) The alternative standards, policies, and procedures, and the selection of institutions or programs to which they will be applied, are approved by the agency's decision-making body and otherwise meet the intent of the agency's expectations and requirements;
(2) The agency sets and applies equivalent goals and metrics for assessing the performance of institutions or programs;
(3) The agency's process for establishing and applying the alternative standards, policies, and procedures is set forth in its published accreditation manuals; and
(4) The agency requires institutions or programs seeking the application of alternative standards to demonstrate the need for an alternative assessment approach, that students will receive equivalent benefit, and that students will not be harmed through such application.

(d) Nothing in this part prohibits an agency from permitting the institution or program to be out of compliance with one or more of its standards, policies, and procedures adopted in satisfaction of §§ 602.16, 602.17, 602.19, 602.20, 602.22, and 602.24 for a period of time, as determined by the agency annually, not to exceed three years unless the agency determines there is good cause to extend the period of time, and if—

(1) The agency and the institution or program can show that the circumstances requiring the period of noncompliance are beyond the institution's or program's control, such as—

(i) A natural disaster or other catastrophic event significantly impacting an institution's or program's operations;
(ii) Accepting students from another institution that is implementing a teach-out or closing;
(iii) Significant and documented local or national economic changes, such as an economic recession or closure of a large local employer;
(iv) Changes relating to State licensure requirements;
(v) The normal application of the agency's standards creates an undue hardship on students; or
(vi) Instructors who do not meet the agency's typical faculty standards, but who are otherwise qualified by education or work experience, to teach courses within a dual or concurrent enrollment program, as defined in 20 U.S.C. 7801, or career and technical education courses;
(2) The grant of the period of noncompliance is approved by the agency's decision-making body;
(3) The agency projects that the institution or program has the resources necessary to achieve compliance with the standard, policy, or procedure postponed within the time allotted; and
(4) The institution or program demonstrates to the satisfaction of the agency that the period of noncompliance will not—

(i) Contribute to the cost of the program to the student without the student's consent;
(ii) Create any undue hardship on, or harm to, students; or
(iii) Compromise the program's academic quality.

§602.20 Enforcement of standards.
(a) If the agency's review of an institution or program under any standard indicates that the institution or program is not in compliance with that standard, the agency must—
(1) Follow its written policy for notifying the institution or program of the finding of noncompliance;
(2) Provide the institution or program with a written timeline for coming into compliance that is reasonable, as determined by the agency's decision-making body, based on the nature of the finding, the stated mission, and educational objectives of the institution or program. The timeline may include intermediate checkpoints on the way to full compliance and must not exceed the lesser of four years or 150 percent of the—
   (i) Length of the program in the case of a programmatic accrediting agency; or
   (ii) Length of the longest program at the institution in the case of an institutional accrediting agency;
(3) Follow its written policies and procedures for granting a good cause extension that may exceed the standard timeframe described in paragraph (a)(2) of this section when such an extension is determined by the agency to be warranted; and
(4) Have a written policy to evaluate and approve or disapprove monitoring or compliance reports it requires, provide ongoing monitoring, if warranted, and evaluate an institution's or program's progress in resolving the finding of noncompliance.
(b) Notwithstanding paragraph (a) of this section, the agency must have a policy for taking an immediate adverse action, and take such action, when the agency has determined that such action is warranted.
(c) If the institution or program does not bring itself into compliance within the period specified in paragraph (a) of this section, the agency must take adverse action against the institution or program, but may maintain the institution's or program's accreditation or preaccreditation until the institution or program has had reasonable time to complete the activities in its teach-out plan or to fulfill the obligations of any teach-out agreement to assist students in transferring or completing their programs.
(d) An agency that accredits institutions may limit the adverse or other action to particular programs that are offered by the institution or to particular additional locations of an institution, without necessarily taking action against the entire institution and all of its programs, provided the noncompliance was limited to that particular program or location.
(e) All adverse actions taken under this subpart are subject to the arbitration requirements in 20 U.S.C. 1099b(e).
(f) An agency is not responsible for enforcing requirements in 34 CFR 668.14, 668.15, 668.16, 668.41, or 668.46, but if, in the course of an agency's work, it identifies instances or potential instances of noncompliance with any of these requirements, it must notify the Department.
(g) The Secretary may not require an agency to take action against an institution or program that does not participate in any title IV, HEA or other Federal program as a result of a requirement specified in this part.

§602.25 Due process.
The agency must demonstrate that the procedures it uses throughout the accrediting process satisfy due process. The agency meets this requirement if the agency does the following:
(a) Provides adequate written specification of its requirements, including clear standards, for an institution or program to be accredited or preaccredited.
(b) Uses procedures that afford an institution or program a reasonable period of time to comply with the agency's requests for information and documents.
(c) Provides written specification of any deficiencies identified at the institution or program examined.
(d) Provides sufficient opportunity for a written response by an institution or program regarding any deficiencies identified by the agency, to be considered by the agency within a time frame determined by the agency, and before any adverse action is taken.
(e) Notifies the institution or program in writing of any adverse accrediting action or an action to place the institution or program on probation or show cause. The notice describes the basis for the action.
(f) Provides an opportunity, upon written request of an institution or program, for the institution or program to appeal any adverse action prior to the action becoming final.
(1) The appeal must take place at a hearing before an appeals panel that--
   (i) May not include current members of the agency's decision-making body that took the initial adverse action;
   (ii) Is subject to a conflict of interest policy;
   (iii) Does not serve only an advisory or procedural role, and has and uses the authority to make the following decisions: To affirm, amend, or remand adverse actions of the original decision-making body; and
   (iv) Affirms, amends, or remands the adverse action. A decision to affirm or amend the adverse action is implemented by the appeals panel or by the original decision-making body, at the agency's option; however, in the event of a decision by the appeals panel to remand the adverse action to the original decision-making body for further consideration, the appeals panel must explain the basis for a decision that differs from that of the original decision-making body and the original decision-making body in a remand must act in a manner consistent with the appeals panel’s decisions or instructions.
(2) The agency must recognize the right of the institution or program to employ counsel to represent the institution or program during its appeal, including to make any presentation that the agency permits the institution or program to make on its own during the appeal.
(g) The agency notifies the institution or program in writing of the result of its appeal and the basis for that result.
(h)(1) The agency must provide for a process, in accordance with written procedures, through which an institution or program may, before the agency reaches a final adverse action decision, seek review of new financial information if all of the following conditions are met:
(i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made.
(ii) The financial information is significant and bears materially on the financial deficiencies identified by the agency. The criteria of significance and materiality are determined by the agency.
(iii) The only remaining deficiency cited by the agency in support of a final adverse action decision is the institution's or program's failure to meet an agency standard pertaining to finances.

(2) An institution or program may seek the review of new financial information described in paragraph (h)(1) of this section only once and any determination by the agency made with respect to that review does not provide a basis for an appeal.

§602.26 Notification of accrediting decisions.
The agency must demonstrate that it has established and follows written procedures requiring it to provide written notice of its accrediting decisions to the Secretary, the appropriate State licensing or authorizing agency, the appropriate accrediting agencies, and the public. The agency meets this requirement if the agency, following its written procedures—

(a) Provides written notice of the following types of decisions to the Secretary, the appropriate State licensing or authorizing agency, the appropriate accrediting agencies, and the public no later than 30 days after it makes the decision:

1. A decision to award initial accreditation or preaccreditation to an institution or program.
2. A decision to renew an institution's or program's accreditation or preaccreditation;

(b) Provides written notice of a final decision of a probation or equivalent status or an initiated adverse action to the Secretary, the appropriate State licensing or authorizing agency, and the appropriate accrediting agencies at the same time it notifies the institution or program of the decision and requires the institution or program to disclose such an action within seven business days of receipt to all current and prospective students;

(c) Provides written notice of the following types of decisions to the Secretary, the appropriate State licensing or authorizing agency, and the appropriate accrediting agencies at the same time it notifies the institution or program of the decision, but no later than 30 days after it reaches the decision:

1. A final decision to deny, withdraw, suspend, revoke, or terminate the accreditation or preaccreditation of an institution or program.
2. A final decision to take any other adverse action, as defined by the agency, not listed in paragraph (c)(1) of this section;

(d) Provides written notice to the public of the decisions listed in paragraphs (b) and (c) of this section within one business day of its notice to the institution or program;

(e) For any decision listed in paragraph (c) of this section, requires the institution or program to disclose the decision to current and prospective students within seven business days of receipt and makes available to the Secretary, the appropriate State licensing or authorizing agency, and the public, no later than 60 days after the decision, a brief statement summarizing the reasons for the agency's decision and the official comments that the affected institution or program may wish to make with regard to that decision, or evidence that the affected institution has been offered the opportunity to provide official comment;

(f) Notifies the Secretary, the appropriate State licensing or authorizing agency, the appropriate accrediting agencies, and, upon request, the public if an accredited or preaccredited institution or program—
(1) Decides to withdraw voluntarily from accreditation or preaccreditation, within 10 business days of receiving notification from the institution or program that it is withdrawing voluntarily from accreditation or preaccreditation; or
(2) Lets its accreditation or preaccreditation lapse, within 10 business days of the date on which accreditation or preaccreditation lapses.

§602.28 Regard for decisions of States and other accrediting agencies.
(a) If the agency is an institutional accrediting agency, it may not accredit or precredit institutions that lack legal authorization under applicable State law to provide a program of education beyond the secondary level.
(b) Except as provided in paragraph (c) of this section, the agency may not grant initial or renewed accreditation or preaccreditation to an institution, or a program offered by an institution, if the agency knows, or has reasonable cause to know, that the institution is the subject of--
(1) A pending or final action brought by a State agency to suspend, revoke, withdraw, or terminate the institution's legal authority to provide postsecondary education in the State;
(2) A decision by a recognized agency to deny accreditation or preaccreditation;
(3) A pending or final action brought by a recognized accrediting agency to suspend, revoke, withdraw, or terminate the institution's accreditation or preaccreditation; or
(4) Probation or an equivalent status imposed by a recognized agency.
(c) The agency may grant accreditation or preaccreditation to an institution or program described in paragraph (b) of this section only if it provides to the Secretary, within 30 days of its action, a thorough and reasonable explanation, consistent with its standards, why the action of the other body does not preclude the agency's grant of accreditation or preaccreditation.
(d) If the agency learns that an institution it accredits or preaccredits, or an institution that offers a program it accredits or preaccredits, is the subject of an adverse action by another recognized accrediting agency or has been placed on probation or an equivalent status by another recognized agency, the agency must promptly review its accreditation or preaccreditation of the institution or program to determine if it should also take adverse action or place the institution or program on probation or show cause.
(e) The agency must, upon request, share with other appropriate recognized accrediting agencies and recognized State approval agencies information about the accreditation or preaccreditation status of an institution or program and any adverse actions it has taken against an accredited or preaccredited institution or program.

§602.3 What definitions apply to this part?

The following definitions apply to this part:

Accreditation means the status of public recognition that an accrediting agency grants to an educational institution or program that meets the agency's standards and requirements.
Accrediting agency or agency means a legal entity, or that part of a legal entity, that conducts accrediting activities through voluntary, non-Federal peer review and makes decisions concerning the accreditation or preaccreditation status of institutions, programs, or both.

Act means the Higher Education Act of 1965, as amended.

Adverse accrediting action or adverse action means the denial, withdrawal, suspension, revocation, or termination of accreditation or preaccreditation, or any comparable accrediting action an agency may take against an institution or program.

Advisory Committee means the National Advisory Committee on Institutional Quality and Integrity.

Compliance report means a written report that the Department requires an agency to file when the agency is found to be out of compliance to demonstrate that the agency has corrected deficiencies specified in the decision letter from the senior Department official or the Secretary. Compliance reports must be reviewed by Department staff and the Advisory Committee and approved by the senior Department official or, in the event of an appeal, by the Secretary.

Designated Federal Official means the Federal officer designated under section 10(f) of the Federal Advisory Committee Act, 5 U.S.C. Appdx. 1.

Distance education means education that uses one or more of the technologies listed in paragraphs (1) through (4) of this definition to deliver instruction to students who are separated from the instructor and to support regular and substantive interaction between the students and the instructor, either synchronously or asynchronously. The technologies may include—

1. The internet;
2. One-way and two-way transmissions through open broadcast, closed circuit, cable, microwave, broadband lines, fiber optics, satellite, or wireless communications devices;
3. Audio conferencing; or
4. Video cassettes, DVDs, and CD-ROMs, if the cassettes, DVDs, or CD-ROMs are used in a course in conjunction with any of the technologies listed in paragraphs (1) through (3) of this definition.

Final accrediting action means a final determination by an accrediting agency regarding the accreditation or preaccreditation status of an institution or program. A final accrediting action is a decision made by the agency, at the conclusion of any appeals process available to the institution or program under the agency's due process policies and procedures.

Institutional accrediting agency means an agency that accredits institutions of higher education.
Monitoring report means a report that an agency is required to submit to Department staff when it is found to be substantially compliant. The report contains documentation to demonstrate that—

(i) The agency is implementing its current or corrected policies; or
(ii) The agency, which is compliant in practice, has updated its policies to align with those compliant practices.

Program means a postsecondary educational program offered by an institution of higher education that leads to an academic or professional degree, certificate, or other recognized educational credential.

Programmatic accrediting agency means an agency that accredits specific educational programs, including those that prepare students in specific academic disciplines or for entry into a profession, occupation, or vocation.

Recognition means an unappealed determination by the senior Department official under §602.36, or a determination by the Secretary on appeal under §602.37, that an accrediting agency complies with the criteria for recognition listed in subpart B of this part and that the agency is effective in its application of those criteria. A grant of recognition to an agency as a reliable authority regarding the quality of education or training offered by institutions or programs it accredits remains in effect for the term granted except upon a determination made in accordance with subpart C of this part that the agency no longer complies with the subpart B criteria or that it has become ineffective in its application of those criteria.

Representative of the public means a person who is not—

(1) An employee, member of the governing board, owner, or shareholder of, or consultant to, an institution or program that either is accredited or preaccredited by the agency or has applied for accreditation or preaccreditation;
(2) A member of any trade association or membership organization related to, affiliated with, or associated with the agency; or
(3) A spouse, parent, child, or sibling of an individual identified in paragraph (1) or (2) of this definition.

Scope of recognition or scope means the range of accrediting activities for which the Secretary recognizes an agency. The Secretary may place a limitation on the scope of an agency's recognition for title IV, HEA purposes. The Secretary's designation of scope defines the recognition granted according to—

(i) Types of degrees and certificates covered;
(ii) Types of institutions and programs covered;
(iii) Types of preaccreditation status covered, if any; and
(iv) Coverage of accrediting activities related to distance education or correspondence courses.

**Senior Department official** means the official in the U.S. Department of Education designated by the Secretary who has, in the judgment of the Secretary, appropriate seniority and relevant subject matter knowledge to make independent decisions on accrediting agency recognition.

**Substantial compliance** means the agency demonstrated to the Department that it has the necessary policies, practices, and standards in place and generally adheres with fidelity to those policies, practices, and standards; or the agency has policies, practices, and standards in place that need minor modifications to reflect its generally compliant practice.
REPORT OF THE AD HOC COMMITTEE ON REVIEW COMMITTEE AND COMMISSION STRUCTURE AND FUNCTION

**Background**: At its August 2019 meeting, the Commission on Dental Accreditation (CODA) considered a report of its Standing Committee on Quality Assurance and Strategic Planning, which included a recommendation regarding a request from the American Society of Dentist Anesthesiologists (ASDA) to establish a separate Review Committee for dental anesthesiology. Following consideration, the Commission directed the formation of an Ad Hoc Committee on Review Committee and Commission Structure and Function to study the Commission’s Review Committee and Board of Commissioners structure and function, with consideration of appropriate Commission policies and development of new policies, as applicable, to established criteria by which the Commission may assess the need for a change in CODA’s structure. The Commission further directed the Ad Hoc Committee to consider how a change in the Commission’s Review Committee and Board of Commissioners structure and function will impact the Commission, and how a change may be implemented, including the Ad Hoc Committee’s recommendations on the potential need for change in the Commission’s current structure. In Fall 2019, the Commission Chair appointed the following individuals to the Ad Hoc Committee: Dr. Linda Casser, Dr. Monica Hebl, Dr. Bradford Johnson (chair of ad hoc committee), Dr. James Katancik, Dr. Sanjay Mallya, Dr. Marsha Pyle, Dr. Marybeth Shaffer, and Ms. Deanna Stentiford. The Ad Hoc Committee conducted tele-/web-conference calls on October 29, 2019 and December 4, 2019 and provided a summary report to the Commission at its Winter 2020 meeting (Appendix 1).

On April 13, 2020 the Commission conducted a special meeting for the purpose of discussing the impact of COVID-19 on dental and dental-related education programs. During the meeting, the Commission discussed its ad hoc committees and noted that the Ad Hoc Committee on Review Committee and Commission Structure and Function had reviewed a significant amount of material related to the Commission’s structure and function; however, additional information was to be collected and reviewed by the Committee prior to making a recommendation to the Commission in Summer 2020. The Commission believed that under the circumstances in which Commissioner and staff time was primarily focused on managing the interruption of education resulting from the COVID-19 pandemic, it would be difficult to complete the work of this Committee by Summer 2020. Following discussion, the Commission directed that the work of the Ad Hoc Committee continue into Fall 2020, with a report to CODA in Winter 2021.

At its Summer 2020 meeting, the Commission considered a request from The American Academy of Oral Medicine that CODA establish an oral medicine review committee. Following consideration of this matter, the Commission directed that the request for an oral medicine review committee be reviewed by the Ad Hoc Committee on Review Committee and Commission Structure and Function.

In Fall 2020, the Commission Chair appointed the following individuals to the Ad Hoc Committee: Dr. Linda Casser (chair of ad hoc committee), Dr. Maxine Feinberg, Dr. Susan Kass, Dr. James Katancik, Dr. Sanjay Mallya, Dr. Marybeth Shaffer, Dr. Alan Stein, and Dr. Lawrence
Wolinsky. The Ad Hoc Committee conducted virtual meetings on November 17, 2020 (all members present except Dr. Mallya), December 8, 2020 (all members present) and January 7, 2021 (all members present except Dr. Feinberg). Additionally, Dr. Jeffery Hicks, chair, CODA was in attendance at all meetings, and Dr. Bruce Rotter, vice chair, CODA was in attendance at the December 8, 2020 and January 7, 2021 meetings. Dr. Sherin Tookes, director, CODA, and Mr. Gregg Marquardt, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, were in attendance at all meetings. Ms. Dawn Herman and Ms. Kirsten Nadler, managers, CODA, were in attendance during the January 7, 2021 meeting.

Below is the Ad Hoc Committee’s report and recommendations to the Commission following its meetings of November 17, 2020, December 8, 2020, and January 7, 2021.

**Report and Recommendations of the Ad Hoc Committee:**
The Ad Hoc Committee initiated each meeting with a review of the history of and charge to the Committee along with a summary of the prior meetings’ discussion and considerations. In follow-up to the Ad Hoc Committee’s requested information at the December 2019 meeting, the Committee reviewed additional materials, including: 1) current United States Department of Education (USDE) regulations on composition of accrediting agencies (Appendix 2), 2) an updated comparison of current and potential alternative models for CODA (Appendix 3), 3) an informal environmental scan of the benefits and risks in making changes to CODA’s structure and function, 4) information on the number and types of site visits conducted annually for each discipline, 5) the last and next site visit date for each educational program under CODA’s purview, 6) current CODA policies related to structure and function, and 7) potential budget impacts to CODA related to its current and potential alternative structure and function. The Ad Hoc Committee also considered the structure of other health-related accrediting organizations, such as the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education; however, the Committee concluded that CODA is unique from other accrediting agencies in that CODA’s accreditation program spans predoctoral, postdoctoral (residency and fellowship), and allied dental education programs.

As with prior meetings, the Ad Hoc Committee continually focused on several key concepts related to CODA’s structure and function, noting the role of each level within CODA’s overall operation and mission (Appendix 4), including Site Visitors, the Review Committees, the Board of Commissioners, and the Appeal Board. The Committee considered historical information, including the initial composition of the Commission, changes to CODA’s review committee structure in the mid-1990’s, and the most recent restructuring of review committees in 2006. The Committee also discussed the historical addition of review committees, noting the Oral and Maxillofacial Radiology Review Committee was the last to be established by CODA in 2000. The Committee noted that 12 members of the Board of Commissioners [four (4) American Dental Association (ADA), four (4) American Dental Education Association (ADEA), and four (4) American Association of Dental Board (AADB)] are dictated by the Governance and Organizational Manual of the American Dental Association (ADA); therefore, changes in these
members would require approval by the ADA House of Delegates. The Commission has full and sole authority of its Review Committees, Site Visitors, and Appeal Board.

The Ad Hoc Committee believed there should be careful consideration of the Commission’s potential changes to its structure and function, to ensure that CODA can apply similar processes to other disciplines that may seek a separate Review Committee and Commissioner in the future. The Committee also believed that the Commission should carefully consider expansion of its Board of Commissioners to ensure that the Commission does not become too large to manage its operations. The Ad Hoc Committee was reminded that two (2) current requests are under review by the Commission in the disciplines of dental anesthesiology and oral medicine.

In consideration of the potential changing landscape of dental and allied dental education, the Committee discussed whether CODA should establish additional review committees for disciplines under its purview while maintaining a consistent number of 30 members on the Board of Commissioners. Under this maintained 30-member Board of Commissioners model, disciplines that do not have a minimum threshold of programs to warrant an independent Commissioner would be grouped with similar dental disciplines and jointly represented by a single Commissioner who may serve as an ex-officio member on each review committee that they represent on the Board of Commissioners. Each review committee would additionally have its own chair who may/may not be a Commissioner. The appointment of Commissioners would be based on a rotation schedule between the multiple disciplines represented by the single Commissioner. The Committee considered several structures that included separate review committees for each advanced dental education discipline and a retained 30-member Board of Commissioners, in which multiple review committees were represented by a single Commissioner who was appointed on a rotation cycle by the disciplines this individual would represent on the Board of Commissioners. The Ad Hoc Committee also discussed whether there should be an additional administrative level between the Review Committees and the Board of Commissioners; however, it was determined that an additional level of administration could create unnecessary delays in CODA’s processes.

Regarding the financial impact to the Commission, the Ad Hoc Committee noted that a number of review committees conduct meetings using virtual methods as a result of their workload. The use of virtual meetings results in a negligible financial impact to the Commission. The Ad Hoc Committee believed that the disciplines requesting separate review committees would likewise conduct meetings virtually, based upon the potential workload of these committees. The Ad Hoc Committee also noted a negligible financial impact on CODA regarding changes to the Board of Commissioners. The Committee discussed CODA’s appointment of public members on the Board of Commissioners consistent with USDE regulations under the “separate and independent” criterion, although CODA is not currently required to comply with this criterion. Furthermore, the advanced dental education review committees each include a public member and general dentist in addition to discipline-specific members. As such, an increase in the Board of Commissioners or the creation of additional review committees would result in increases in the need for public members and general dentists although, again, the Committee believed that the financial impact to CODA would be negligible.
When considering the functional and operational impact of changes in the Commission’s structure and function, the substantive concern of the Ad Hoc Committee was the assurance that each discipline with its own review committee would ensure a sufficient and sustainable number of volunteers at all levels of the Commission (i.e., site visitors, review committee members, commissioners, and appeal board) to sustain the Commission’s operations and accreditation program for the discipline. The Ad Hoc Committee believed that CODA should anticipate additional requests for establishment of discipline-specific review committees and corresponding Commissioners, as the Commission considers future requests for accreditation of programs in new dental education areas or disciplines. The Committee believed that CODA could develop policies to require a minimum number of accredited programs and assurance of sufficient volunteers in the discipline to warrant establishment of a separate Review Committee and additional Commissioner. The Committee noted that for the past four (4) disciplines (dental anesthesiology, oral medicine, orofacial pain, and dental therapy) for which CODA has established an accreditation program, the Commission had essentially utilized this method. The continued review and development of policy could occur either through this Ad Hoc Committee, CODA’s strategic planning activities, or assignment to another standing or ad hoc committee of the Commission.

Following multiple meetings and lengthy discussion, the Ad Hoc Committee concluded that the disciplines of dental anesthesiology, oral medicine and orofacial pain have been effectively and consistently represented by the Commission’s current Review Committee and Commission structure. However, given CODA’s commitment to representation of content experts at the decision-making level, the Ad Hoc Committee concluded that the Commission should expand its Review Committee, Commissioner, and Appeal Board structure in the disciplines of dental anesthesiology, oral medicine and orofacial pain. The Ad Hoc Committee noted that the financial and operational impact to the Commission in making the changes to CODA’s structure and function will be negligible, as noted above.

The Ad Hoc Committee recommended that CODA establish three (3) Review Committees and three (3) Commissioners for the disciplines of dental anesthesiology, oral medicine and orofacial pain. The current and proposed revised structures for the Board of Commissioners and Review Committees are found in Appendix 5 and 6, respectively. The Ad Hoc Committee suggested that each discipline-specific Review Committee consist of five (5) members. Additionally, the Committee believed that the Commission should establish three (3) Appeal Board members, for the disciplines of dental anesthesiology, oral medicine and orofacial pain. All proposed changes to CODA’s structure and function are noted in the proposed revisions to policies within the Evaluation and Operational Policies and Procedures manual (Appendix 7). The Ad Hoc Committee also recommended that the Commission implement the changes to each Review Committee, the Commission and Appeal Board effective January 1, 2022, with a notice to the respective sponsoring organizations and certifying boards, as applicable based upon appointing role, that the new structure will not be implemented until the discipline provides an appointee for Commissioner, appointee for Appeal Board member, and a sufficient number of nominees for Review Committee members, without depleting the site visitor pool in the discipline.
Additionally, the appointments and terms of current Review Committee members will be retained to ensure a level of ongoing consistency and staggered appointment of Review Committee members.

**Ad Hoc Committee on Review Committee and Commission Structure and Function Recommendation:** It is recommended that the Commission on Dental Accreditation direct the establishment of a five-person Review Committee for Dental Anesthesiology Education, effective January 1, 2022 pending sufficient nominees from the appropriate sponsoring organization and certifying board without depletion of CODA site visitors in the discipline ([Appendix 6 and 7](#)).

It is further recommended that the Commission on Dental Accreditation direct the establishment of a five-person Review Committee for Oral Medicine Education, effective January 1, 2022 pending sufficient nominees from the appropriate sponsoring organization and certifying board without depletion of CODA site visitors in the discipline ([Appendix 6 and 7](#)).

It is further recommended that the Commission on Dental Accreditation direct the establishment of a five-person Review Committee for Orofacial Pain Education, effective January 1, 2022 pending sufficient nominees from the appropriate sponsoring organization and certifying board without depletion of CODA site visitors in the discipline ([Appendix 6 and 7](#)).

It is further recommended that the Commission on Dental Accreditation direct the addition of a Commissioner for dental anesthesiology, effective January 1, 2022 pending appointment of an individual from the appropriate sponsoring organization without depletion of CODA site visitors in the discipline ([Appendix 6 and 7](#)).

It is further recommended that the Commission on Dental Accreditation direct the addition of a Commissioner for oral medicine, effective January 1, 2022 pending appointment of an individual from the appropriate sponsoring organization without depletion of CODA site visitors in the discipline ([Appendix 6 and 7](#)).

It is further recommended that the Commission on Dental Accreditation direct the addition of a Commissioner for orofacial pain, effective January 1, 2022 pending appointment of an individual from the appropriate sponsoring organization without depletion of CODA site visitors in the discipline ([Appendix 6 and 7](#)).

It is further recommended that the Commission on Dental Accreditation direct the appointment of an Appeal Board member for dental anesthesiology, effective January 1, 2022 pending appointment of an individual from the appropriate sponsoring organization without depletion of CODA site visitors in the discipline ([Appendix 7](#)).
It is further recommended that the Commission on Dental Accreditation direct the appointment of an Appeal Board member for oral medicine, effective January 1, 2022 pending appointment of an individual from the appropriate sponsoring organization without depletion of CODA site visitors in the discipline (Appendix 7).

It is further recommended that the Commission on Dental Accreditation direct the appointment of an Appeal Board member for orofacial pain, effective January 1, 2022 pending appointment of an individual from the appropriate sponsoring organization without depletion of CODA site visitors in the discipline (Appendix 7).

It is further recommended that the Commission on Dental Accreditation adopt the proposed revisions to the Evaluation and Operational Policies and Procedures manual (Appendix 7), with immediate implementation.

It is further recommended that the Commission on Dental Accreditation direct Commission staff to operationalize the revision to the Commission’s Review Committee, Board of Commissioners, and Appeal Board structure and function, including but not limited to the establishing meeting dates of the new Review Committees, revision to CODA numbering system for Commission meeting agendas, updates to CODA documents and website, training of new volunteers, and other areas as needed.

It is further recommended that the Commission on Dental Accreditation direct further review of CODA policies and procedures on CODA structure by the appropriate ad hoc or standing committee, which may include development of policies to initiate a discipline’s oversight within the appropriate existing Review Committee, and require a minimum number of accredited programs and assurance of sufficient volunteers in the discipline, to warrant establishment of a separate Review Committee and additional Commissioner.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
REPORT OF THE AD HOC COMMITTEE ON REVIEW COMMITTEE AND COMMISSION STRUCTURE AND FUNCTION

Background: At its August 2019 meeting, the Commission on Dental Accreditation (CODA), through its Standing Committee on Quality Assurance and Strategic Planning (QASP), considered a request from the American Society of Dentist Anesthesiologists (ASDA) to establish a separate Review Committee for dental anesthesiology. Following consideration of, and in accordance with, the QASP recommendations, the Commission directed the formation of the Ad Hoc Committee on Review Committee and Commission Structure and Function to study the Commission’s Review Committee and Board of Commissioners structure and function, with consideration of appropriate Commission policies and development of new policies, as applicable, to established criteria by which the Commission may assess the need for a change in CODA’s structure. The Commission further directed the Ad Hoc Committee to consider how a change in the Commission’s Review Committee and Board of Commissioners structure and function will impact the Commission, and how a change may be implemented, including the Ad Hoc Committee’s recommendations on the potential need for change in the Commission’s current structure. Finally, the Commission directed that a report be submitted for the Commission’s consideration in Summer 2020.

In fall 2019, the Commission Chair appointed the following individuals to the Ad Hoc Committee: Dr. Linda Casser, Dr. Monica Hebl, Dr. Bradford Johnson (chair of ad hoc committee), Dr. James Katancik, Dr. Sanjay Mallya, Dr. Marsha Pyle, Dr. Marybeth Shaffer, and Ms. Deanna Stentiford.

The Ad Hoc Committee conducted tele-/web-conference calls on October 29, 2019 and December 4, 2019. Below is a summary of the activities related to the Ad Hoc Committee’s meetings.

October 29, 2019 Meeting: All Ad Hoc Committee members were present for the first meeting. Dr. Arthur Chen-Shu Jee, chair, and Dr. Jeffery Hicks, vice chair, Commission on Dental Accreditation, ex-officio, were also in attendance. Additionally, Dr. Sherin Tooks, director, CODA, Mr. Gregg Marquardt, manager, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, were in attendance.

The Ad Hoc Committee initiated its first meeting with a review of the history of and charge to the Committee. The Ad Hoc Committee also reviewed meeting materials and proposed materials for future meetings, which included: 1) the Committee’s charge, 2) reports leading to development of the Ad Hoc Committee, 3) current policies on the Commission’s structure and function, and 4) a topical outline of potential data to gather for committee consideration related
to the Commission’s current structure, scenarios for potential restructure, and policy implications including, for example, information on CODA’s current structure at each level of the Commission and workload considerations, the number of accredited programs, the number of CODA volunteers, potential factors related to restructure scenarios, data on prior restructures of the Review Committees, and data on the structure of other accrediting agencies.

The Committee noted several factors that should be considered through review of the Commission’s structure and function, including the Commission’s current and future strategic plan, the potential future landscape of dental education, the Commission’s current structure strengths and weaknesses, CODA’s capacity to operationalize changes and resource implications (e.g., volunteers, staff, facility, infrastructure, technology), requirements of the United States Department of Education (USDE), and policy implications.

The Ad Hoc Committee discussed several key concepts related to the Commission’s structure and function at all levels of the organization. The Committee engaged in preliminary discussion related to the concepts of equitability and efficiency in the Review Committees’ composition and operations, noting that CODA revised its Review Committee structure in 2006. The Ad Hoc Committee also considered and discussed CODA’s policy to request additional Review Committee members to support increases in workload. The Ad Hoc Committee further discussed the structure of Review Committees, Commission and the Appeal Board in accordance with USDE regulations. The Committee noted that 12 Commissioner appointees [four (4) American Dental Association (ADA), four (4) American Dental Education Association (ADEA), and four (4) American Association of Dental Board (AADB)] are prescribed in the ADA Bylaws, which would require an ADA House of Delegates action to amend. Regarding the Appeal Board, the Ad Hoc Committee noted that further review is warranted to ensure the appeal board membership includes appropriate individuals to consider each appeal. Additionally, the Ad Hoc engaged in preliminary discussions related to CODA’s leadership structure (i.e., chair and vice-chair) noting that CODA may want to consider formation of an executive committee.

Following lengthy discussion, the Ad Hoc Committee requested that Commission staff obtain additional information to provide a graphical representation of CODA’s structure, and to gather additional information on the history of CODA’s structure, the composition of each level, and further details on the number of programs and volunteers to support each level of Commission oversight.

**December 4, 2019 Meeting:** All Ad Hoc Committee members except Dr. Marsha Pyle were present for the second meeting. Dr. Jeffery Hicks, vice chair; Commission on Dental Accreditation, *ex-officio,* was also in attendance. Additionally, Dr. Sherin Tooks, director,
CODA, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA, were in attendance.

The Ad Hoc Committee initiated its second meeting with a review of the agenda materials that were prepared, which included: 1) a history of CODA’s structure, 2) a graphical representation of CODA’s site visitor, Review Committee, Commission, and Appeal Board structure and the role of each level of Commission oversight, 3) current policies on the Commission’s structure and function, 4) the number of programs and current accreditation status in each discipline, 5) the number of programs and CODA volunteers in each discipline at each level of the Commission, 6) CODA’s meeting date schedule, format for meetings (e.g., in-person versus virtual) and cost implications for each meeting, 7) information on possible Review Committee structure options considered previously by CODA in Summer 2018, and 8) historical resources related to the Commission’s prior consideration of its structure and function.

The Ad Hoc Committee noted CODA’s historic structure began with a 12-member Commission in 1974, which was changed to a 20-member Commission in 1975 when the ADA House of Delegates transferred dentistry’s accreditation program from the Council on Dental Education to the Commission on Dental Accreditation of Dental and Dental Auxiliary Education Programs. The 20-member Commission included the original 12 members and an additional eight (8) members [two (2) dental specialists, one (1) dental hygienist, one (1) dental assistant, one (1) dental laboratory technician, one (1) student representative, and two (2) public representatives]. In 1997, the Commission adopted revised Rules and its membership changed to the current 30-member structure of today.

The Committee also discussed the current structure of Review Committees, noting that the size of each committee is dictated by a need for diverse representation and workload. It was noted that some advanced dental education committees include five (5) members while others include six (6) members. In accordance with CODA policy, a Review Committee may request additional members as the workload increases. The Ad Hoc Committee also noted CODA’s recent revisions to the structure of the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain (AGDOO), which includes a joint appointment of this Committee’s chair by the sponsoring organizations of the five (5) disciplines represented on the Committee. The Ad Hoc Committee considered whether it should survey the existing Review Committees to obtain their perspective on the structure and operation but determined that a survey was not necessary at this time.

The Ad Hoc Committee discussed the number of programs, accreditation statuses, and number of volunteers at each level for each discipline under the Commission’s purview. The Committee also discussed preliminary restructure of Review Committees and the Commission, with
discussion on the USDE requirements, particularly in the area of public member representation. The Ad Hoc Committee discussed whether CODA should reduce the number of Review Committees or reduce the membership on some Review Committees, due to the limited number of programs and/or workload under a Committee’s purview. The Committee determined that changes to the current structure must be well thought out and supported. It was noted that Review Committees with heavy workload meet in person, while Committees with less workload meet virtually; therefore, the cost impact to CODA is minimal.

The Ad Hoc Committee also considered the 2014 and 2015 work of the Commission through its Standing Committee on Quality Assurance and Strategic Planning, which included a comparative analysis of the Commission and other accrediting agencies related to the Commission’s structure, and potential alternative models for the structure of the Commission. The Ad Hoc Committee members believed that updated information in a similar presentation would be helpful. The Ad Hoc Committee also suggested that CODA’s Director speak with other accrediting agencies that have recently revised their structure to determine how they considered and accomplished this activity. While discussing other accrediting agencies, the Ad Hoc Committee noted that some agencies select their members at all levels of the organization; it was noted that within the Commission, the Commissioners are appointed by sponsoring organizations, while Review Committee members and Site Visitors are selected appointed by the Commission.

Following lengthy discussion, the Ad Hoc Committee requested that additional information be collected for its next meeting, including: 1) current USDE regulations on composition of accrediting agencies, 2) an updated comparison of current and potential alternative models for CODA, 3) an updated comparison of the structure of health-related accrediting bodies including all levels (Review Committee and Commission) and applicable policies that govern the agencies with special emphasis on agencies that have recently modified their structure or function, 4) an informal environmental scan on the benefits and risks in making changes to CODA’s structure and function, 5) information on the number and types of site visits conducted annually for each discipline, 6) the last and next site visit date for each educational program under CODA’s purview, 7) CODA policy on structure and function, with areas of consideration highlighted, and 8) potential budget impacts to CODA related to its current and potential alternative structure and function.

**Ad Hoc Committee on Review Committee and Commission Structure and Function Recommendation:** This report is informational in nature and no action is required.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
CURRENT UNITED STATES DEPARTMENT OF EDUCATION REGULATIONS
ON COMPOSITION OF ACCREDITING AGENCIES

§602.3 What definitions apply to this part?

Representative of the public means a person who is not—
(1) An employee, member of the governing board, owner, or shareholder of, or consultant to, an institution or program that either is accredited or preaccredited by the agency or has applied for accreditation or preaccreditation;
(2) A member of any trade association or membership organization related to, affiliated with, or associated with the agency; or
(3) A spouse, parent, child, or sibling of an individual identified in paragraph (1) or (2) of this definition.

602.14 Category of Agency

(a) The Secretary recognizes only the following four categories of accrediting agencies:

(1) A State agency that—
   (i) Has as a principal purpose the accrediting of institutions of higher education, higher education programs, or both; and
   (ii) Has been listed by the Secretary as a nationally recognized accrediting agency on or before October 1, 1991.

(2) An accrediting agency that—
   (i) Has a voluntary membership of institutions of higher education;
   (ii) Has as a principal purpose the accrediting of institutions of higher education and that accreditation is used to provide a link to Federal HEA programs in accordance with §602.10; and
   (iii) Satisfies the “separate and independent” requirements in paragraph (b) of this section.

(3) An accrediting agency that—
   (i) Has a voluntary membership; and
   (ii) Has as its principal purpose the accrediting of institutions of higher education or programs, and the accreditation it offers is
used to provide a link to non-HEA Federal programs in accordance with §602.10.

(4) An accrediting agency that, for purposes of determining eligibility for title IV, HEA programs—

(i) (A) Has a voluntary membership of individuals participating in a profession; or

(B) Has as its principal purpose the accrediting of programs within institutions that are accredited by another nationally recognized accrediting agency; and

(ii) Satisfies the "separate and independent" requirements in paragraph (b) of this section or obtains a waiver of those requirements under paragraph (d) of this section.

(b) For purposes of this section, "separate and independent" means that—

(1) The members of the agency's decision-making body, who decide the accreditation or preaccreditation status of institutions or programs, establish the agency's accreditation policies, or both, are not elected or selected by the board or chief executive officer of any related, associated, or affiliated trade association, professional organization, or membership organization and are not staff of the related, associated, or affiliated trade association, professional organization, or membership organization;

(2) At least one member of the agency's decision-making body is a representative of the public, and at least one-seventh of the body consists of representatives of the public;

(3) The agency has established and implemented guidelines for each member of the decision-making body including guidelines on avoiding conflicts of interest in making decisions;

(4) The agency's dues are paid separately from any dues paid to any related, associated, or affiliated trade association or membership organization; and

(5) The agency develops and determines its own budget, with no review by or consultation with any other entity or organization.
(c) The Secretary considers that any joint use of personnel, services, equipment, or facilities by an agency and a related, associated, or affiliated trade association or membership organization does not violate the "separate and independent" requirements in paragraph (b) of this section if—

1. The agency pays the fair market value for its proportionate share of the joint use; and
2. The joint use does not compromise the independence and confidentiality of the accreditation process.

(d) For purposes of paragraph (a)(4) of this section, the Secretary may waive the "separate and independent" requirements in paragraph (b) of this section if the agency demonstrates that—

1. The Secretary listed the agency as a nationally recognized agency on or before October 1, 1991, and has recognized it continuously since that date;
2. The related, associated, or affiliated trade association or membership organization plays no role in making or ratifying either the accrediting or policy decisions of the agency;
3. The agency has sufficient budgetary and administrative autonomy to carry out its accrediting functions independently;
4. The agency provides to the related, associated, or affiliated trade association or membership organization only information it makes available to the public.

(e) An agency seeking a waiver of the "separate and independent" requirements under paragraph (d) of this section must apply for the waiver each time the agency seeks recognition or continued recognition.

(NOTE: An agency must respond to this section only if it is requesting a waiver of the "separate and independent" requirement.)
### 602.15 – Administrative and fiscal responsibilities

<table>
<thead>
<tr>
<th>The agency must have the administrative and fiscal capability to carry out its accreditation activities in light of its requested scope of recognition. The agency meets this requirement if the agency demonstrates that—</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) The agency has—</td>
</tr>
<tr>
<td>(1) Adequate administrative staff and financial resources to carry out its accrediting responsibilities;</td>
</tr>
<tr>
<td>(2) Competent and knowledgeable individuals, qualified by education or experience in their own right and trained by the agency on their responsibilities, as appropriate for their roles, regarding the agency's standards, policies, and procedures, to conduct its on-site evaluations, apply or establish its policies, and make its accrediting and preaccrediting decisions, including, if applicable to the agency's scope, their responsibilities regarding distance education and correspondence courses;</td>
</tr>
<tr>
<td>(3) Academic and administrative personnel on its evaluation, policy, and decision-making bodies, if the agency accredits institutions;</td>
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<tr>
<td>(4) Educators, practitioners, and/or employers on its evaluation, policy, and decision-making bodies, if the agency accredits programs or single-purpose institutions that prepare students for a specific profession;</td>
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<tr>
<td>(5) Representatives of the public, which may include students, on all decision-making bodies; and</td>
</tr>
<tr>
<td>(6) Clear and effective controls, including guidelines, to prevent or resolve conflicts of interest, or the appearance of conflicts of interest, by the agency's—</td>
</tr>
<tr>
<td>(i) Board members;</td>
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<td>(ii) Commissioners;</td>
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<tr>
<td>(iii) Evaluation team members;</td>
</tr>
<tr>
<td>(iv) Consultants;</td>
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<tr>
<td>(v) Administrative staff; and</td>
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<tr>
<td>(vi) Other agency representatives; and</td>
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</tbody>
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COMPARISON OF CURRENT AND ALTERNATIVE MODELS FOR CODA – updated 11/2020

Assumptions:
1. All RCs retain current structure and function.
2. All standing committees retain current structure and function.
3. Expenses for RCs and standing committees remain constant across all models
4. Estimated meeting expenses (travel, meals, etc.): $1,300 per person per 1-day meeting
   $1,700 per person per 2-day meeting
5. All direct operating expenses the same except as specifically listed under each model.
6. All indirect/overhead expenses the same for all models.
7. Regardless of model adopted/retained, a significant communications initiative will be required to inform stakeholders.
8. The total operating expense budget of CODA for 2019 was $3,282,335, with budgeted revenue of $4,102,546.
   The total operating expense budget of CODA for 2020 was $3,434,957, with budgeted revenue of $4,060,886.

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<tr>
<th>Current Review Committee Structure</th>
<th>Cost per in-person meeting</th>
<th>Total cost for in-person meeting per year</th>
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<tr>
<td>Predoc RC (9 member) (1 or 2 days)</td>
<td>$11,700 (1 day) $15,300 (2 day)</td>
<td>$23,400 (1 day) $30,600 (2 day)</td>
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<td>Advanced RC (5 member) (1 day)</td>
<td>3RC @ $6,500 each ($19,500 total)</td>
<td>3RC @ $13,000 each ($39,000 total)</td>
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<tr>
<td>Advanced RC (6 member) (1 day)</td>
<td>6RC @ $7,800 each ($46,800 total)</td>
<td>6RC @ $15,600 each ($93,600 total)</td>
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<td>AGDOO RC (12 member) (2 day)</td>
<td>$20,400</td>
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<td>DA RC (10 member) (2 day)</td>
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<td>DH RC (11 member) (2 day)</td>
<td>$18,700</td>
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<tr>
<td>DLT RC (5 member) (1 day)</td>
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<td>Total RC Expense: $281,200 (with one day Predoc RC)</td>
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   $288,400 (with two day Predoc RC) |
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<th>Option 3</th>
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<td><strong>Description/Structure</strong></td>
<td><strong>Single Commission with 30 members:</strong></td>
<td><strong>Single Commission with 27 members</strong></td>
<td><strong>Single Commission with 33 or 34 members</strong></td>
<td>2 separate Commissions with oversight/executive committee</td>
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<td>ADA</td>
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<td>ADA</td>
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<tr>
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<td>2*</td>
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<tr>
<td><strong>2 separate Commissions with oversight/executive committee</strong></td>
<td></td>
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<tr>
<td>Advanced Commission (16 members)*:</td>
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<tr>
<td>AEGD, GPR</td>
<td>1</td>
<td>DPH, OMP, OM</td>
<td>1</td>
<td>DPH, OMP, OM</td>
</tr>
<tr>
<td>ENDO, OMS, ORTHO, PED, PERIO, PROS</td>
<td>9</td>
<td>ENDO, OMS, ORTHO, PED, PERIO, PROS</td>
<td>9</td>
<td>ENDO, OMS, ORTHO, PED, PERIO, PROS</td>
</tr>
<tr>
<td>OFP OM</td>
<td>1</td>
<td>Resident</td>
<td>1</td>
<td>Resident</td>
</tr>
<tr>
<td>DentAnesth</td>
<td>12</td>
<td>Public</td>
<td>2</td>
<td>Public</td>
</tr>
<tr>
<td><strong>Predoc/Allied Commission (8 members):</strong></td>
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<tr>
<td>ADA</td>
<td>1</td>
<td>ADA</td>
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<td>ADA</td>
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<tr>
<td>ADEA</td>
<td>1</td>
<td>AADB</td>
<td>1</td>
<td>AADB</td>
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<tr>
<td>ADHA</td>
<td>1</td>
<td>ADAA</td>
<td>1</td>
<td>ADAA</td>
</tr>
<tr>
<td>NADL</td>
<td>1</td>
<td>NADL</td>
<td>1</td>
<td>NADL</td>
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<tr>
<td>Student</td>
<td>1</td>
<td>Student</td>
<td>1</td>
<td>Student</td>
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<tr>
<td>Public</td>
<td>1</td>
<td>Public</td>
<td>1</td>
<td>Public</td>
</tr>
</tbody>
</table>

*May be reduced to 3, 2 or 1 individual.*
<table>
<thead>
<tr>
<th>Expense of convening Commission (based on 2 day meeting)</th>
<th>$102,000 ($51,000 per meeting)</th>
<th>$91,800 ($45,900 per meeting)</th>
<th>$112,200 ($56,100 per meeting)</th>
<th>$108,800 (2 meetings of Commissions and 4 meetings of Oversight Committee) ($40,800 per meeting for 2 Commissions plus $6,800 per meeting for Oversight Committee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional 3RCs In-Person Meeting Budget @ $13,000 each ($39,000 total)</td>
<td>Additional 3RCs In-Person Meeting Budget @ $13,000 each ($39,000 total)</td>
<td>Additional 3RCs In-Person Meeting Budget @ $13,000 each ($39,000 total)</td>
<td>Additional 3RCs In-Person Meeting Budget @ $13,000 each ($39,000 total)</td>
<td>Additional 3RCs In-Person Meeting Budget @ $13,000 each ($39,000 total)</td>
</tr>
<tr>
<td>Restructure and additional staffing (on-</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$100,000+ plus hiring additional staff</td>
</tr>
<tr>
<td><strong>going expense)</strong></td>
<td><strong>Total on-going expense</strong></td>
<td><strong>$91,800 to $130,800</strong></td>
<td><strong>$112,200 to $151,200</strong></td>
<td><strong>Plus additional staff expenses</strong></td>
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<td>----------------------------------</td>
</tr>
<tr>
<td>USDE petition, temporary staffing, travel + misc exp. (one-time initial + every 5 years addl. expense)</td>
<td>0</td>
<td>Reporting to USDE and possible travel</td>
<td>Reporting to USDE and possible travel</td>
<td>$30,000-$50,000 Estimate for USDE petition, development of new Commission rules and regulations, structural changes, etc.</td>
</tr>
<tr>
<td><strong>Overall impact on expenses</strong></td>
<td>No impact/same</td>
<td>Commission meeting travel expense reduced by $10,200 with 3 fewer members if the, if 3 new RCs conduct meetings virtually. Commission meeting travel expense increase by $28,800 if 3 new RCs conduct meetings in-person.</td>
<td>Commission meeting travel expense increase with addition of 3 Commissioners and 1 public member. Expenses may further increase if 3 new RCs conduct meetings in-person.</td>
<td>If only Commissions meet in person, meeting travel expense would be almost the same as Option 1. However, if Oversight Committee meets in person for 2 additional meetings, there is a slight increase in meeting travel expense. There is an increased staffing expense and increased costs for coordination, communication, and workload to staff and the two separate commissions and oversight committee.</td>
</tr>
<tr>
<td><strong>Stakeholder representation, inclusivity and membership balance</strong></td>
<td>Equal representation of practitioners, educators and examiners (ADEA, ADA, AADB). Advanced Education Commissioners may also be educators or practitioners with impact on balance.</td>
<td>Equal representation of practitioners, educators, examiners. Addition of three (3) areas with own Commissioner and Review Committee Structure</td>
<td>Equal representation of practitioners, educators, examiners. Addition of three (3) areas with own Commissioner and Review Committee Structure</td>
<td>Separate commissions will lack balance. Advanced general dentistry will be under-represented in Advanced Commission. General dentists likely to be over-represented in Predoc/Allied Commission.</td>
</tr>
<tr>
<td>Commissioner Workload</td>
<td>ADA, ADEA, AADB appointees may have advanced training.</td>
<td>Advanced education more likely to predominate if also appointed by ADA, ADEA, AADB</td>
<td>Advanced education more likely to predominate if also appointed by ADA, ADEA, AADB</td>
<td>Public, practicing, and licensing community representation limited.</td>
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<td>------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Commissioner Workload</td>
<td>Same/no impact</td>
<td>Same or Increased. Commissioners may have to serve on multiple RCs, standing committees and ad hoc committees.</td>
<td>Same or Increased. Commissioners may have to serve on multiple RCs, standing committees and ad hoc committees.</td>
<td>Predoc/Allied Commission and Oversight Committee will have substantially increased workload, including service on multiple RCs, standing committees and ad hoc committees. Slight impact on advanced commissioners.</td>
</tr>
<tr>
<td>Preservation of Dental Team</td>
<td>Continuity, integration, interface and interdisciplinary communication and coordination maintained</td>
<td>Continuity, integration, interface and interdisciplinary communication and coordination maintained</td>
<td>Continuity, integration, interface and interdisciplinary communication and coordination maintained</td>
<td>Lack of continuity, integration, interface and interdisciplinary communication and coordination between advanced and predoc and advanced and allied.</td>
</tr>
</tbody>
</table>
| "Pros" of model: | - No single group’s agenda can predominate  
  • Strong conflict of interest and simultaneous service policies ensure that Commission decisions are based on the good of the profession, not parochial interests  
  • Current structure provides program review at three different levels: site visitor, review committee, and the Commission itself-this provides due process for the programs and ensures that bias is eliminated (evidence: the Appeal Board is rarely convened) | - Multi-disciplinary participation retained for credibility, continuity and input of varied perspectives for policy issues. RC chairs available as content resources.  
  - Reduced size is more efficient and may be more cost effective.  
  - Retains balance in decision-making so no single community of interest controls | - Multi-disciplinary participation retained for credibility, continuity and input of varied perspectives for policy issues. RC chairs available as content resources.  
  - Maintains balance of practitioner, educator and examiner representation so no single community of interest controls | - The commissions are smaller and, therefore, have a smaller scope of accrediting activities.  
  - The members of each commission are specifically "matched" to the programs being evaluated, i.e., there would only be advanced dental representatives on one commission and only predoctoral and allied dental on the other. There would still be student/resident and public members on each. |
1. **Orientation and training for new Commissioners and RC members now addresses the issue of conflict of interest and the roles of these individuals in conducting the work of the Commission.**

- Current structure allows the continuum of dental education to be more coordinated—"team concept"

1. **All communities of interest have a say on all aspects of dental education; i.e., employers of allied dental team members have input on allied education; advanced education disciplines have input on the predoctoral and postdoctoral general dental education that applicants for their programs receive, etc.**

- Practicing dentists and dental educators are a majority under the current structure and accreditation is based on the concept of peer review

- Public and non-content expert perspective is important, as many standards and policies of the Commission are for public and student protection, not
- Current size of the Commission allows for division of work related to the large number of standing committees and *ad hoc* committees

- Already USDE recognized for this structure; recognition of a different structure by USDE would be time-consuming and could be costly

- Staff resources are most efficiently used in the current structure; restructuring will require an increase in the number of staff to administer and potential for greater expense

- The vast majority of accrediting agencies in the US have a similar structure

- The ability to add content experts to review committees for workload, is noted in current policy

- Ability to add Commission members is noted in current policy

- Use of the consent calendar and consideration of accreditation actions on the first
- Training efforts for review committee members and site visitors have been enhanced.

<table>
<thead>
<tr>
<th>“Cons” of model:</th>
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</thead>
<tbody>
<tr>
<td>▪ Non-content experts have input into accreditation decisions; content experts on review committees can only make recommendations to the Commission, not actual accreditation decisions.</td>
<td>▪ Disciplines that do not have as many seats on CODA as previously will feel alienated.</td>
<td>▪ Unclear whether all RCs have sufficient peers to support CODA process at site visit, review committee, and Commission levels.</td>
<td>▪ The model does not allow for a forum for communication/discussion among all disciplines within dentistry on either educational issues that affect dentistry as a whole or standards, policies, and procedures that should govern all of dentistry.</td>
</tr>
<tr>
<td>▪ One of the largest Commissions in the U.S. in terms of number of Commissioners-agreement on policy issues may be difficult to achieve; agenda can be long and involved, so time cannot be spent on important issues.</td>
<td>▪ Will require ADA Bylaws change to reduce seats for ADA, ADEA, AADB.</td>
<td></td>
<td>▪ The model effectively splits dentistry into two autonomous “silos” – Advanced education and Predoctoral/Allied education.</td>
</tr>
<tr>
<td>▪ Difficult for the Commission to act in a nimble/quick manner on pressing issues.</td>
<td>▪ Number of commissioners may not be sufficient to handle ad hoc and standing committee assignments.</td>
<td></td>
<td>▪ The model would encourage the creation of other autonomous “silos,” e.g., a predoctoral silo, an allied dental silo, etc.</td>
</tr>
<tr>
<td>▪ Commission size may have to increase to accommodate new dental team members; exacerbating the issues outlined above.</td>
<td>▪ Unclear whether all RCs have sufficient peers to support CODA process at site visit, review committee, and Commission levels.</td>
<td></td>
<td>▪ It would be very difficult to keep the “silos” operating in parallel, even with the oversight body in place.</td>
</tr>
<tr>
<td>▪ Commission seats are not allocated proportionately to the number of programs in a particular discipline (some disciplines/communities of</td>
<td>▪ Cost savings may be small in relation to overall budget.</td>
<td></td>
<td>▪ Each Commission would have to seek recognition from USDE and/or CHEA on its own.</td>
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<tr>
<td>day of the meeting have allowed more time for discussion of accreditation decisions</td>
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</tbody>
</table>
| interest over-represented, and visa-versa |  |  | need to service two commissions rather than one. Additional staff would be required to manage workload.  
  - Meeting logistics would be more complicated and possibly more expensive due to the need for separate meeting space and additional meetings of the oversight body. |
## Possible Review Committee Structure Options

<table>
<thead>
<tr>
<th>Option</th>
<th>Scenario</th>
<th>Increase in Annual Expense to Commission</th>
<th>#Programs</th>
<th>#Site Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Establish one or more discipline-specific Review Committee(s) with AGDOO Commissioner or another CODA Commissioner as Chair:</td>
<td>Training</td>
<td>Dent Anes</td>
<td>Dent Anes</td>
</tr>
<tr>
<td></td>
<td>Five (5) Member RC:</td>
<td>Possible site visit observers (as needed) - $1,300 per person</td>
<td>Currently 8</td>
<td>19 active</td>
</tr>
<tr>
<td></td>
<td>• 1 AGDOO or another Commissioner</td>
<td>Teleconference meetings = approx. $100</td>
<td>Oral Med</td>
<td>Oral Med</td>
</tr>
<tr>
<td></td>
<td>• 1 sponsoring organization representative</td>
<td></td>
<td>Currently 6</td>
<td>13 active</td>
</tr>
<tr>
<td></td>
<td>• 1 certifying board representative</td>
<td></td>
<td>Orofacial Pain</td>
<td>Orofacial Pain</td>
</tr>
<tr>
<td></td>
<td>• 1 general dentist</td>
<td></td>
<td>Currently 12</td>
<td>10 active</td>
</tr>
<tr>
<td></td>
<td>• 1 public</td>
<td></td>
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<tr>
<td><strong>B</strong></td>
<td>Establish one or more discipline-specific Review Committee(s) with a new discipline-specific Commissioner as Chair:</td>
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<td></td>
<td>Five (5) Member RC:</td>
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<tr>
<td></td>
<td>• 1 Discipline-Specific Commissioner</td>
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<tr>
<td></td>
<td>• 1 sponsoring organization representative</td>
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<td></td>
<td>• 1 public</td>
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<td></td>
<td>Training</td>
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<td></td>
<td>Possible site visit observers (as needed) - $1,300 per person</td>
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<td></td>
<td>Teleconference meetings = approx. $100</td>
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<td></td>
<td>In-person meeting = approx. $6,500 (about $1,300 per person)</td>
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<tr>
<td></td>
<td>Dent Anes</td>
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<tr>
<td></td>
<td>Currently 8</td>
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<td>10 active</td>
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</table>

<table>
<thead>
<tr>
<th><strong>C</strong></th>
<th>Establish a new joint RC for Dental Anesthesiology, Oral Medicine and Orofacial Pain with AGDOO Commissioner or another CODA Commissioner as Chair:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nine (9) Member RC:</td>
</tr>
<tr>
<td></td>
<td>• 1 AGDOO or another Commissioner</td>
</tr>
<tr>
<td></td>
<td>• 1 dental anesthesiology organization representative</td>
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<tr>
<td></td>
<td>• 1 dental anesthesiology board representative</td>
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<tr>
<td></td>
<td>• 1 oral med organization representative</td>
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<tr>
<td></td>
<td>• 1 oral med board representative</td>
</tr>
<tr>
<td></td>
<td>• 1 orofacial pain organization representative</td>
</tr>
<tr>
<td></td>
<td>• 1 orofacial pain board representative</td>
</tr>
<tr>
<td></td>
<td>• 1 general dentist</td>
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<td></td>
<td>• 1 public</td>
</tr>
<tr>
<td></td>
<td>Training</td>
</tr>
<tr>
<td></td>
<td>Possible site visit observers (as needed) - $1,300 per person</td>
</tr>
<tr>
<td></td>
<td>Teleconference meetings = approx. $100</td>
</tr>
<tr>
<td></td>
<td>In-person meeting = approx. $11,700 (about $1,300 per person) – There may be a slight cost savings if existing Commissioner travels only once for in-person meetings</td>
</tr>
<tr>
<td></td>
<td>Dent Anes</td>
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<td>Currently 8</td>
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<td></td>
<td>Oral Med</td>
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<td></td>
<td>Orofacial Pain</td>
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<td></td>
<td>10 active</td>
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<td></td>
<td>Establish a new RC for Dental Anesthesiology, Oral Medicine and Orofacial Pain with joint appointment of a single new Commissioner as Chair:</td>
</tr>
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<tr>
<td></td>
<td>during Review Committee Week</td>
</tr>
<tr>
<td>D</td>
<td>Training</td>
</tr>
<tr>
<td></td>
<td>Possible site visit observers (as needed) - $1,300 per person</td>
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<td>Teleconference meetings = approx. $100</td>
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<td>Currently 6</td>
</tr>
<tr>
<td>Orofacial Pain</td>
<td>Currently 12</td>
</tr>
</tbody>
</table>

Nine (9) Member RC:
- 1 joint appointment - Dent Anes/Oral Medicine/Orofacial Pain Commissioner
- 1 dental anesthesiology organization representative
- 1 dental anesthesiology board representative
- 1 oral med organization representative
- 1 oral med board representative
- 1 orofacial pain organization representative
- 1 orofacial pain board representative
- 1 general dentist
- 1 Public

Dent Anes
- 19 active

Oral Med
- 13 active

Orofacial Pain
- 10 active
Commission Composition

Commission on Dental Accreditation:
  • 30 Commissioners
    – 4 ADA
    – 4 ADEA
    – 4 AADB
    – 4 public members
    – 1 each AAOMP, AAOMR, AAPD, AAP, AAE, AAOMS, AAO, AAPHD, and ACP
    – 1 joint ADEA, SCDA, ASDA, AAOM, and AAOP
    – 1 dental hygiene
    – 1 dental assisting
    – 1 dental laboratory technology
    – 1 dental student (ADEA/ASDA)

Note – 4 in blue are noted in ADA Governance Manual

Review Committees:
  • Predoctoral Dental Education Review Committee (includes Dental Therapy) (9 members)
  • DPH, OMP, and OMR Review Committees (5 members each)
  • ENDO, OMS (residency and fellowship), ORTHO (residency and fellowship), PERIO, PED and PROS Review Committees (6 members each)
  • AEGD, GPR, Dental Anesth, Oral Med, Orofacial Pain Review Committee (12 members)
  • Dental Assisting Education Review Committee (10 members)
  • Dental Hygiene Review Committee (11 members)
  • Dental Laboratory Technology Review Committee (5 members)

Appeal Board:
  • Separate membership from the Commission
    – ADA, ADEA, AADB, Public (permanent members = 4)
    – 5th member - In addition, a representative from either an allied or advanced dental education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or advanced dental education organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American Dental Education Association and the Special Care Dentistry Association.
Appeal Board

A separate body, outside of the Commission, that will convene to consider appeals related to adverse accreditation actions taken by the Commission

Site Visitors
- Conduct on-site reviews of programs
- Site visitors are specific to each discipline within CODA
- Site visitors apply annually and are reviewed by Review Committees and appointed by CODA

Review Committees
- 14 review committees (RC)
- Each RC Chair serves on the Commission
- Members are nominated, with appointment by CODA
- Some RCs oversee one discipline while others oversee multiple disciplines

Board of Commissioners (Commission)
- Board of Commissioners that serves as the final decision-making body
- Made up of 30 Commissioners who are appointed by organizations
- Standing and Ad Hoc Committees are subsumed within CODA structure
CURRENT STRUCTURE OF THE COMMISSION ON DENTAL ACCREDITATION
(Commissioner Appointments and Review Committee Structure)

BOARD OF COMMISSIONERS (N=30 Commissioners)

- 4 ADA
- 4 AADB
- 4 ADEA
- 4 PUBLIC
- 1 STUDENT
- 3 ALLIED DENTAL*
- 10 ADVANCED DENTAL**

REVIEW COMMITTEES (RC) (N=14 Review Committees)

- Predoctoral Dental Education RC
  - Predoctoral Dental
  - Dental Therapy
- Dental Assisting RC*
- Dental Hygiene RC*
- Dental Laboratory Technology RC*
- Dental Public Health RC**
- Endodontics RC**
- Oral and Maxillofacial Pathology RC**
- Oral and Maxillofacial Radiology RC**
- AGDOO RC**
  - Advanced Education in General Dentistry
  - General Practice Residency
  - Dental Anesthesiology
  - Oral Medicine
  - Orofacial Pain
- Oral and Maxillofacial Surgery RC**
- Orthodontics and Dentofacial Orthopedics RC**
- Pediatric Dentistry RC**
- Periodontics RC**
- Prosthodontics RC**
PROPOSED STRUCTURE OF THE COMMISSION ON DENTAL ACCREDITATION
(Commissioner Appointments and Review Committee Structure)

BOARD OF COMMISSIONERS (N=33 Commissioners)

- 4 ADA
- 4 AADB
- 4 ADEA
- 4 PUBLIC
- 1 STUDENT
- 3 ALLIED DENTAL*
- 1 POSTDOCTORAL GENERAL DENTISTRY
- 12 ADVANCED DENTAL**
  (3 New Proposed)

REVIEW COMMITTEES (RC) (N=17 Review Committees)

- Predoctoral Dental Education RC
  - Predoctoral Dental
  - Dental Therapy
- Dental Assisting RC*
- Dental Hygiene RC*
- Dental Laboratory Technology RC*
- Advanced Dental Review Committees**
  - Dental Public Health RC
  - Endodontics RC
  - Oral and Maxillofacial Pathology RC
  - Oral and Maxillofacial Radiology RC
  - Oral and Maxillofacial Surgery RC
  - Orthodontics and Dentofacial Orthopedics RC
  - Pediatric Dentistry RC
  - Periodontics RC
  - Prosthodontics RC
  - Dental Anesthesiology RC (New)
  - Orofacial Pain RC (New)
  - Oral Medicine RC (New)
- Postdoctoral General Dentistry RC
  - Advanced Education in General Dentistry
  - General Practice Residency
PROPOSED REVISIONS TO THE COMMISSION ON DENTAL ACCREDITATION
POLICIES ON REVIEW COMMITTEE AND COMMISSION
STRUCTURE AND FUNCTION

(Underline indicates addition; Strikethrough indicates deletion)

2. Rules Of The Commission On Dental Accreditation:

   Article II. BOARD OF COMMISSIONERS

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or
retired members of this Association. None of the appointees shall be a faculty member of any dental
education program working more than one day per week or a member of a state board of dental examiners
or jurisdictional dental licensing agency.

Four (4) members who are active, life or retired members of this Association and also active members of
the American Association of Dental Boards shall be selected by the American Association of Dental
Boards. None of these members shall be a faculty member of any dental education program.

Four (4) members who are active, life or retired members of this Association and also active members of
the American Dental Education Association shall be selected by the American Dental Education
Association. None of these members shall be a member of any state board of dental examiners or
jurisdictional dental licensing agency.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by
the American Dental Assistants Association from its active or life membership, one (1) licensed dental
hygienist selected by the American Dental Hygienists’ Association, one (1) certified dental laboratory
technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by
the American Student Dental Association and the Council of Students, Residents and Fellows of the
American Dental Education Association, one (1) dentist who is board certified in the respective
discipline-specific area of practice and is selected by each of the following organizations: American
Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology,
American Academy of Oral Medicine, American Academy of Orofacial Pain, American Academy of
Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists,
American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists,
American Association of Public Health Dentistry, American College of Prosthodontists, American
Society of Dentist Anesthesiologists; one (1) dentist who is jointly appointed by the American Dental
Education Association and the Special Care Dentistry Association, the American Society of Dentist
Anesthesiologists, the American Academy of Oral Medicine, and the American Academy of Orofacial
Pain and four (4) members of the public who are neither dentists nor allied dental personnel nor teaching
in a dental or allied dental education institution and who are selected by the Commission, based on
established and publicized criteria. In the event a Commission member sponsoring organization fails to
select a Commissioner, it shall be the responsibility of the Commission to select an appropriate
representative to serve as a Commissioner. The Director of the Commission shall be an ex-officio member of the Board without the right to vote.

Section 3.  TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be one four (4) year term except that the member jointly selected by the American Dental Education Association and the American Student Dental Association shall serve only one two (2) year term.

Article III.  APPEAL BOARD

Section 1.  APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational and allied dental educational programs from decisions rendered by the Board of Commissioners denying or revoking accreditation. Such appeals shall be heard pursuant to procedures established by these Rules and the Commission’s Evaluation and Operational Policies and Procedures manual.

Section 2.  COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association from the active, life or retired membership of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education and Licensure, one (1) member selected by the American Association of Dental Boards from the active membership of that body, one (1) member selected by the American Dental Education Association from the active membership of that body and one (1) consumer member who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental educational program and who is selected by the Commission, based on established and publicized criteria. In addition, a representative from either an allied or advanced dental education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or advanced dental education organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American Dental Education Association and the Special Care Dentistry Association. One (1) member of the Appeal Board shall be appointed annually by the Chair of the Commission to serve as the Chair and shall preside at all meetings of the Appeal Board. If the Chair is unable to attend any given meeting of the Appeal Board, the other members of the Appeal Board present and voting shall elect by majority vote an acting Chair for that meeting only. The Director of the Commission shall provide assistance to the Appeal Board.

Section 3.  TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4) year term.

Article V.  OFFICERS

Section 1.  OFFICERS: The officers of the Commission shall be a Chair, Vice-chair, a Director and such other officers as the Board of Commissioners may authorize. The Chair and Vice-chair shall be elected by the Board of Commissioners.

Section 2.  ELIGIBILITY: The Chair and Vice-chair shall be dentists who are members of the Board of Commissioners. The Chair and Vice-chair shall be active, life or retired members of the American Dental
Section 3. ELECTION AND TERM: The Chair and Vice-chair of the Commission shall be elected annually by the Board of Commissioners. The term of the Chair and Vice-chair shall be one (1) year beginning and ending with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association.

Section 4: DUTIES: The duties of the officers are as follows:

A. CHAIR:
   1. Appoint members and chairs of such committees as are necessary for the orderly conduct of business except as otherwise provided in these Rules.
   2. Circulate or cause to be circulated an announcement and an agenda for each regular or special meeting of the Board of Commissioners.
   3. Preside during meetings of the Board of Commissioners.
   4. Prepare or supervise the preparation of an annual report of the Commission.
   5. Prepare or supervise the preparation of an annual budget of the Commission.

B. VICE-CHAIR: The Vice-chair of the Commission shall assist the Chair in the performance of his or her duties. If the Chair is unable to attend any given meeting of the Board of Commissioners, the Vice-chair shall preside at the meeting. If the Vice-chair also is unable to attend the meeting, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.

C. VACANCIES: In the event the vacancy involves the Chair, the Vice-chair shall immediately assume all duties of the Chair. In the event the vacancy involves the Vice-chair, a meeting of the Commission shall be convened to select a new Vice-chair.

Section 5. DIRECTOR:

A. Appointment: The Director of the Commission shall be an employee of the American Dental Association selected by the Executive Director of that Association.

B. Duties: The Director of the Commission shall:
   1. Prepare an agenda and keep minutes of meetings of the Board of Commissioners.
   2. See that all notices are duly given in accordance with the provisions of these Rules or as required by law.
   3. Be the custodian of records of the Commission.
   4. Manage the office and staff of the Commission.
   5. In general shall perform all duties incident to the office of Director.
Article VI. REMOVAL FOR CAUSE

Pursuant to the Rules of the Commission on Dental Accreditation, the following are causes for removal of a member from the Board of Commissioners, Committees, or Appeal Board:

- continued, gross or willful neglect of the duties of the office;
- failure to comply with the Commission’s policies on conflict of interest;
- failure or refusal to disclose necessary information on matters of Commission business;
- failure to keep confidential any exclusive information protected by secrecy that becomes known to the member by reason of the performance of his or her duties on the Commission’s behalf;
- failure to comply with the Association’s professional conduct policy and prohibition against harassment;
- unauthorized expenditures or misuse of Commission funds;
- unwarranted attacks on the Commission, any of its committees or any person serving the Commission in an elected, appointed or employed capacity;
- unwarranted refusal to cooperate with any Commission officer, Commission, Review Committee or Appeal Board member or staff;
- misrepresentation of the Commission and any person serving the Commission in an elected, appointed or employed capacity to outside persons;
- being found to have engaged in conduct subject to discipline pursuant to Chapter XI of the Governance and Organizational Manual of the American Dental Association; and
- conviction of a felony.

II. REVIEW COMMITTEES AND BOARD OF COMMISSIONERS

A. REVIEW COMMITTEES AND REVIEW COMMITTEE MEETINGS

1. Structure: The chair of each Review Committee will be the appointed Commissioner from the relevant discipline.
   i. The Commission will appoint all Review Committee members.
      a. Review Committee positions not designated as discipline-specific will be appointed from the Commission where feasible, e.g. a public representative on the Commission could be appointed to serve as the public member on the Dental Laboratory Technology Review Committee; an ADA appointee to the Commission could be appointed to the Dental Assisting Review Committee as the general dentist practitioner.
      b. Discipline-specific positions on Review Committees will be filled by appointment by the Commission of an individual from a small group of qualified nominees (at least two) submitted by the relevant national organization, discipline-specific sponsoring organization or certifying board. Nominating organizations may elect to rank their nominees, if they so choose. If fewer than two (2) qualified nominees are submitted, the appointment process will be delayed until such time as the minimum number of required qualified nominations is received.
ii. Consensus is the method used for decision making; however if consensus cannot be reached and a vote is required, then the Chair may only vote in the case of a tie (American Institute of Parliamentarians Standard Code of Parliamentary Procedures).

iii. Member terms will be staggered, four year appointments; multiple terms may be served on the same or a different committee, with a one-year waiting period between terms. A maximum of two (2) terms may be served in total. The one-year waiting period between terms does not apply to public members.

iv. One public member will be appointed to each committee.

v. The size of each Review Committee will be determined by the committee’s workload.

vi. As a committee’s workload increases, additional members will be appointed while maintaining the balance between the number of content experts and non-content experts. Committees may formally request an additional member through New Business at Review Committee/Commission meetings. If an additional member is approved, this member must be a joint nomination from the professional organization and certifying board, as applicable.

vii. Conflict of interest policies and procedures are applicable to all Review Committee members.

viii. Review Committee members who have not been on a site visit within the last two (2) years prior to their appointment on a Review Committee should observe at least one site visit within their first year of service on the Review Committee.

ix. In the event that fewer than 50% of discipline-specific experts are present for any one discipline, the decision by a quorum of the Review Committee shall be acceptable. In the case of less than 50% of discipline-specific experts, including the Chair, available for a review committee meeting, for specified agenda items or for the entire meeting, the Review Committee Chair may temporarily appoint an additional discipline-specific expert(s) with the approval of the CODA Director. The substitute should be a previous Review Committee member or an individual approved by both the Review Committee Chair and the CODA Director. The substitute would have the privileges of speaking, making motions and voting.

x. Consent agendas may be used by Review Committees, when appropriate, and may be approved by a quorum of the Review Committee present at the meeting.

Revised: 8/20; 1/20; 8/18; 8/17; 2/15; 1/14, 2/13, 8/10, 7/09; 7/08; 7/07; Adopted: 1/06

2. Composition
Predoctoral Education Review Committee (9 members)

1 discipline-specific Commissioner appointed by American Dental Education Association
1 public member
3 dental educators who are involved with a predoctoral dental education program (two must be general dentists)
1 general dentist (One of whom is a practitioner
1 non-general* dentist (dentist and the other an educator)
1 dental assistant, dental hygienist, dental therapist or dental laboratory technology professional educator
1 dental therapist educator
*a dentist who has completed an advanced dental education program in dental anesthesiology, dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthodontics.
Six (6) Advanced Dental Education Review Committees (DENTANESTH*, DPH, OFP*, OMP, OMR, OM*, 5 members each. At least one member must be a dental educator.)

1 discipline-specific Commissioner appointed by the discipline-specific sponsoring organization
1 public member
1 dentist nominated by the discipline-specific sponsoring organization
1 dentist nominated by the discipline-specific certifying board
1 general dentist

* Effective January 1, 2021

Six (6) Advanced Dental Education Review Committees (ENDO, OMS, ORTHO, PERIO, PED, PROS - 6 members each. At least one member must be a dental educator.)

1 discipline-specific Commissioner appointed by the discipline-specific sponsoring organization
1 public member
1 dentist nominated by the discipline-specific sponsoring organization
1 dentist nominated by the discipline-specific certifying board
1 dentist nominated by the discipline-specific certifying board and discipline-specific sponsoring organization
1 general dentist

Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Postdoctoral General Dentistry Review Committee (42 9 members)

1 discipline-specific Commissioner, jointly appointed by American Dental Education Association (ADEA), and the Special Care Dentistry Association (SCDA), the American Society of Dentist Anesthesiologists (ASDA), the American Academy of Oral Medicine (AAOM), and the American Academy of Orofacial Pain (AAOP)
1 public member
2 current General Practice Residency (GPR) educators nominated by the SCDA
2 current Advanced Education in General Dentistry (AEGD) educators nominated by ADEA
1 oral medicine educator nominated by the American Academy of Oral Medicine
1 dental anesthesiology educator nominated by the American Society of Dentist Anesthesiologists
1 orofacial pain educator nominated by the American Academy of Orofacial Pain
1 general dentist graduate of a GPR or AEGD
1 non-general* dentist
1 higher education or hospital administrator with past or present experience in administration in a teaching institution
*a dentist who has completed an advanced dental education program in dental anesthesiology, dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthodontics.

Dental Assisting Education Review Committee (10 members)

1 discipline-specific Commissioner appointed by American Dental Assistants Association
1 public member
2 general dentists (practitioner or educator)
3. Nomination Criteria: The following criteria are requirements for nominating members to serve on the Review Committees. Rules related to the appointment term on Review Committees apply.

All Nominees:
- Ability to commit to one (1) four (4) year term;
- Willingness to commit ten (10) to twenty (20) days per year to Review Committee activities, including training, comprehensive review of print and electronically delivered materials and travel to Commission headquarters;
- Ability to evaluate an educational program objectively in terms of such broad areas as curriculum, faculty, facilities, student evaluation and outcomes assessment;
- Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; HIPAA Training, Licensure Attestation, and Professional Conduct Policy and Prohibition Against Harassment);
- Ability to conduct business through electronic means (email, Commission Web Sites); and
- Active, life or retired member of the American Dental Association, where applicable.

Educator Nominees:
- Commitment to predoctoral, advanced, and/or allied dental education;
- Active involvement in an accredited predoctoral, advanced, or allied dental education program as a full- or part-time faculty member;
- Subject matter experts with formal education and credentialed in the applicable discipline; and
- Prior or current experience as a Commission site visitor.
Practitioner Nominees:
• Commitment to predoctoral, advanced, and/or allied dental education;
• Majority of current work effort as a practitioner; and
• Formal education and credential in the applicable discipline.

Public/Consumer Nominees:
• A commitment to bring the public/consumer perspective to Review Committee deliberations. The nominee should not have any formal or informal connection to the profession of dentistry; also, the nominee should have an interest in, or knowledge of, health-related and accreditation issues. In order to serve, the nominee must not be a:
  a. Dentist or member of an allied dental discipline;
  b. Member of a predoctoral, advanced, or allied dental education program faculty;
  c. Employee, member of the governing board, owner, or shareholder of, or independent consultant to, a predoctoral, advanced, or allied dental education program that is accredited by the Commission on Dental Accreditation, has applied for initial accreditation or is not-accredited;
  d. Member or employee of any professional/trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission, dental education or dentistry; and
  e. Spouse, parent, child or sibling of an individual identified above (a through d).

Higher Education Administrator:
• A commitment to bring the higher education administrator perspective to the Review Committee deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission; and
  b. Spouse, parent, child or sibling of an individual identified above.

Hospital Administrator:
• A commitment to bring the hospital administrator perspective to Review Committee deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission; and
  b. Spouse, parent, child or sibling of an individual identified above.

Revised: 8/18; 8/17; 8/14; 8/10; Adopted: 07/08

5. Chairs Of Review Committees: Review Committees are chaired by the Commissioner for the respective discipline(s). The Chair of the Predoctoral Review Committee is selected by the Chair of the Commission from among the four (4) Commissioners appointed by ADEA.

Revised: 8/17; Reaffirmed: 8/10
B. COMMISSION AND COMMISSION MEETINGS

The Commission and its Review Committees meet twice each year to consider site visit reports and institutional responses, progress reports, information from annual surveys, applications for initial accreditation, and policies related to accreditation. These meetings are held in the winter and the summer.

Reports from site visits conducted less than 90 days prior to a Commission meeting are usually deferred and considered at the next Commission meeting. Commission staff can provide information about the specific dates for consideration of a particular report.

The Commission has established policy and procedures for due process which are detailed in the Due Process section of this manual.

Revised: 8/17; 8/14; 7/06, 7/96; Reaffirmed: 8/10; Adopted: 7/96

1. Composition and Criteria

Composition
The Board of Commissioners shall consist of:

Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this association, no one of whom shall be a faculty member working more than one day per week of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the American Dental Association House of Delegates.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member of any dental education program working more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency.

Four (4) members who are active, life or retired members of this Association and also active members of the American Association of Dental Boards shall be selected by the American Association of Dental Boards. None of these members shall be a faculty member of any dental education program.

Four (4) members who are active, life or retired members of this Association and also active members of the American Dental Education Association shall be selected by the American Dental Education
None of these members shall be a member of any state board of dental examiners or jurisdictional dental licensing agency.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (1) licensed dental hygienist selected by the American Dental Hygienists' Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students, Residents and Fellows of the American Dental Education Association, one (1) dentist who is board certified in the respective discipline-specific area of practice and is selected by each of the following organizations: American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and Maxillofacial Radiology, American Academy of Oral Medicine, American Academy of Orofacial Pain, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontists, American Association of Public Health Dentistry, American College of Prosthodontists, American Society of Dentist Anesthesiologists; one (1) dentist who is jointly appointed by the American Dental Education Association, and the Special Care Dentistry Association, the American Society of Dentist Anesthesiologists, the American Academy of Oral Medicine, and the American Academy of Orofacial Pain and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission shall be ex-officio members of the Board without the right to vote.

Criteria (All Appointees)

- Ability to commit to one (1) four (4) year term;
- Willingness to commit ten (10) to twenty (20) days per year to activities, including training, comprehensive review of print and electronically delivered materials, and travel to Commission headquarters;
- Ability to evaluate an educational program objectively in terms of such broad areas as curriculum, faculty, facilities, student evaluation and outcomes assessment;
- Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; HIPAA Training, Licensure Attestation, and Professional Conduct Policy and Prohibition Against Harassment);
- Ability to conduct business through electronic means (email, Commission Web Sites); and
- Active, life or retired member of the American Dental Association, where applicable.

Revised: 2/21, 8/18; 8/17; Adopted: 8/14

2. Policy On Absence From Commission Meetings: When a Commissioner notifies the Director that he/she will be unable to attend a meeting of the Commission, the Director will notify the Chair. The Chair determines if another individual should be invited to attend the meeting in the Commissioner’s absence. A substitute will be invited if the Commissioner’s discipline would not otherwise be represented. This individual must be familiar with the Commission’s policies and procedures; and
therefore, must be a current or former member of the appropriate Review Committee and must represent the same discipline or appointing organization as the absent Commissioner. In the event that these criteria cannot be met, the Commission Chair may elect not to invite another individual to the meeting. The substitute would have the privileges of speaking, introducing business, making motions, and voting.

Revised: 8/17; 8/10, 7/97; Reaffirmed: 7/07, 7/01; CODA: 12/86:14

C. POLICY ON CHANGES TO THE COMPOSITION OF REVIEW COMMITTEES AND THE BOARD OF COMMISSIONERS

The Commission believes it is imperative that content area experts are represented on site visit committees, Review Committees and on the Commission to accomplish its mission. However, the Commission does not establish Review Committees or add Commissioner positions based upon the number of programs accredited or number of students/residents enrolled within a given discipline.

The Board of Commissioners is composed of representatives and subject area experts from the dental education, dental licensure and private practice communities, advanced dental education, allied dental education, and the public at large. The Commission’s Review Committees mirror this structure with committees devoted to dental, dental assisting, dental hygiene, dental laboratory technology, dental anesthesiology, dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics. The Review Committee on Postdoctoral General Dentistry Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain reviews programs in advanced education in general dentistry, and general practice residency, dental anesthesiology, oral medicine, and orofacial pain; content experts from each of these areas are represented on the Committee. The Predoctoral Dental Education Review Committee reviews programs in predoctoral dental education and dental therapy education; content experts from each of these areas are represented on the Committee. The Review Committees function to ensure the quality of predoctoral, advanced, and allied dental education programs accredited by the Commission is maintained; they are advisory to the Commission on matters of accreditation policy and program review.

As predoctoral, advanced, and allied dental education and practice continues to evolve, the Board of Commissioners may consider a change in its composition, consistent with its Rules. The Board may also modify the number or composition of its Review Committees. Such changes may be necessary to reflect changes in the makeup of the dental profession workforce and to provide standards and quality accreditation services to the educational programs in these areas.

For example, changes to the Board of Commissioners or Review Committees may be considered by the Board of Commissioners under the following circumstances:

- When a new dental workforce or discipline is recognized by a nationally accepted agency.
- When development of accreditation standards or accreditation services for a new or existing dental workforce or discipline cannot be supported by the existing structure(s).
- When the Board of Commissioners identifies the need to modify its composition or that of a
Procedure for Requesting a New Review Committee and/or Commissioner Position:

- A request is submitted to the Commission for either a new Review Committee and/or Commissioner position.
- The Chair of the Commission may refer the request to the appropriate standing committee and/or review committee(s) for evaluation or may present the request to the Commission at its next regularly scheduled meeting.
- If referred to a committee, the committee considers the request and provides a recommendation to the Commission.
- The Commission considers the report and recommendation of standing/review committee(s) or considers the request directly as presented by the chair and makes a final determination.
- If the Commission approves the request and directs a new Review Committee, a period of implementation and training will also be provided. If a modification to the existing composition of the Board of Commissioners is approved, the Commission’s Rules will be modified.

Revised: 2/21; 8/18; 8/17; 2/16; Adopted 8/14

D. POLICY ON REMOVAL OF COMMISSION, REVIEW COMMITTEE, AND APPEAL BOARD MEMBERS

Pursuant to the Rules of the Commission on Dental Accreditation, the Commission may remove from office a member of the Commission, Review Committee, or Appeal Board for cause. The causes for removal from office are documented within the Commission’s Rules. Before a member is removed for cause, the following procedures shall be followed by the Board of Commissioners:

The Chair of the Board of Commissioners shall notify the accused member in writing of the allegations concerning the member’s performance. The written notice shall include a description of the conduct purported to constitute each charge. The accused shall be invited to respond in writing. If the accused member wishes, he or she may resign the position voluntarily or may request the opportunity to appear before the Board to respond to the allegations received. If an appearance is requested, the Board shall schedule it during the next meeting of the Board.

If the Commission, Review Committee, or Appeal Board on which the accused holds an office is scheduled to meet before the date of the appearance, the Board of Commissioners at its discretion may excuse the accused member from attending that meeting only after the Board of Commissioners offers the accused an opportunity to be heard or where it determines that compelling reasons exist for excusal. It shall specify the reasons for excusal in writing.

Formal rules of evidence shall not apply to the appearance to discuss the allegations made, but if requested, the Board of Commissioners shall permit the accused member to be assisted by legal counsel. Following the appearance, the Board shall decide by majority vote whether or not to remove the accused member. Every decision, which results in removal of a Commission, Review Committee, or Appeal Board member for cause, shall be reduced to writing and shall specify the
findings of fact which support the decision to remove the accused members. If the Board of Commissioners decides to remove the accused, that action shall create a vacancy on that Commission, Review Committee, or Appeal Board which shall be filled in accordance with the appropriate provisions in these Rules. All records of the proceedings and the cause for removal shall be confidential information.

The Commission on Dental Accreditation shall provide notice to the ADA Board of Trustees once the Commission acts to remove a member for cause.

Adopted: 8/18; Revised 10/18
REPORT OF THE AD HOC COMMITTEE ON USE OF EDUCATIONAL ACTIVITY SITES

**Background:** At its August 2019 meeting, the Commission on Dental Accreditation (CODA), directed the formal study of the use of sites where educational activity occurs (domestic and international) for all programs under its purview, with a report on progress in Winter 2020 and culmination of the study through a Commission-only Mega Issue Discussion in Summer 2020. The Commission further directed that through the study of educational activity sites, the Commission will also study the Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs as it relates to the classification of “supplemental” sites for required community service and/or service learning requirements, as well as sites that are owned by the sponsoring institution or where the sponsoring organization has legal responsibility and operational oversight. In Fall 2019, the Commission Chair appointed the following individuals to the Ad Hoc Committee on Educational Activity Sites: Dr. Steven Friedrichsen (Committee chair), Dr. Kevin Haubrick, Dr. Susan Kass, Dr. Steven Levy, Dr. William Nelson, Dr. Bruce Rotter, Dr. Timmothy Schwartz, and Dr. Marshall Titus. The Ad Hoc Committee conducted tele-/web-conference calls on October 29, 2019 and December 6, 2019 and provided a summary report to the Commission at its Winter 2020 meeting (Appendix 1).

On April 13, 2020 the Commission conducted a special meeting for the purpose of discussing the impact of COVID-19 on dental and dental-related education programs. During the meeting, the Commission discussed its ad hoc committees and noted that the Ad Hoc Committee on Use of Educational Activity Sites reviewed a significant amount of material related to use of educational activity sites among CODA-accredited dental education programs; however, additional information was to be collected and reviewed by the Committee prior to making a recommendation to the Commission in Summer 2020. The Commission believed that under the circumstances at that time, in which Commissioner and staff time was primarily focused on managing the interruption of education resulting from COVID-19, it would be difficult to complete the work of this Committee by Summer 2020. Additionally, it would be inappropriate and insensitive to circulate the CODA-directed mandatory survey of programs’ use of educational activity sites at a time while programs are struggling to manage the interruption of education of their students, residents, and fellows. The Commission also noted that it would be premature to conduct a Mega Issue Discussion on this topic at the Summer 2020 meeting, as previously directed by CODA, and that the Mega Issue Discussion should be canceled. The Commission believed the work of the Ad Hoc Committee should continue into Fall 2020, with a report to CODA in Winter 2021. Accordingly, the Commission directed that the Ad Hoc Committee on Use of Educational Activity Sites continue its work, with a report in Winter 2021 rather than Summer 2020. The Commission further directed that its mandatory survey of all dental education programs on the use of educational activity sites be delayed during the COVID-19 interruption. The Commission further directed cancelation of the Summer 2020 Mega Issue Discussion on the use of educational activity sites.

In Fall 2020, the Commission Chair appointed the following individuals to the Ad Hoc Committee: Dr. Timmothy Schwartz (chair of ad hoc committee), Dr. Kevin Haubrick, Dr. Susan
Kass, Ms. Martha McCaslin, Dr. Carol Anne Murdoch-Kinch, Dr. William Nelson, Dr. Bruce Rotter (vice chair, CODA), and Dr. Marshall Titus. The Ad Hoc Committee conducted a virtual meeting on December 8, 2020, and all members were present. Additionally, Dr. Jeffrey Hicks, chair, CODA, ex officio, was in attendance. Dr. Sherin Took, director, CODA, and Mr. Gregg Marquardt, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, were in attendance.

Below is the Ad Hoc Committee’s report and recommendations to the Commission following its December 8, 2020 meeting.

**Report and Recommendations of the Ad Hoc Committee:**
The Ad Hoc Committee initiated its meeting with a review of the history of and charge to the Committee, along with a summary of the prior meeting discussions and considerations ([Appendix 1](#)). The Committee noted that the Mega Issue Discussion and mandatory survey of educational programs were not completed as a result of the COVID-19 pandemic. As the pandemic continued at the time of the Ad Hoc Committee’s December 8, 2020 meeting, the Committee concluded that a survey to educational programs continued to be unnecessary. As such, no survey was conducted in regard to current CODA-accredited programs’ use of educational activity sites.

The Ad Hoc Committee reviewed additional materials collected since its last meeting, including: 1) CODA Standards, by discipline, related to use of educational activity sites ([Appendix 2](#)); 2) policies and procedures of other accrediting agencies on the use of educational activity sites; 3) data on the number of sites visited by CODA compared to sites used by programs; 4) data from the prior six (6) years on the number of program change reports related to use of educational activity sites that were considered by the Commission; 5) Annual Survey data from dental and advanced dental education program on reported site usage; and 6) CODA’s current policies and procedures related to use of educational activity sites ([Appendix 3](#)).

**Review of CODA Policies and Procedures Related to Educational Activity Sites:**
The Ad Hoc Committee focused on several key concepts, starting with a review of current policies and procedures on the use of educational activity sites. The Committee discussed the Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs as it relates to the classification of “supplemental” sites used for community service and/or service learning requirements, as well as sites that are owned by the sponsoring institution or where the sponsoring organization has legal responsibility and operational oversight. Related to sites used for community service and/or service learning requirements, the Ad Hoc Committee noted that dental and dental related education programs often use these sites to provide educational context and experience working within a community, not necessarily as a site to develop clinical skills. Community service and/or service learning sites may include school sites in which oral hygiene instruction is provided, for example. Additionally, due to the nature of the use, community service and/or service learning sites may vary from year to year and may be used by the program only once. Following discussion, the Ad Hoc Committee recommended that there be no change
in CODA’s policy, and sites used for community service and/or service learning should remain exempt from reporting to the Commission.

The Ad Hoc Committee reviewed other components of the Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs, including sites that are owned by the sponsoring institution or where the sponsoring organization has legal responsibility and operational oversight, and concluded that no (0) revisions are warranted at this time.

CODA Oversight of Educational Activity Sites for CODA-Accredited Programs:
In further discussion of educational activity sites used among CODA-accredited dental education programs, the Ad Hoc Committee noted CODA’s Summer 2019 directive that CODA formally study the use of educational activity sites (domestic and international) for all programs under its purview. At the same meeting, CODA reaffirmed that international sites are not permitted to provide education related to program goals, objectives or educational requirements, and may not impact program length. In consideration of this topic, the Ad Hoc Committee discussed CODA’s current oversight of educational activity sites, including concepts related to the number of sites visited by CODA compared to sites used by programs, the number of program change reports related to use of educational activity sites that were considered by the Commission in the past few years, and Annual Survey data from dental and advanced dental education program on reported site usage.

Oversight of Educational Activity Sites in the United States*:
The Ad Hoc Committee noted that the use of educational activity sites among dental education programs accredited by the Commission has increased over the last several years. With the increased use of educational activity sites, it is becoming difficult for the Commission to monitor the number of sites used by dental education programs and how programs ensure educational quality at the sites. The Committee noted that Annual Survey data on educational activity sites is collected for dental and advanced dental education programs, and not allied dental education programs. The Committee recommended that CODA’s Annual Surveys for dental and advanced dental education programs be revised to clarify the questions related to educational activity site usage, so that programs accurately and completely report the number of sites used for educational purposes.

The Committee further noted the increase in use of “major” educational activity sites in which competency assessment occurs. There is also an increase in student/resident/fellow rotations to multiple “minor” sites (no competency assessment occurs), which removes the student/resident/fellow for long periods of time from the program’s own clinic and primary faculty oversight. The Ad Hoc Committee deliberated on the sufficiency of formative learning and summative (competency) skill development if “minor” site rotations remove the student/resident/fellow from the program for a significant length of time. The Committee noted that some dental education programs use best practices related to monitoring the educational quality of sites, although not every program follows a best practices approach.
Following discussion, the Ad Hoc Committee believed that CODA-accredited programs should monitor the quality of education at “major” and “minor” sites through a process of best practices, and quality assurance review systems. Through best practices and quality assurance review systems, the program should ensure calibration of faculty and student/resident/fellow training and evaluation (formative and summative) comparable to the program’s on-site clinic facility. Finally, the Ad Hoc Committee noted that as technology improves, evaluation of educational activity sites using virtual methods could be incorporated into CODA’s site visit process. Following consideration, the Ad Hoc Committee recommended that the Commission direct all Review Committees to consider the discipline-specific Accreditation Standards under their purview for potential revision to address expectations related to use of U.S.-based educational activity sites including, but not limited to: 1) consideration of time away from the program and 2) program use of best practices and quality assurance review systems to ensure calibration of faculty, and student/resident/fellow training and evaluation (formative and summative) comparable to the program’s on-site clinic facility.

Oversight of Educational Activity Sites Outside the United States*: Following consideration of U.S.-based educational activity sites, the Ad Hoc Committee focused its attention on educational activity site rotations that could be developed outside the United States. The Ad Hoc Committee believed that CODA could develop methods to monitor internationally located educational activity sites using the discipline-specific Accreditation Standards, noting permitted uses or limitations, and through program reporting requirements found within CODA’s policies and procedures. The Ad Hoc Committee again noted that as technology improves, evaluation of educational activity sites using virtual methods could be incorporated into CODA’s site visit process. The Ad Hoc Committee recommended that use of international educational activity sites not be permitted until the Commission reviews, revises, adopts, and implements changes to its Accreditation Standards to address quality assurance and other expectations for the disciplines under CODA’s purview, as noted above, related to use of educational activity sites. The Ad Hoc Committee further recommended that after Accreditation Standards are developed and implemented for the use of U.S.-based educational activity sites, the Commission review and revise its Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs to permit use of internationally located educational activity sites, as permitted by the discipline-specific Standards, and reported, approved and monitored by the Commission through its policies and procedures.

* For CODA-accredited international dental education programs, references to “United States” should be used interchangeably with the country in which the international program is located.

Summary: The Ad Hoc Committee reviewed the Commission’s Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs, noting no changes are warranted at this time. The Committee considered use of U.S.-based educational activity sites among CODA-accredited programs, noting that the Annual Survey for dental and advanced dental education programs should be clarified to collect accurate program data on educational activity sites used. Further, CODA’s Accreditation Standards for each discipline should be reviewed and revised to include permitted uses of educational activity sites and enhanced program oversight and
assurance of equivalent training to the program’s on-site facility. Finally, the Ad Hoc Committee noted that following revision of CODA’s Standards and processes related to U.S.-based educational activity sites, the Commission should develop and implement policies and procedures to permit use of internationally located educational activity sites within the allowable uses of each discipline.

**Ad Hoc Committee on Use of Educational Activity Sites Recommendations:** It is recommended that the Commission on Dental Accreditation direct that CODA’s Annual Surveys for dental and advanced dental education programs be revised to clarify the questions related to educational activity site usage, so that programs accurately and completely report the number of sites used for educational purposes, with implementation Fall 2021.

It is further recommended that the Commission on Dental Accreditation direct all Review Committees to consider the discipline-specific Accreditation Standards under their purview for potential revision to address expectations related to use of U.S.-based educational activity sites including, but not limited to: 1) consideration of time away from the program and 2) program use of best practices and quality assurance review systems to ensure calibration of faculty, and student/resident/fellow training and evaluation (formative and summative) comparable to the program’s on-site clinic facility, with a report to the Commission in Summer 2021.

It is further recommended that the Commission on Dental Accreditation direct that use of international educational activity sites not be permitted until the Commission reviews, revises, adopts, and implements changes to its Accreditation Standards to address quality assurance and other expectations for the disciplines under CODA’s purview, as noted above, related to use of educational activity sites.

It is further recommended that the Commission on Dental Accreditation direct that after Accreditation Standards are developed and implemented for the use of U.S.-based educational activity sites, the Commission review and revise its Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs to permit use of internationally located educational activity sites, as permitted by the discipline-specific Standards, and reported, approved and monitored by the Commission through its policies and procedures.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
WINTER 2020 REPORT OF THE AD HOC COMMITTEE ON EDUCATIONAL ACTIVITY SITES

Background: At its August 2019 meeting, the Commission on Dental Accreditation (CODA), directed the formal study of the use of sites where educational activity occurs (domestic and international) for all programs under its purview, with a report on progress in Winter 2020 and culmination of the study through a Commission-only Mega Issue Discussion in Summer 2020. The Commission further directed that through the study of educational activity sites, the Commission will also study the Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs as it relates to the classification of “supplemental” sites for required community service and/or service learning requirements, as well as sites that are owned by the sponsoring institution or where the sponsoring organization has legal responsibility and operational oversight.

In Fall 2019, the Commission Chair appointed the following individuals to the Ad Hoc Committee on Educational Activity Sites: Dr. Steven Friedrichsen (Committee chair), Dr. Kevin Haubrick, Dr. Susan Kass, Dr. Steven Levy, Dr. William Nelson, Dr. Bruce Rotter, Dr. Timmothy Schwartz, and Dr. Marshal Titus.

The Ad Hoc Committee conducted tele-/web-conference calls on October 29, 2019 and December 6, 2019. Below is a summary of the activities related to the Ad Hoc Committee’s meetings.

October 29, 2019 Meeting: All Ad Hoc Committee members except Dr. Susan Kass were present for the first meeting. Dr. Arthur Chen-Shu Jee, chair, and Dr. Jeffery Hicks, vice chair, Commission on Dental Accreditation, ex-officio, were also in attendance. Additionally, Dr. Sherin Tooks, director, CODA, and Mr. Gregg Marquardt, manager, CODA, were in attendance.

The Ad Hoc Committee convened its first meeting with a review of the history of and charge to the Committee. The Ad Hoc Committee also reviewed meeting materials and proposed materials for future meetings, which included: 1) the Committee’s charge, 2) reports leading to development of the Ad Hoc Committee, 3) current policies on the use of educational activity sites and related policies, and 4) a topical outline of potential data to gather for committee consideration including, for example: information on the Commission’s 2015 Mega Issue on Off-Campus Sites; CODA’s strategic plan; the number of programs, site visitors and site visits per discipline; survey data on the current and potential future utilization of educational activity sites by dental education programs under CODA’s purview; the future landscape of dental education; the general logistics and costs to facilitate site visits; the Commission’s current and future capacity to operationalize changes and resource implications related to the use of
educational activity sites (e.g., volunteers, staff, site visit logistics, facility, infrastructure, technology); the methods by which other accrediting agencies continuously monitor the use of educational activity sites; requirements of the United States Department of Education (USDE), and policy implications.

The Ad Hoc Committee discussed several key concepts related to the Commission’s use of educational activity sites. First, the Committee noted that CODA’s Predoctoral Review Committee and Dental Public Health Review Committee postponed their discussions related to potential standards involving the use of international educational activity sites. The Committee noted that other disciplines are similarly interested in using international sites to provide educational experiences; however, in Summer 2019 the Commission reaffirmed that international sites are not permitted at this time to provide education related to program goals, objectives or educational requirements, and may not impact program length.

The Committee noted that CODA currently defines educational activity sites as “major,” “minor,” and “supplemental” through its current policy. The Committee engaged in preliminary discussion related to the concepts of site usage, including differences between core instruction and enrichment experiences that may be obtained at sites. The Ad Hoc Committee discussed whether the three (3) current classifications (i.e., major, minor and supplemental) need further development. For example, it was noted that an external site rotation may be minor but could be for a long period of time within the educational continuum. Some sites may be used for clinical experiences while others may be non-clinical or observational. The Ad Hoc Committee believed that the three (3) classifications may not completely and adequately define the various uses of educational activity sites among programs accredited by the Commission, nor provide the level of CODA oversight that may be appropriate based upon specific usage. The Committee believed that the definition of sites should be further examined through the work of the Ad Hoc Committee, with a potential revision to categories.

The Ad Hoc Committee also engaged in lengthy discussion related to the uses of educational sites. The Committee noted that there are a variety of reasons why a program may use educational activity sites. Additionally, the varied disciplines under the Commission’s purview may use educational activity sites for different purposes; it is not a “one size fits all” educational practice. Further, usage of sites may vary by length, experience gained, faculty oversight, assessment of formative and/or summative skills, distance from the program’s main facility, ownership by the program, and the type of site (e.g., community health center, hospital or facility not owned by the sponsoring institution, mission trip sites, etc.). The Committee determined that all of these factors should be carefully considered if the Commission is to develop a protocol to permit use of sites (domestic and/or international) to ensure appropriate Commission oversight of the educational experience.
The Committee noted that further study of the management tools used by other accrediting agencies to permit use of educational activity sites may be of interest to the Commission. The Ad Hoc Committee further discussed whether the Commission itself, or its site visit team as is currently the case, should dictate when a site is reviewed during the regular accreditation site visit to a program. The Committee noted that site visit teams may select some but not all sites to visit during an accreditation visit.

Following lengthy discussion, the Ad Hoc Committee believed it would be important to develop a survey tool to obtain information from programs on the use of educational activity sites. A small subcommittee of the Ad Hoc Committee was tasked with developing the survey. Additionally, the Committee requested that the CODA staff obtain additional information, including the practices of other accrediting agencies, and additional materials noted in the topical outline of potential data to gather for committee consideration.

**December 6, 2019 Meeting:** Dr. Steven Friedrichsen (Committee chair), Dr. Kevin Haubrick, Dr. William Nelson, Dr. Bruce Rotter, and Dr. Timmothy Schwartz attended the second meeting of the Ad Hoc Committee. Dr. Susan Kass, Dr. Steven Levy, and Dr. Marshal Titus were unable to attend. Dr. Arthur Chen-Shu Jee, chair, and Dr. Jeffery Hicks, vice chair, Commission on Dental Accreditation, *ex-officio,* were also in attendance. Additionally, Dr. Sherin Tooks, director, CODA, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA, were in attendance.

The Ad Hoc Committee initiated its second meeting with a review of the agenda materials that were prepared, which included: 1) the CODA Strategic Plan, 2) the policy on distance education, 3) policies related to educational activity sites, 4) the Guidelines for Reporting and Approval of Educational Activity Sites, 5) the number of CODA-accredited programs and volunteers in each discipline, 6) information on site visit scheduling, site visit length, and cost, 7) the number of special focused site visits for the prior seven (7) years, 8) information from the USDE on clinical site visits, and 9) information from the 2015 Mega Issue Discussion on External Sites.

The Ad Hoc Committee noted CODA’s historic policy on the use of educational activity sites, which required programs to report to CODA on sites that are used for 20% or more of a student’s/resident’s training. It was noted that CODA rescinded the prior policy in lieu of the first version of the current policy in 2010; this revision required all sites to be reported. Following its 2015 Mega Issue Discussion on External Sites, the Commission defined the categories of site usage and reporting requirements. The Ad Hoc Committee also noted that on-site evaluations of educational activity sites may be less frequent now that site visit teams select sites to be visited. The Committee discussed whether there could be a standardized way to
collect appropriate material on the use of sites to allow CODA to monitor sites in accordance with the requirements of the Accreditation Standards. The Committee believed a long-term goal could be a real-time database in which programs must maintain accurate records related to prescribed guidelines and requirements for each site that is used for educational purposes. Nonetheless, a standardized review process was looked upon favorably by the Ad Hoc Committee to create a continuous monitoring mechanism.

The Ad Hoc Committee again noted the vast differences that may exist with each site used by a program. These differences could relate to patient population, quality of the facility, and dilution of educational experiences if multiple programs use the same site. It was noted that there is no current tracking mechanism to identify sites that are used by multiple programs concurrently.

The Committee then focused its discussion on site visits to educational activity sites, noting that visits to program sites may require multiple teams, multiple visitors, and multiple days, depending on the program’s use of sites and each site’s distance from the program. International sites would require additional considerations such as travel visas, confirmation of health and safety precautions, and other nuances as already addressed by CODA’s international accreditation process for dental education programs. Further, the additional cost of visiting sites is a factor that must be further discussed.

The Committee believed that a mandatory survey should be distributed to all dental education programs within CODA’s purview in spring 2020. The Ad Hoc Committee will further develop the survey in Spring 2020. The survey should include special questions that are discipline specific to capture variances between disciplines and use of educational activity sites. Survey questions could include concepts related to: 1) how the site is being used, 2) how much of the curriculum is received at the site, 3) the number of sites and their proximity to the program, 4) the ownership or contractual relationship between sites and the sponsoring institution, 5) the purpose of site affiliation agreements and contracts, 6) how the program ensures an appropriate educational experience at the site, 7) oversight of students at the site (by primary program faculty or site-specific faculty), 8) program resources to manage oversight of sites, 9) site oversight by other agencies (federal, state, or another accrediting agency), 10) the reason sites are chosen, and 11) prospective use of international site locations and the purpose they would serve.

Following lengthy discussion, the Ad Hoc Committee requested that additional information be collected for its next meeting, including: 1) identification of standards related to use of educational activity sites for each discipline under CODA’s purview, 2) policies and procedures of other accrediting agencies related to use of educational activity sites, 3) the number of sites visited compared to the number of program sites used for programs site visited in the prior year, and 4) program changes reported to CODA and actions taken (approve, postpone, deny) related
to educational activity sites in the prior 5 years. The Committee also suggested that a mandatory survey be developed for dissemination in Spring 2020.

**Ad Hoc Committee on Educational Activity Sites Recommendation:** This report is informational in nature and no action is required.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
### IDENTIFICATION OF STANDARDS RELATED TO USE OF EDUCATIONAL ACTIVITY SITES FOR EACH DISCIPLINE UNDER CODA’S PURVIEW

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Standard Number</th>
<th>Standard Text</th>
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<tbody>
<tr>
<td>Predoctoral Dental</td>
<td></td>
<td><strong>Policy on sites Where Educational Activity Occurs</strong></td>
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<tr>
<td>PREDOC</td>
<td>PREDOC</td>
<td>For predoctoral dental education programs, when primary program faculty travel with student(s) to a site and competency is assessed, the site may be treated as a minor site for reporting purposes.</td>
</tr>
<tr>
<td>PREDOC</td>
<td>Definition and Terms</td>
<td><strong>Community-based experience:</strong> 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.</td>
</tr>
<tr>
<td>PREDOC</td>
<td>Definition and Terms</td>
<td><strong>Service learning:</strong> 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.</td>
</tr>
<tr>
<td>PREDOC</td>
<td>2-6</td>
<td>Students <strong>must</strong> receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.</td>
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<tr>
<td>PREDOC</td>
<td>2-26</td>
<td>Dental education programs <strong>must</strong> make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.</td>
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<td>PREDOC</td>
<td>3-1</td>
<td>The number, distribution and qualifications of faculty and staff <strong>must</strong> 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 <strong>must</strong> be qualified through appropriate knowledge and experience.</td>
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<td>Program</td>
<td>Code</td>
<td>Description</td>
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<td>Ad Hoc Educational Activity Sites</td>
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<td>in the discipline as determined by the credentialing of the individual faculty as defined by the program/institution.</td>
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<tr>
<td>PREDOC</td>
<td>4-6</td>
<td>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.</td>
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<tr>
<td>Dental Assisting</td>
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<tr>
<td>DA</td>
<td>1-6</td>
<td>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.</td>
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<tr>
<td>DA</td>
<td>4-10</td>
<td>It is preferable and, therefore recommended, that the educational institution provide physical facilities and equipment which are adequate to permit achievement of the program’s objectives. If the institution finds it necessary to contract for use of an existing facility for laboratory, preclinical and/or clinical education, then the following conditions must be met in addition to all existing standards.</td>
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<td>a. There is a formal agreement between the educational institution and agency or institution providing the facility.</td>
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<td>b. The program administrator retains authority and responsibility for instruction.</td>
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<td>c. All students receive instruction and practice experience in the facility.</td>
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<td>d. Policies and procedures for operation of the facility are consistent with the philosophy and objectives of the educational program.</td>
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<td>e. Availability of the facility accommodates the scheduling needs of the program.</td>
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<td>f. Notification for termination of the contract ensures that instruction will not be interrupted for currently enrolled students.</td>
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<td>g. Instruction is provided and evaluated by calibrated dental assisting program faculty.</td>
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<tr>
<td>Dental Hygiene</td>
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<tr>
<td>DH</td>
<td>1-6</td>
<td>All arrangements with co-sponsoring or affiliated institutions must be formalized by means of written</td>
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</table>
agreements which clearly define the roles and responsibilities of each institution involved.

DH 4-4 The educational institution must provide physical facilities and equipment which are sufficient to permit achievement of program objectives. If the institution finds it necessary to contract for use of an existing facility for basic clinical education and/or distance education, then the following conditions must be met in addition to all existing Standards:

a) a formal contract between the educational institution and the facility;

b) a two-year notice for termination of the contract stipulated to ensure that instruction will not be interrupted or;

c) a contingency plan developed by the institution should the contract be terminated;

d) a location and time available for use of the facility compatible with the instructional needs of the dental hygiene program;

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

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

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

h) the policies and procedures of the facility are compatible with the goals of the educational program.

Dental Laboratory Technology

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

DLT 4-3 Although it is preferable and therefore recommended that the educational institution provide physical facilities and equipment which are adequate to permit achievement of program objectives, the institution may contract for use of an existing laboratory facility if the conditions stipulated by the Commission are met. If a clinic and/or laboratory in the community is used as a
primary facility for laboratory instruction, the standards specified for program facilities and the following provisions must be met:

1. There is a formal agreement between the educational institution and agency or institution providing the facility.
2. The program administrator retains authority and responsibility for instruction and student assignments.
3. All students receive instruction and practical experience in the facility.
4. Policies and procedures for operation of the facility are consistent with the philosophy and goals of the educational program.
5. A two-year notification of termination of the contract is required to ensure that instruction will not be interrupted.
6. A contingency plan is developed by the institution should the contract terminate.
7. The location and time available for use of the facility are compatible with the instructional needs of the program.
8. Clinical or laboratory instruction is provided and evaluated by program faculty.
9. All students receive comparable instruction in the facility.
10. All faculty are calibrated.

### Dental Therapy

<table>
<thead>
<tr>
<th>DT</th>
<th>Definition and Terms</th>
<th>Community-based experience:</th>
<th>Service learning:</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td>A structured experience with specific learning objectives that combines community service with academic preparation. Students engaged in service</td>
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</table>
learning learn about their roles as dental therapists through provision of patient care and related services in response to community-based problems.

| DT   | 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. |
| DT   | 2-5 | Students must receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty. |
| DT   | 2-24 | Dental therapy education programs must have students engage in service learning experiences and/or community-based learning experiences. |
| DT   | 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. |
| DT   | 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. |

### Advanced Education in General Dentistry

| AEGD | 1-2 | The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program. |
| AEGD | 1-5 | Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. |
| AEGD | 2-5 | Each assigned rotation or experience must have: a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned; b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and c) evaluations performed by the designated supervisor. |
| AEGD | 3-3 | For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or... |
clinical experience in the curriculum areas for which he/she is responsible.

<table>
<thead>
<tr>
<th>AEGD</th>
<th>3-4</th>
<th>All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dentistry included in the program.</th>
</tr>
</thead>
</table>
| AEGD  | 3-9 | At each site where educational activity occurs, adequate support staff must be consistently available to ensure:  
  a) residents do not regularly perform the tasks of allied dental personnel and clerical staff;  
  b) resident training and experience in the use of current concepts of oral health care delivery and  
  c) efficient administration of the program. |
| AEGD  | 3-10| The program must provide ongoing faculty calibration at all sites where educational activity occurs. |

### General Practice Residency

<table>
<thead>
<tr>
<th>GPR</th>
<th>1-2</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPR</td>
<td>1-5</td>
<td>Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
</tbody>
</table>
| GPR   | 2-8 | Each assigned rotation or experience must have:  
  a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;  
  b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and  
  c) evaluations performed by the designated supervisor. |
| GPR   | 3-3 | For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible. |
| GPR   | 3-4 | All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are |
| GPR   | 3-9                                                                 | At each site where educational activity occurs, adequate support staff must be consistently available to ensure:  
|       |                                                                     | a) residents do not regularly perform the tasks of allied dental personnel and clerical staff;  
|       |                                                                     | b) resident training and experience in the use of current concepts of oral health care delivery and  
|       |                                                                     | c) efficient administration of the program.  
| GPR   | 3-10                                                                | The program must provide ongoing faculty calibration at all sites where educational activity occurs.  

**Dental Anesthesiology**

| DentAnesth | Policy on sites Where Educational Activity Occurs | The Commission recognizes that advanced dental education programs in dental anesthesiology utilize numerous mobile ambulatory settings and rotations to provide residents with opportunities to gain required clinical experiences. The program will provide a list of all currently used settings and rotations in the self-study document. The visiting committee will randomly select and visit several settings and rotation locations during the site visit to the program to evaluate compliance with Commission on Dental Accreditation standards. Prior Commission approval of these settings and rotations will not be required.  
| DentAnesth | 1-2                                                                 | The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.  
| DentAnesth | 1-5                                                                 | Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.  
| DentAnesth | 2-11                                                                | Each assigned rotation or experience must have:  
|           |                                                                     | a) Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;  
|           |                                                                     | b) Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and  
|           |                                                                     | c) Evaluations performed by designated faculty.  


<table>
<thead>
<tr>
<th>DentAnesth</th>
<th>2-14</th>
<th>The program <strong>must</strong> provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DentAnesth</td>
<td>3-3</td>
<td>All sites where educational activity occurs <strong>must</strong> be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.</td>
</tr>
<tr>
<td>DentAnesth</td>
<td>3-8</td>
<td>At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, <strong>must</strong> be consistently available to allow for efficient administration of the program.</td>
</tr>
<tr>
<td>DentAnesth</td>
<td>3-9</td>
<td>The program <strong>must</strong> provide ongoing faculty calibration at all sites where educational activity occurs.</td>
</tr>
<tr>
<td>DentAnesth</td>
<td>5-2</td>
<td>In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies <strong>must</strong> be available in accord with all applicable accrediting bodies and state rules and regulations.</td>
</tr>
<tr>
<td>OralMed</td>
<td>1-2</td>
<td>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</td>
</tr>
<tr>
<td>OralMed</td>
<td>1-5</td>
<td>Arrangements with all sites not owned by the sponsoring institution where educational activity occurs <strong>must</strong> be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
</tbody>
</table>
| OralMed      | 2-19 | Each assigned rotation or experience **must** have:  
  a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;  
  b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and  
  c) evaluations performed by the designated supervisor. |
| OralMed      | 3-3  | All sites where educational activity occurs **must** be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program. |
### Ad Hoc Educational Activity Sites

**Commission Only**

**Winter 2021**

<table>
<thead>
<tr>
<th>OralMed</th>
<th>3-7</th>
<th>At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, <strong>must</strong> be consistently available to allow for efficient administration of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OralMed</td>
<td>3-10</td>
<td>The program <strong>must</strong> provide ongoing faculty calibration at all sites where educational activity occurs.</td>
</tr>
</tbody>
</table>

#### Orofacial Pain

<table>
<thead>
<tr>
<th>OFP</th>
<th>1-2</th>
<th>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OFP</td>
<td>1-5</td>
<td>Arrangements with all sites not owned by the sponsoring institution where educational activity occurs <strong>must</strong> be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
</tbody>
</table>
| OFP | 2-12 | Each assigned rotation or experience **must** have:
  a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
  b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
  c) evaluations performed by the designated supervisor. |
| OFP | 3-3 | All sites where educational activity occurs **must** be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program. |
| OFP | 3-6 | At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, **must** be consistently available to allow for efficient administration of the program. |
| OFP | 3-9 | The program **must** provide ongoing faculty calibration at all sites where educational activity occurs. |

#### Dental Public Health

| DPH | Policy on sites Where Educational Activity Occurs | The Commission recognizes that dental public health programs utilize numerous off-campus sites to provide students/residents with opportunities to conduct their supervised field experience. The program will provide a list of all currently used sites in the self-study document. |
The visiting committee will select and visit facilities during the site visit to the program to evaluate compliance with CODA accreditation standards. Prior Commission approval of these supervised field experience sites will not be required. Programs where 30% or more of the overall student/resident training occurs at off-campus site(s) must report the off-campus site(s) under the Commissions Policy Statement on Approval of Sites Where Educational Activity Occurs.

<table>
<thead>
<tr>
<th>DPH</th>
<th>Standard 1</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPH</td>
<td>Standard 1</td>
<td>The primary sponsor of the educational program must accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
</tbody>
</table>
| DPH | 1-2 | All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. The following items must be covered in such inter-institutional agreements:  
  a. Designation of a single program director;  
  b. The teaching staff;  
  c. The educational objectives of the program;  
  d. The period of assignment of students/residents; and  
  e. Each institution’s financial commitment. |
<p>| DPH | 1-3 | For each site where educational activity occurs, there must be an appropriate on-site supervisor who is qualified by education in the curriculum areas for which he/she is responsible. |
| DPH | 1-4 | The selection of educational activity sites must be based on careful assessment of the resources of the sponsoring institution, program objectives, student/resident needs and accreditation requirements. |
| DPH | 1-5 | The objectives of the assignments to each affiliated educational activity site must be identified and must be used in evaluating the effectiveness of assignments. |
| DPH | 2-4 | All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program. |</p>
<table>
<thead>
<tr>
<th>DPH</th>
<th>Standard 3</th>
<th>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPH</td>
<td>4-7</td>
<td>The program must include a supervised field experience at a location determined by the program director which requires the students/residents to gain an understanding of one or more of the competencies listed in Standard 4-5.</td>
</tr>
</tbody>
</table>

**Endodontics**

<table>
<thead>
<tr>
<th>ENDO</th>
<th>1</th>
<th>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENDO</td>
<td>1</td>
<td>The primary sponsor of the educational program <strong>must</strong> accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
<tr>
<td>ENDO</td>
<td>1-2</td>
<td>All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, <strong>must</strong> be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
<tr>
<td>ENDO</td>
<td>1-3</td>
<td>For each site where educational activity occurs, there <strong>must</strong> be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.</td>
</tr>
<tr>
<td>ENDO</td>
<td>2-4</td>
<td>There <strong>must</strong> be attending faculty responsible for all clinical activities.</td>
</tr>
<tr>
<td>ENDO</td>
<td>2-4.1</td>
<td>Attending faculty <strong>must</strong> have specific and regularly scheduled clinic assignments to provide direct supervision appropriate to a student’s/resident’s level of training in all patient care.</td>
</tr>
<tr>
<td>ENDO</td>
<td>2-6</td>
<td>All faculty, including those at major and minor educational activity sites, <strong>must</strong> be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.</td>
</tr>
<tr>
<td>ENDO</td>
<td>3</td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</td>
</tr>
<tr>
<td>ENDO</td>
<td>3-1</td>
<td>The clinical facilities for students/residents in endodontics <strong>must</strong> be specifically identified and readily available.</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>ENDO</td>
<td>3-1.1</td>
<td>The design of units <strong>must</strong> be suitable for all endodontic clinical procedures, including four-handed dentistry.</td>
</tr>
<tr>
<td>ENDO</td>
<td>3-2</td>
<td>Radiographic or imaging equipment and equipment specific for endodontic procedures <strong>must</strong> be readily available.</td>
</tr>
<tr>
<td>ENDO</td>
<td>3-5</td>
<td>Clinical support personnel <strong>must</strong> be sufficient to ensure efficient operation of clinical program and to provide students/residents with the opportunity to practice four-handed dentistry techniques.</td>
</tr>
</tbody>
</table>

**Oral and Maxillofacial Pathology**

<table>
<thead>
<tr>
<th>OMP</th>
<th>Standard 1</th>
<th>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMP</td>
<td>Standard 1</td>
<td>The primary sponsor of the educational program <strong>must</strong> accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
</tbody>
</table>
| OMP   | 1-3         | All arrangements with sites not owned by the sponsoring institution where educational activity occurs **must** be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. The following items must be covered in such inter-institutional agreements:  
a. Designation of a single program director;  
b. The teaching staff;  
c. The educational objectives of the program;  
d. The period of assignment of students/residents; and  
e. Each institution’s financial commitment. |
| OMP   | 1-4         | For each site where educational activity occurs, there **must** be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible. |
| OMP   | 2-3         | All faculty, including those at major and minor educational activity sites, **must** be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program. |
| OMP   | Standard 3  | The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that |
defines the use of such facilities in its discipline-specific standards.

<table>
<thead>
<tr>
<th>Oral and Maxillofacial Radiology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OMR</strong></td>
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<tr>
<td><strong>OMR</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral and Maxillofacial Surgery (Residency and Fellowship)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OMS</strong></td>
</tr>
<tr>
<td><strong>OMS</strong></td>
</tr>
<tr>
<td><strong>OMS</strong></td>
</tr>
<tr>
<td><strong>OMS</strong></td>
</tr>
</tbody>
</table>
be available. The following items **must** be covered in such inter-institutional agreements:

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

<table>
<thead>
<tr>
<th>OMS</th>
<th>1-8</th>
<th>Rotations to an affiliated institution which sponsors its own accredited oral and maxillofacial surgery residency program <strong>must</strong> not exceed 26 weeks in duration.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMS</td>
<td>1-9</td>
<td>Any program that rotates a resident to an affiliated institution which also sponsors its own separately accredited oral and maxillofacial surgery residency program <strong>must</strong> submit each year a supplement to its Annual Survey. The supplement <strong>must</strong> identify the affiliated institution by name and the oral and maxillofacial surgery cases on which the rotating resident was surgeon or first assistant to an attending surgeon. This report <strong>must</strong> be signed by the program director of the sponsoring institution and the chief of oral and maxillofacial surgery at the affiliated institution.</td>
</tr>
<tr>
<td>OMS</td>
<td>1-10</td>
<td>All standards in this document <strong>must</strong> apply to training provided in affiliated institutions.</td>
</tr>
<tr>
<td>OMS</td>
<td>2-2.1</td>
<td>The teaching staff <strong>must</strong> be of adequate size and <strong>must</strong> provide for the following: Provide direct supervision in all patient care settings appropriate to a resident’s competence and level of training.</td>
</tr>
<tr>
<td>OMS</td>
<td>3</td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</td>
</tr>
<tr>
<td>OMS</td>
<td>3-1</td>
<td>Clinical facilities <strong>must</strong> be properly equipped for performance of all ambulatory oral and maxillofacial surgery procedures, including administration of general anesthesia and sedation for ambulatory patients.</td>
</tr>
<tr>
<td>OMS</td>
<td>3-2</td>
<td>There <strong>must</strong> be a space properly equipped for monitoring patients' recovery from ambulatory surgery, general anesthesia and sedation.</td>
</tr>
<tr>
<td>OMS</td>
<td>3-5</td>
<td>Adequate on call facilities <strong>must</strong> be provided to residents when fulfilling in-house call responsibilities.</td>
</tr>
</tbody>
</table>
Ad Hoc Educational Activity Sites
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<table>
<thead>
<tr>
<th>OMS</th>
<th>3-6</th>
<th>Adequate and accessible diagnostic imaging facilities must be available to residents to utilize for patient care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMS</td>
<td>4-2.2</td>
<td>Rotations to affiliated institutions outside the United States and Canada must not be used to fulfill the core 120 weeks clinical oral and maxillofacial surgery training experience. Surgical procedures performed during foreign rotations must not count toward fulfillment of the 175 major surgical procedures.</td>
</tr>
<tr>
<td>OMS</td>
<td>4-2.3</td>
<td>Rotations to a private practice must not be used to fulfill the core 120 weeks clinical oral and maxillofacial surgery training experience.</td>
</tr>
<tr>
<td>OMS-CF</td>
<td>1</td>
<td>The primary sponsor of the fellowship program must accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
<tr>
<td>OMS-CF</td>
<td>1-3</td>
<td>All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
</tbody>
</table>
| OMS-CF | 1-4 | Documentary evidence of agreements, for major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:  
  a. Designation of a single program director;  
  b. The teaching staff;  
  c. The educational objectives of the program;  
  d. The period of assignment of fellows; and  
  e. Each institution’s financial commitment. |

### Orthodontics and Dentofacial Orthopedics (Residency and Fellowship)

<table>
<thead>
<tr>
<th>ORTHO</th>
<th>1</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORTHO</td>
<td>1</td>
<td>The primary sponsor of the educational program must accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>1-2</td>
<td>All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>1-3</td>
<td>Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not</td>
</tr>
</tbody>
</table>
owned by the sponsoring institution, **must** be available. The following items **must** be covered in such inter-institutional agreements:

- Designation of a single program director;
- The teaching staff;
- The educational objectives of the program;
- The period of assignment of students/residents; and
- Each institution’s financial commitment.

<table>
<thead>
<tr>
<th>ORTHO</th>
<th>1-4</th>
<th>For each site where educational activity occurs, there <strong>must</strong> be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORTHO</td>
<td>1-5</td>
<td>All faculty, including those at major and minor educational activity sites, <strong>must</strong> be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>2-3</td>
<td>A majority of the discipline-specific instruction and supervision <strong>must</strong> be conducted by individuals who are educationally qualified in orthodontics and dentofacial orthopedics.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>2-6</td>
<td>The faculty <strong>must</strong> have knowledge of the required biomedical sciences relating to orthodontics and dentofacial orthopedics. Clinical instruction and supervision in orthodontics and dentofacial orthopedics <strong>must</strong> be provided by individuals who have completed an advanced dental education program in orthodontics and dentofacial orthopedics approved by the Commission on Dental Accreditation (grandfathered), or by individuals who have equivalent education in orthodontics and dentofacial orthopedics.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>2-8</td>
<td>The number and time commitment of faculty <strong>must</strong> be sufficient to provide full supervision of the clinical portion of the program.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>3</td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>3-1</td>
<td>Adequate space <strong>must</strong> be designated specifically for the advanced dental education program in orthodontics and dentofacial orthopedics.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>3-2</td>
<td>Facilities <strong>must</strong> permit the students/residents to work effectively with trained allied dental personnel.</td>
</tr>
<tr>
<td>------------</td>
<td>-----</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ORTHO</td>
<td>3-3</td>
<td>Radiographic, biometric and data collecting facilities <strong>must</strong> be readily available to document both clinical and research data. Imaging equipment <strong>must</strong> be available.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>3-6</td>
<td>Clinical facilities <strong>must</strong> be provided within the sponsoring or affiliated institution to fulfill the educational needs of the program.</td>
</tr>
<tr>
<td>ORTHO</td>
<td>3-9</td>
<td>Digital radiography equipment <strong>must</strong> be available and accessible to the orthodontic clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>1</td>
<td>The sponsoring institution <strong>must</strong> assure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>1</td>
<td>The primary sponsor of the fellowship program <strong>must</strong> accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
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<tr>
<td>ORTHO-CF</td>
<td>1-3</td>
<td>All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, <strong>must</strong> be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
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<td>ORTHO-CF</td>
<td>1-4</td>
<td>Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not owned by the sponsoring institution, <strong>must</strong> be available. The following items <strong>must</strong> be covered in such inter-institutional agreements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. Designation of a single program director;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. The teaching staff;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>h. The educational objectives of the program;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. The period of assignment of students/fellows; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>j. Each institution’s financial commitment.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>1-5</td>
<td>For each site where educational activity occurs, there <strong>must</strong> be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>1-6</td>
<td>All faculty, including those at major and minor educational activity sites, <strong>must</strong> be calibrated to ensure consistency in</td>
</tr>
</tbody>
</table>
training and evaluation of students/residents that supports the goals and objectives of the program.

<table>
<thead>
<tr>
<th>ORTHO-CF</th>
<th>2-2.1</th>
<th>The teaching staff must be of adequate size and must provide for the following: Provide direct supervision appropriate to a student’s/fellow’s competence, level of training, in all patient care settings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORTHO-CF</td>
<td>3</td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is not approved, unless the discipline has included language that defines the use of such facilities in its discipline-specific Standards.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>3-2</td>
<td>Facilities must permit the students/fellows to work effectively with trained allied dental personnel.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>3-3</td>
<td>Radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. Imaging equipment must be available.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>3-6</td>
<td>Clinical facilities must be provided within the sponsoring, affiliated institution or surgical center to fulfill the educational needs of the program.</td>
</tr>
<tr>
<td>ORTHO-CF</td>
<td>3-9</td>
<td>Radiography equipment must be available and accessible to the craniofacial clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Dentistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>PED Standard 1</td>
</tr>
<tr>
<td>PED Standard 1</td>
</tr>
</tbody>
</table>
| PED 1-1             | All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. The following items must be covered in such inter-institutional agreements:  
a. Designation of a single program director;  
b. The teaching staff;  
c. The educational objectives of the program;  
d. The period of assignment of students/residents; and  
e. Each institution's financial commitment. |
### Ad Hoc Educational Activity Sites

**Commission Only**

**Winter 2021**

<table>
<thead>
<tr>
<th>PED</th>
<th>1-3</th>
<th>For each site where educational activity occurs, there <strong>must</strong> be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PED</td>
<td>2-5</td>
<td>All faculty, including those at major and minor educational activity sites, <strong>must</strong> be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.</td>
</tr>
<tr>
<td>PED</td>
<td><strong>Standard 3</strong></td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</td>
</tr>
<tr>
<td>PED</td>
<td>3-2</td>
<td>Private practitioners who provide training <strong>must</strong> have faculty appointments.</td>
</tr>
</tbody>
</table>

**Periodontics**

<table>
<thead>
<tr>
<th>PERIO</th>
<th>1</th>
<th>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERIO</td>
<td>1</td>
<td>The primary sponsor of the educational program <strong>must</strong> accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
<tr>
<td>PERIO</td>
<td>1-2</td>
<td>All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, <strong>must</strong> be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.</td>
</tr>
</tbody>
</table>
| PERIO | 1-3 | The following items **must** be covered in such interinstitutional agreements:
  a. Designation of a single program director;
  b. Teaching staff and means for calibration where competency assessments occur;
  c. Availability and adequacy of staff;
  d. Student/Resident oversight and responsibility;
  e. The educational objectives of the program;
  f. The period of assignment of students/residents; and
  g. Each institution's financial commitment. |
| PERIO | 2-5 | All faculty, including those at major and minor educational activity sites, **must** be calibrated to ensure consistency in...
<table>
<thead>
<tr>
<th>PERIO</th>
<th>2-6</th>
<th>Faculty <strong>must</strong> be assigned for all clinical sessions and immediately available for consultation with students/residents and patients. There <strong>must</strong> be direct supervision by periodontists of students/residents who are performing periodontal and dental implant related surgical procedures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERIO</td>
<td>3</td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</td>
</tr>
<tr>
<td>PERIO</td>
<td>3-1</td>
<td>Adequate clinical and radiographic facilities <strong>must</strong> be readily available in order to meet the objectives of the program. State-of-the-art imaging resources should be accessible to the student/resident. There <strong>must</strong> be a sufficient number of operatories to efficiently accommodate the number of students/residents enrolled. One operatory should be available to each student/resident during clinic assignments.</td>
</tr>
<tr>
<td>PERIO</td>
<td>3-7</td>
<td>Adequate support personnel <strong>must</strong> be assigned to the program to ensure chairside and technical assistance.</td>
</tr>
</tbody>
</table>

**Prosthodontics**

<table>
<thead>
<tr>
<th>PROS</th>
<th>Standard 1</th>
<th>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROS</td>
<td>Standard 1</td>
<td>The primary sponsor of the educational program <strong>must</strong> accept full responsibility for the quality of education provided in all sites where educational activity occurs.</td>
</tr>
</tbody>
</table>
| PROS   | 1-1         | All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, **must** be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved such as:  
  a. Designation of a single program director;  
  b. The teaching staff;  
  c. The educational objectives of the program;  
  d. The period of assignment of students/residents; and  
  e. Each institution’s financial commitment. |
<table>
<thead>
<tr>
<th>PROS</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROS</td>
<td>1-2</td>
<td>For each site, including those at major and minor educational activity sites, there <strong>must</strong> be an on-site clinical supervisor who is an educationally qualified specialist in the curriculum areas for which he/she is responsible.</td>
</tr>
<tr>
<td>PROS</td>
<td>2-5</td>
<td>All faculty, including those at major and minor educational activity sites, <strong>must</strong> be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.</td>
</tr>
<tr>
<td>PROS</td>
<td>Standard 3</td>
<td>The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.</td>
</tr>
</tbody>
</table>
R. POLICY STATEMENT ON REPORTING AND APPROVAL OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

The Commission on Dental Accreditation recognizes that students/residents may gain educational experiences in a variety of settings and locations.

An accredited program may use one or more than one setting or location to support student/resident learning and meet Commission on Dental Accreditation standards and/or program requirements. The Commission expects programs to follow the EOPP guidelines and accreditation standards when developing, implementing and monitoring activity sites used to provide educational experiences.

Reporting Requirements:
The Commission on Dental Accreditation must be informed when a program accredited by the Commission plans to initiate educational experiences in new settings and locations. Off-Campus training sites that are owned by the sponsoring institution or where the sponsoring organization has legal responsibility and operational oversight do not need prior approval before utilization but must be reported to the Commission in accordance with the Policy on Reporting Program Changes in Accredited Programs.

<table>
<thead>
<tr>
<th>Reporting Requirements for Off-Campus Sites</th>
<th>Major Activity Sites</th>
<th>Minor Activity Sites</th>
<th>Supplemental Activity Sites*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
<td>Students/Residents <strong>required</strong> to complete an experience at this site to meet a program requirements or accreditation standards, and Competency assessments or comparable summative assessments performed at the site</td>
<td>Students/Residents <strong>required</strong> to complete an experience at this or another site to meet a program requirements or accreditation standards, and No competency assessments or comparable summative assessments performed at the site. Evaluation may occur.</td>
<td>Student/Resident chooses whether to visit the site outside of the educational program (e.g. volunteer mission trips, health fair, etc. not used to fulfill program or accreditation requirements).</td>
</tr>
<tr>
<td>Program Report Requirement</td>
<td>Report required by June 1 or December 1</td>
<td>Report required at least 30 days prior to planned implementation of educational activity site.</td>
<td>No report required.</td>
</tr>
</tbody>
</table>
Acknowledgement/Approval

Commission approval required prior to implementation of the educational activity site. Approval of the major activity sites required prior to recruiting students/residents for the site and initiating use of the site.

Commission acknowledgement of review at the program’s next site visit.

No approval required.

Site Visit(s) to Educational Activity Site

Commission may direct special focused site visit to review educational activity site prior to or after approval of the site. Commission may review site at future site visits.

Commission may visit educational activity site during program’s next site visit.

No site visit required.

sites used for community service and service learning are exempt

The Commission must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all students/residents enrolled in an accredited program. Generally, only programs without reporting requirements will be approved to initiate educational experiences at major activity sites.

When the Commission has received notification that an institution plans to offer its accredited program at an off-campus educational activity site, the Commission may conduct a special focused site visit to each educational activity site where each student’s/resident’s educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, or if other cause exists for such a visit as determined by the Commission. There may be extenuating circumstances when a special review is necessary.

The program must report the rationale for adding an educational activity site and how that site affects the program’s goals, objectives, and outcomes. For example, program goals, objectives, and outcome measures may address institutional support, faculty support, curriculum, student didactic and clinical learning, research, and community service. The program must support the addition of an educational activity site with trends from pertinent areas of its outcomes assessment program that indicates the rationale for the additional site.

When conducting a review of the program, the Commission’s site visit team will identify the sites to be visited based upon educational experiences at the site (for example based upon length of training at the site, educational experience or evaluation/competencies achieved). After the initial visit or review, each educational activity site may be visited during the regularly scheduled CODA evaluation visit to the program.
Discipline-specific Exemptions:
The Commission recognizes that dental assisting and dental laboratory technology programs utilize numerous extramural private dental offices and laboratories to provide students with clinical/laboratory work experience. The program will provide a list of all currently used extramural sites in the self-study document. The Commission may then randomly select and visit facilities at the time of a site visit to the program. Prior Commission approval of these extramural dental office and laboratory sites will not be required.

The Commission recognizes that dental public health programs utilize numerous off-campus sites to provide students/residents with opportunities to conduct their supervised field experience. The program will provide a list of all currently used sites in the self-study document. The visiting committee will select and visit facilities during the site visit to the program to evaluate compliance with CODA accreditation standards. Prior Commission approval of these supervised field experience sites will not be required. Programs where 30% or more of the overall student/resident training occurs at off-campus site(s) must report the off-campus site(s) under the Commission's Policy Statement on Approval of Sites Where Educational Activity Occurs.

The Commission recognizes that advanced dental education programs in dental anesthesiology utilize numerous mobile ambulatory settings and rotations to provide residents with opportunities to gain required clinical experiences. The program will provide a list of all currently used settings and rotations in the self-study document. The visiting committee will randomly select and visit several settings and rotation locations during the site visit to the program to evaluate compliance with Commission on Dental Accreditation standards. Prior Commission approval of these settings and rotations will not be required.

For predoctoral dental education programs, when primary program faculty travel with student(s) to a site and competency is assessed, the site may be treated as a minor site for reporting purposes.

Expansion of a developing dental hygiene program and/or current or developing dental assisting program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

Fees Related to the Use of Educational Activity Sites:
All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to and educational activity site. The Commission office should be contacted for current information on fees.

Commission on Dental Accreditation Consideration of Educational Activity Sites:
The Commission uses the following process when considering reports for adding educational activity sites. Program administrators have the option of consulting with Commission staff at any time during this process.

1. Depending upon the type of educational activity site established, a program administrator submits either: (1) the major educational activity site report by June 1 or December 1 or (2) the minor educational activity site report at least thirty (30) days prior to planned implementation of educational activity site.
2. Commission staff reviews the report to assess its completeness and to determine whether the change
could impact the program’s potential ability to comply with the accreditation standards. If this is the
case, whether the site is major or minor, the report is reviewed by the appropriate Review Committee
for the discipline and by the Commission.

3. Receipt of the educational activity site report and accompanying documentation is acknowledged in
one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review
      Committee and by the Commission at their next regularly scheduled meeting. Additional
      information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next
      site visit.

4. If the report will be considered by a Review Committee and by the Commission, the report is added
to the appropriate agendas. The program administrator receives notice of the results of the
Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the
Commission in relation to the review of reports of addition of educational activity sites received from
accredited educational programs.

- **Approve the addition of the educational activity site**: If the Review Committees or Commission does
  not identify any concerns regarding the program’s continued compliance with the accreditation
  standards, the transmittal letter should advise the institution that the change has been noted and will
  be reviewed at the next regularly-scheduled site visit to the program.

- **Approve the addition of the educational activity site and request additional information**: If the
  Review Committees or Commission does not identify any concerns regarding the program’s
  compliance with the accreditation standards, but believes follow up reporting is required to ensure
  continued compliance with accreditation standards, additional information will be requested for
  review by the Commission. Additional information could occur through a supplemental report or a
  focused site visit. Use of the educational site is permitted.

- **Postpone action and continue the program’s accreditation status, but request additional information**: The
  transmittal letter will inform the institution that the report of the addition of the educational
  activity site has been considered, but that concerns regarding continued compliance with the
  accreditation standards have been identified. Additional specific information regarding the identified
  concerns will be requested for review by the Commission. The institution will be further advised
  that, if the additional information submitted does not satisfy the Commission regarding the identified
  concerns, the Commission reserves the right to request additional documentation, conduct a special
  focused site visit of the program, or deny the request. Use of the educational activity site is not
  permitted until Commission approval is granted.

- **Deny the request**: If the submitted information does not indicate that the program will continue to
  comply with the accreditation standards, the Commission will deny the request for the addition of
  educational activity sites. The institutions will be advised that they may re-submit the request with
  additional information if they choose.

Revised: 8/18; 8/17; Adopted: 2/16 (Former Off-Campus Policy)
J. PROGRAM FEE POLICY

Programs accredited by the Commission pay an annual fee. The annual fee is doubled in the year of the program’s regular interval accreditation site visit. As there is some variation in fees for different disciplines based on actual accreditation costs, programs should contact the Commission office for specific information. Other than doubling of the annual fee during the site visit year, site visits are conducted without any additional charge to the institution and the Commission assumes all expenses incurred by its site visitors. However, accredited programs with multiple sites which must be site visited during a regular site visit and programs sponsored by the U.S. military in international locations are assessed a fee at the time of the site visit. The fee is established on a case-by-case basis, dependent upon the specific requirements to conduct the visit (e.g. additional site visitors, additional days, and additional travel time and expenses). Fees are also assessed to the program for the conduct of special focused site visits. (See Invoicing Process for Special Focused Site Visits in Policy on Special Site Visits).

International dental education programs also pay an annual fee and site visit fees (See International Dental Education Site Visits). Expenses for representatives from the state board of dentistry or from other agencies, such as a regional accrediting agency, are not assumed by the Commission. Fee structures are evaluated annually by the Commission. The Commission office should be contacted for current information on fees.

An annual administrative fee is also applied to each program. Fees may also be associated with staff consulting services (See Staff Consulting Services, and International Policies and Procedures) administrative fees related to the Commission policy on protected health information and personally identifiable information (See Policy and Procedures Related to Compliance with the Health Insurance Portability and Accountability Act).

All institutions offering programs accredited by the Commission on Dental Accreditation are expected to adhere to the due date for payment of all fees for each accredited program sponsored by the institution. Written requests for an extension must specify a payment date no later than thirty (30) days beyond the initial due date. Failure to pay fees by the designated deadline is viewed as an institutional decision to no longer participate in the Commission’s accreditation program. Following appropriate reminder notice(s), if payment or a request for extension is not received, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting. Programs which have been discontinued or had accreditation withdrawn will not be issued a refund of accreditation fees.

Revised: 1/20; 2/19; 2/15; 8/14; 8/13; 7/08; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01, 7/95

D. POLICY ON PLANNING AND IMPLEMENTING PRELIMINARY ACCREDITATION CONSULTATION VISIT (PACV) AND INTERNATIONAL ACCREDITATION SITE VISITS

The Commission on Dental Accreditation has developed the following policy and procedures for use in planning and implementing international Preliminary Accreditation Consultation Visit (PACV) and Commission accreditation site visits. (See the policy on Staff Consulting Services).

Prior to staff and volunteer travel, travel warnings from the US Department of State, US Department of
Health and Human Services, and the Centers for Disease Control and Prevention will be continuously monitored. Additionally, the Commission will ensure there are no cultural restrictions or legal restrictions which would make PACV or accreditation site visits in any international location by Commission staff and volunteers problematic. Volunteers will be identified and invited to attend with the full knowledge of travel warnings. Prior to travel, the Commission Director in consultation with the Commission Chair will determine whether CODA volunteers and staff require additional security, which would be the responsibility of the international dental education program to which the Commission is traveling.

The Commission reserves the right to change travel plans due to safety, health, or similar concerns, as warranted by the Commission Director in consultation with the Commission Chair. The Commission also reserves the right to cancel international travel when US State Department or other concerns discourage travel due to potential threats to safety or health (war, terrorism, health, etc.). All costs incurred by the Commission and/or its volunteers will be borne by the international program.

Site visits may be rescheduled within the same calendar year without prior approval by the full Commission. Site visits rescheduled in the following calendar year must be approved by the Commission (See Rescheduling Dates of Site Visits). Accreditation decisions for programs whose site visit has been rescheduled or cancelled due to circumstances beyond the control of the Commission and/or program will be made on a case-by-case basis.

Adopted: 8/17

I. SITE VISITS

5. **Policy On Special Site Visits:** Special site visits are conducted when it is necessary for the Commission to review information about the program that can only be obtained or documented on-site. When necessary, special site visits are conducted to ensure the quality of the educational program, but are used selectively in order to avoid perceived harassment of programs. A special site visit may be either focused, limited to specified standards, or comprehensive, covering all accreditation standards. In making recommendations to the Commission for a special site visit, the Review Committee will indicate the specific standards or required accreditation policy in question. The Commission will communicate these concerns to the program in the letter transmitting the action related to a special site visit. If a comprehensive special visit will be conducted, the program must prepare a self-study prior to the visit. If a focused visit will be conducted, the program will be required to complete some portions of the self-study and/or to develop some other materials related to the specific standards or required policies that have been identified as areas of concern. With the exception of a special site visit due to falsification of information, all costs related to special site visits are borne by the program, including an administrative special focused site visit fee. (See Invoicing Process for Special Focused Site Visits)

The Commission may conduct a special site visit for any of the following reasons:

a. **Failure to document compliance:** A special site visit may be directed for an accredited program when, six (6) months prior to the time period allowed to achieve compliance through progress reports (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), the program has not adequately documented compliance with the accreditation standards. The special site visit will be focused on the recommendations
contained in the site visit report. Recommendations for which supplemental information or documentation is submitted after the last progress report or special site visit report is reviewed by the appropriate Review Committee or the Commission and that in the Commission’s opinion requires on-site verification, shall be considered as not met for purposes of accreditation. Following the special site visit, if compliance is not demonstrated, the Commission will withdraw the program’s accreditation unless the Commission extends the period for achieving compliance for good cause.

b. Change within a program: A special site visit may be directed for an accredited program when a report of program change, review of annual survey data, or information received in other ways, indicates that changes in a program may have affected its ability to maintain compliance with the accreditation standards. The Commission may also request a special report from the involved program prior to conducting a special site visit. The Commission’s Policy on Reporting Program Changes in Accredited Programs found in Section V.C of this manual provides details.

c. Investigating complaints: A special site visit may be directed for an accredited program to investigate a complaint raising questions about the program’s compliance with the accreditation standards. The Commission’s Policy and Procedure Regarding Investigation of Complaints Against Educational Programs found in Section V.D of this manual provides details.

d. Falsifying information: A special site visit may be directed for an accredited program to investigate the possible intentional falsification of information provided to the Commission. The Commission’s policy on Integrity found in Section I.G provides details. The cost of such a special site visit is shared by the Commission and the program.

e. Sites Where Educational Activity Occurs: The Commission’s Policy Statement on Reporting and Approval of Sites Where Educational Activity Occurs found in Section V.R provides details.

f. Other reasons: A special site visit may, on occasion, be directed for an accredited program to respond to a request to the Commission from the chief executive officer or program administrator. The Commission may also direct that a focused site visit is necessary for just cause if it determines that a program may be unable to maintain compliance with the accreditation standards.

Revised: 8/19

Invoicing Process for Special Focused Site Visits
In advance of the special focused site visit, the program must remit payment for the Administrative Fee ($5,000 in 2020 and 2021) plus $1,500 per site visitor/staff attending visits up to two (2) days in length. Site visits that are three (3) or more days will be billed an additional $500 per site visitor/staff for each additional day; further, if additional airfare or transportation expenses are incurred, these will be assessed to the program. Failure to submit the special focused site visit fee in advance of the visit may result in a delay of the visit and additional rescheduling cost to the program, and may impact the program’s accreditation status. See Program Fee Policy.

Revised: 1/20; 8/19; 2/19; 2/18; 2/17; 8/16; 2/16; 8/14; 8/13; 1/00, 1/99, 1/98; Reaffirmed: 8/13; 8/10, 7/06; Adopted: 7/96

C. REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.
At times, however, more significant changes occur in a program. Changes have a direct and significant impact on the program’s potential ability to comply with the accreditation standards. These changes tend to occur in the areas of finances, program administration, enrollment, curriculum and clinical/laboratory facilities, but may also occur in other areas. All program changes that could affect the ability of the program to comply with the Accreditation Standards must be reported to the Commission. When a change is planned, Commission staff should be consulted to determine reporting requirements. Reporting program changes in the Annual Survey does not preclude the requirement to report changes directly to the Commission. Failure to report and receive approval in advance of implementing the change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program’s accreditation status.

Advanced dental education programs must adhere to the Policy on Enrollment Increases in Advanced Dental Education Programs. In addition, programs adding off-campus sites must adhere to the Policy on Reporting and Approval of Sites Where Educational Activity Occurs. Guidelines for Reporting and Approval of Sites where Educational Activity Occurs are available from the Commission office. Guidelines for Requesting an Increase in Enrollment in a Predoctoral Dental Education Program and Guidelines for Reporting Enrollment Increases in Advanced Dental Education Programs are available from the Commission office.

On occasion, the Commission may learn of program changes which may impact the program’s ability to comply with accreditation standards or policy. In these situations, CODA will contact the sponsoring institution and program to determine whether reporting may be necessary. Failure to report and receive approval prior to the program change may result in further review by the Commission and/or a special site visit, and may jeopardize the program’s accreditation status.

The Commission’s Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breech of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

A Report of Program Change must document how the program will continue to meet accreditation standards. The Commission’s Guidelines for Reporting Program Changes are available on the Commission’s website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported by June 1 or December 1 and must be reviewed by the appropriate Review Committee and approved by the Commission prior to the implementation to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites not owned by the sponsoring institution used to meet accreditation standards or program requirements (See Guidelines on Reporting and Approval of Sites Where Educational Activity Occurs);
- Changes to Off-Campus Sites not owned by the sponsoring institution that impacts the use of the site (e.g. minor site to major site, or termination of enrollment at or discontinued use of major site);
• Transfer of sponsorship from one institution to another;
• Moving a program from one geographic site to another, including but not limited to geographic
  moves within the same institution;
• Program director qualifications not in compliance with the standards. In lieu of a CV, a copy of the
  new or acting program director’s completed BioSketch must be provided to Commission staff.
  Contact Commission Staff for the BioSketch template.
• Substantial increase in program enrollment as determined by preliminary review by the discipline-
  specific Review Committee Chair.
  o Requests for retroactive permanent increases in enrollment will not be considered. Requests
    for retroactive temporary increases in enrollment may be considered due to special
    circumstances on a case-by-case basis. Programs are reminded that resources must be
    maintained even when the full complement of students/residents is not enrolled in the
    program. (see Policy on Enrollment Increases In Advanced Dental Education Programs and
    Predoctoral programs see Guidelines for Requesting an Increase in Enrollment in a
    Predoctoral Dental Education Program);
• Change in the nature of the program’s financial support that could affect the ability of the program to
  meet the standards;
• Curriculum changes that could affect the ability of the program to meet the standards;
• Reduction in faculty or support staff time commitment that could affect the ability of the program to
  meet the standards;
• Change in the required length of the program;
• Reduction of program dental facilities that could affect the ability of the program to meet the
  standards;
• Addition of advanced standing opportunity; and/or
• Expansion of a developing dental hygiene or assisting program which will only be considered after
  the program has demonstrated success by graduating the first class, measured outcomes of the
  academic program, and received approval without reporting requirements.

The Commission recognizes that unexpected, changes may occur. If an unexpected change occurs, it must
be reported no more than 30 days following the occurrence. Unexpected changes may be the result of
sudden changes in institutional commitment, affiliated agreements between institutions, faculty support,
or facility compromise resulting from natural disaster (See Policy/Guidelines on Interruption of
Education). Failure to proactively plan for change will not be considered an unexpected change.
Depending upon the timing and nature of the change, appropriate investigative procedures including a site
visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that must be
reported in writing at least thirty (30) days prior to the anticipated implementation of the change and are
not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:
• Establishment of Off-Campus Sites owned by the sponsoring institution used to meet accreditation
  standards or program requirements;
• Expansion or relocation of dental facilities within the same building;
• Change in program director. In lieu of a CV, a copy of the new or acting program director’s
The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of program changes received from accredited educational programs.

- **Approve the report of program change:** If the Review Committee or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change(s) have been noted and will be reviewed at the next regularly-scheduled site visit to the program.

- **Approve the report of program change and request additional information:** If the Review Committees or Commission does not identify any concerns regarding the program’s compliance with the accreditation standards, but believes follow up reporting is required to ensure continued compliance with accreditation standards, additional information will be requested for review by the Commission. Additional information could occur through a supplemental report or a focused site visit.

- **Postpone action and continue the program’s accreditation status, but request additional information:** The transmittal letter will inform the institution that the report of program change has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request.

- **Postpone action and continue the program’s accreditation status pending conduct of a special site visit:** If the information submitted with the initial request is insufficient to provide reasonable
assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.

- **Deny the request**: If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for a program change. The institution will be advised that they may re-submit the request of program change with additional information if they choose. If the program change was submitted retroactively, and non-compliance is identified, the program’s accreditation status will be changed. The transmittal letter will inform the institution that the report of program change has been considered, but an area of non-compliance with the accreditation standards has been identified. The program’s accreditation status is changed and additional specific information regarding the identified area(s) of non-compliance will be requested for review by the Commission.

Revised: 8/20; 1/20; 8/18; 2/18; 8/17; 8/16; 2/16; 8/15; 2/15; 8/13 2/12, 8/11, 8/10, 7/09, 7/07, 8/02, 7/97; Reaffirmed: 7/07, 7/01, 5/90; CODA: 05/91:11
REPORT OF THE AD HOC COMMITTEE ON ALTERNATIVE SITE VISIT METHODS

Background: At its August 2020 meeting, the Commission on Dental Accreditation (CODA) considered ongoing operations in response to the COVID-19 pandemic and the impact on site visits. The Commission directed that it pursue alternative site visit methods, as needed to employ in 2021. The Commission further directed investigation and development of policies and procedures for alternative site visit methods, with a report to CODA in Winter 2021. The Commission believed that input from its 14 Review Committees on the elements of a site visit that may be conducted virtually versus the elements that must be reviewed on-site was warranted and, as such, directed that the 14 Review Committees be consulted related to this matter. Finally, the Commission directed the appointment of an Ad Hoc Committee to study virtual site visits, including development of policies and procedures for the conduct of virtual visits, for consideration by the Commission in Winter 2021.

The Commission Chair appointed the following individuals to the Ad Hoc Committee on Alternative Site Visit Methods: Dr. Kevin Haubrick (chair), Dr. Joel Berg, Dr. Susan Kass, Dr. Sanjay Mallya, Dr. William Nelson, Dr. Alan Stein, Dr. Marshall Titus, and Dr. Lawrence Wolinsky. The Ad Hoc Committee conducted virtual meetings on December 7, 2020 (all members present) and January 7, 2021 (all members present except Dr. Titus). Additionally, Dr. Jeffery Hicks, chair, and Dr. Bruce Rotter, vice chair, CODA, ex officio, were in attendance at all meetings. Dr. Sherin Took, director, CODA, and Mr. Gregg Marquardt, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA, and Ms. Cathryn Albrecht, senior associate general counsel, ADA/CODA, were in attendance at all meetings. Ms. Dawn Herman and Ms. Kirsten Nadler, managers, CODA, were in attendance during the January 7, 2021 meeting.

Below is the Ad Hoc Committee’s report and recommendations to the Commission following its meetings of December 7, 2020, and January 7, 2021.

Report and Recommendations of the Ad Hoc Committee:
The Ad Hoc Committee reviewed its charge and the information that was collected to support the work of the Committee. The Committee considered the United States Department of Education (USDE) recognition criteria and USDE letter of March 2020 (Appendix 1), which provided accreditors with temporary flexibility during the COVID-19 pandemic to permit, but not require, accrediting agencies to conduct virtual site visits as long as the agency’s board approves changes to its policies governing site visits. The Committee also considered CODA’s current policies and procedures which govern its site visit process, and related program change and other policies that may lead to a site visit, as found in Appendix 2. The Committee further considered the site visit schedule for 2021, noting the Commission’s prior action to direct that all site visits not conducted in 2020 be shifted to 2021, and that all programs’ site visits be shifted one year forward. As directed by the Commission, each Review Committee’s comments related to alternative site visits was forwarded to the Ad Hoc Committee for consideration (Appendix 3). The Committee also noted the technology implications for the conduct of virtual site visits for
the Commission, programs, and Commission site visitors (Appendix 4). The Committee also considered legal implications of conducting site visits virtually, specifically related to privacy and data security, and confidentiality of the site visit process. Finally, the Committee reviewed information on similar accrediting agencies’ use of alternative site visit methods, as well as policies and procedures that had been developed by these agencies.

**Use of Alternative Site Visit Methods:**

The Ad Hoc Committee discussed whether the alternative (i.e., virtual) site visit process should be used during the COVID-19 pandemic and, if used, whether the process should be solely reserved for re-accreditation site visits to CODA-accredited programs. Following discussion, the Ad Hoc Committee determined that alternative site visit methods could be used equally for re-accreditation (regular) site visits, as well as special focused site visits and visits to educational programs that had applied for accreditation by the Commission. The Committee noted that in all cases, the USDE expected that the accrediting agency return for an on-site review within a reasonable time following the conduct of a virtual site visit.

In consideration of CODA’s international accreditation process for predoctoral dental education programs, including the Preliminary Accreditation Consultation Visit (PACV) process, the Ad Hoc Committee concluded that CODA should delay all site visits to international locations until an in-person visit can be conducted. No aspect of an international program review by the Commission should occur virtually. Therefore, the Committees recommendations below are limited to US-based programs, which are accredited by the Commission.

Having established its scope of review and recommended uses for alternative site visit methods, as noted above, the Ad Hoc Committee continued its discussion of the current climate related to travel and potential conduct of on-site visits. The Committee noted that travel restrictions can occur at the local, state, and national level, as well as being impacted by institutional/university policies of the program being visited. Additionally, the institutional/university policies of CODA’s site visitors, as well as their personal comfort in travel at this time, could affect site visit logistical planning activities leading up to the date of the site visit. Based upon these changing variables, the Ad Hoc Committee further concluded that the Commission should proceed with alternative site visit methods, as necessary, and should plan to return to a program in a reasonable amount of time to conduct the USDE required in-person review.

The Committee also discussed the timeline that might be appropriate for an in-person visit to the program, following the virtual site visit. The Committee concluded that the in-person visit should occur within a time period not to exceed 18 months following the conduct of a virtual site visit. Additionally, the Committee determined that there may be visits that are conducted completely virtually (all site visits distant to the program) while others may be conducted in a hybrid fashion (at least one discipline-specific site visitor is on-site at the program). It was the belief of the Ad Hoc Committee that if a hybrid visit were to occur, there would be no need for a subsequent in-person visit. The Committee noted that the USDE’s flexibility requires an in-person visit following a virtual visit, though not necessarily a full peer-review visit. Based upon this flexibility, the Committee believed a hybrid visit would satisfy the virtual and in-person...
review, given at least one discipline-specific site visitor would be on-site at the program’s facility during the evaluation. The Ad Hoc Committee believed that in all cases with site visit scheduling and logistics, it should be the Commission, not the program, which dictates the process used for the program’s evaluation. Finally, the Committee determined that the program’s next site visit date would be based upon its virtual/hybrid visit date using CODA’s formula of regular site visits occurring at seven (7) year intervals in all disciplines except oral and maxillofacial surgery, which occur every five (5) years.

Alternative Site Visit Process and Procedures:
The Ad Hoc Committee discussed the portions of the site visit that may occur virtually versus the portions that must occur on-site. Following review of the information gathered from CODA’s 14 Review Committees (Appendix 3), the Ad Hoc Committee concluded that the Review Committees were generally calibrated and in agreement on the requirements for on-site versus virtual program review. The Review Committees and Ad Hoc Committee, believed that a majority of the site visit could occur virtually, through submission of materials in advance to the site visitors and Commission office, as well as through confidential virtual site visit interviews. Program documentation that would typically be provided on-site must be limited to only the materials absolutely necessary to demonstrate compliance, and be uploaded to CODA’s electronic accreditation portal along with the program’s self-study for review by the site visitors.

While a majority of the visit can occur virtually, on-site visits remain important, at least in some capacity, in order for the Commission and its site visitors to conduct the following aspects of program review: 1) clinical observation of patient care; 2) review of confidential program documents, including records that would be sensitive under regulations of patient, faculty, and student/resident/fellow privacy, although aggregate data should be provided for a virtual visit to demonstrate compliance; 3) clinic tours of the program’s facility and educational activity sites used by the program; 4) student/resident/fellow interview sessions, although initial interviews could occur virtually and be supplemented on-site; and 5) any other areas in which the virtual site visit did not result in sufficient review and verification of compliance by the program.

The Ad Hoc Committee believed that following a virtual visit, areas of non-compliance should be reviewed and monitored by the Commission, through its Review Committees based upon existing policies and procedures. If a program is reporting to the Commission on areas of non-compliance at the time of its on-site visit, the program will be expected to continue to report on progress directly to the Commission; however, the preexisting areas of non-compliance would not be included in the on-site visit review. The on-site visit would, generally, be limited to review of continued compliance with CODA policies on complaints and third party comments, as well as evaluation of standards related to the aforementioned five (5) areas, including clinical operations and student/resident/fellow clinical experiences, facility tours including educational activity sites, student/resident/fellow interviews, and review of on-site documentation that could not be transmitted during the virtual site visit, and any other items that arise during the on-site evaluation.
Alternative Site Visit Schedule and Technology Usage:
The Ad Hoc Committee also considered the site visit schedule and use of technology to conduct a virtual or hybrid site visit, including technology requirements for the program, Commission, and Commission’s site visitors, in order to conduct reviews virtually. The Committee determined that the site visit schedule, whether virtual, hybrid, or in-person, should remain the same as CODA’s current site visit schedule. The virtual or hybrid site visit would be conducted based upon the time zone of the program being visited, and the program would be expected to prepare a schedule that includes references to all time zones in the United States in order to guide site visitors on the schedule.

Following discussion regarding the technology that would be used to facilitate site visits, the Ad Hoc Committee concluded that the program must be responsible to support the technology used for the visit, recognizing that Zoom is CODA’s preferred tool, including providing real-time virtual support to site visitors regarding technology issues that may arise. Additionally, the program would be expected to pre-set breakout rooms and provide links on the site visit schedule to support the concept of individual, private conference rooms which are used during an on-site visit. The program must also ensure the confidentiality of the review process, including the Commission’s expectation that there be no recording of any kind of the site visit process. The Committee believed the program’s obligations should be documented in a program manual and agreement, which must be signed by the program in advance of the site visit.

Summary of Recommendations:
Following extensive discussion, the Ad Hoc Committee on Alternative Site Visit Methods believed that the proposed temporary policy on the use of virtual site visits should be considered and approved by the Commission (Appendix 5). The Ad Hoc Committee also believed that the proposed Site Visitor Manual on Alternative Site Visit Methods (Appendix 6) and Program Manual on Alternative Site Visit Methods (Appendix 7) should be considered for adoption by the Commission and circulation to programs and site visitors. Additionally, the Ad Hoc Committee believed that each program preparing for a site visit that will occur via alternative methods should be required to sign the proposed Alternative Site Visit Program Agreement presented in Appendix 8. The Committee further believed that CODA should direct staff to develop educational webinars, either synchronous or asynchronous, to inform all affected individuals and programs of the Commission’s expectations related to alternative site visit methods. Finally, the Ad Hoc Committee also believed that the Commission should study the use of alternative site visit methods in the future and identify whether any changes in processes or procedures for the conduct of site visits using alternative methods could be implemented long-term.

Ad Hoc Committee on Alternative Site Visit Methods Recommendations: It is recommended that the Commission on Dental Accreditation adopt the proposed Policy on Temporary Use of Alternative Site Visit Methods (Appendix 5), with immediate implementation.
It is further recommended that the Commission on Dental Accreditation adopt the proposed Site Visitor Manual on Alternative Site Visit Methods (Appendix 6), with immediate implementation.

It is further recommended that the Commission on Dental Accreditation adopt the proposed Program Manual on Alternative Site Visit Methods (Appendix 7), with immediate implementation.

It is further recommended that the Commission on Dental Accreditation adopt the proposed Alternative Site Visit Program Agreement (Appendix 8), with immediate implementation.

It is further recommended that the Commission on Dental Accreditation direct staff to develop educational webinars, either synchronous or asynchronous, to inform all affected individuals and programs of the Commission’s expectations related to alternative site visit methods.

It is further recommended that the Commission on Dental Accreditation conduct a future study of alternative site visit methods to identify whether any changes in processes or procedures for the conduct of site visits using alternative methods could be implemented long-term.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
USDE REGULATIONS AND TEMPORARY FLEXIBILITY RELATED TO SITE VISITS

Current USDE Criteria for Recognition of Accrediting Agencies

602.15 – Administrative and fiscal responsibilities
The agency must have the administrative and fiscal capability to carry out its accreditation activities in light of its requested scope of recognition. The agency meets this requirement if the agency demonstrates that—

(b) The agency maintains complete and accurate records of—
   (1) Its last full accreditation or preaccreditation review of each institution or program, including on-site evaluation team reports, the institution's or program's responses to onsite reports, periodic review reports, any reports of special reviews conducted by the agency between regular reviews, and a copy of the institution's or program's most recent self-study; and

   (2) All decision letters issued by the agency regarding the accreditation and preaccreditation of any institution or program and any substantive changes.

602.17 Application of standards in reaching an accrediting decision
The agency must have effective mechanisms for evaluating an institution’s or program’s compliance with the agency’s standards before reaching a decision to accredit or preaccredit the institution or program. The agency meets this requirement if the agency demonstrates that it--

(b) Requires the institution or program to engage in a self-study process that assesses the institution's or program's education quality and success in meeting its mission and objectives, highlights opportunities for improvement, and includes a plan for making those improvements;

(c) Conducts at least one on-site review of the institution or program during which it obtains sufficient information to determine if the institution or program complies with the agency's standards;

(d) Allows the institution or program the opportunity to respond in writing to the report of the on-site review;

(e) Conducts its own analysis of the self-study and supporting documentation furnished by the institution or program, the report of the on-site review, the institution's or program's response to the report, and any other information substantiated by the agency from other sources to determine whether the institution or program complies with the agency's standards;
**USDE Temporary Flexibility Related to Site Visits (Excerpts from USDE Letter 3.17.2020)**

*Letter is attached as Tab 2.1b*

- The Department has determined that it is reasonable and prudent to permit on a temporary basis – but not require – accrediting agencies to perform virtual site visits during this period (even if their existing procedures do not provide for virtual visits).

- The agency board (or other decision-making body) should approve any change to policies governing virtual visits (or increased use of virtual visits) using the abbreviated process described at the end of this letter.

- If agencies implement virtual visits, they should follow-up with in-person visits to meet the statutory and regulatory requirements to perform regular on-site inspections.

- Virtual site visits should rely on an engaged, interactive format (*e.g.*, telephonic meetings, video conference calls, and the like), rather than solely document reviews or exchanges of emails.

- If an accreditor employs a virtual site visit, the agency must perform a follow-up, in-person visit to the campus (though not necessarily a full peer-review site visit) within a reasonable period of time following the virtual site visit.

- At its discretion, an accrediting agency may limit virtual site visits to institutions or programs that are otherwise in good standing or to institutions or programs that are engaged in renewal of accreditation, as opposed to those institutions or programs seeking an initial award of accreditation.

- It is the responsibility of the accreditation agency to determine if, and under what conditions, it would perform virtual site visits during this temporary flexibility period.

- Moreover, during this period of COVID-19 interruption, the Department is permitting accreditors the flexibility to develop, adopt, modify, and implement temporary virtual site visit policies.

- With the approval of the agency’s board (or other decision-making body) during a telephonic or video conference meeting, accreditors may adopt or modify temporary virtual site visit policies without a public comment period. Because these policies would be temporary and arise from the unique set of circumstances and challenges presented by the COVID-19 interruption, this approval would not require a vote of the full membership of the accrediting agency. Should an agency desire to make a temporary
virtual site visit policy or policy modification permanent after the period of COVID-19 interruption, it must adhere to applicable statutory and regulatory requirements.

- The Department is also offering accrediting agencies the discretion to extend the term of accreditation, for a reasonable period of time during the COVID-19 interruption, for an institution that is undergoing renewal of accreditation and was scheduled to have a site visit during a COVID-19 interruption.

- The Department expects each agency to resume normal practices as soon as reasonably possible after the COVID-19 interruption has ended and will inform agencies of its expectations as the circumstances created by COVID-19 unfold.

- Finally, the Department is aware that, in some instances, an accrediting agency may have scheduled a site visit of a program or institution such that the results of that site visit would inform an agency accreditation decision in time to ensure that students who graduate during the current or prior term will be considered to have graduated from an accredited program. The Department is reminding accrediting agencies that retroactive accreditation is permissible as long as the effective date of accreditation is no earlier than the date on which the institution or program accepted the program or agency as an applicant on the pathway to accreditation, or the date of a previous negative decision regarding an initial award of accreditation. If an agency typically has a retroactive accreditation policy that establishes the effective date as the date of a site visit to the program or institution and that site visit has now been cancelled as a result of COVID-19, the effective date of the final decision could still be assigned based on the date of the scheduled site visit or an earlier date, but no earlier than the date on which the institution or program was accepted as an applicant on the pathway toward accreditation.

- To allow the flexibility that the current COVID-19 situation requires, the Department is waiving the normal process by which accrediting agencies are required to develop, seek public comment, and enact new policies for the limited purpose of allowing agencies to implement the changes described above (and in the earlier distance education communication), so long as the policy changes are approved by the agency’s board (or other decision-making body). The agency may obtain this approval at a telephonic or videoconference meeting of the board; this approval would not require a public comment period or a vote of the full membership during this period of temporary flexibility. Should an agency desire to make a policy or policy modification permanent after the period of COVID-19 interruption, it must adhere to applicable statutory and regulatory requirements.

- Agencies should record in writing and publish on their websites a decision to use the temporary flexibilities explained in this electronic announcement and include in its records the name of the school, a description of the waiver or extension, an explanation
of the basis for granting the waiver or extension, the date on which the agency granted the waiver or extension, and a description of the suspended activity resulting from the waiver or extension. Agencies should also record in writing the vote of its board (or other decision-making body) when establishing a new or revised policy in response to circumstances created by COVID-19.
RE: Information for Accrediting Agencies Regarding Temporary Flexibilities Provided to Coronavirus Impacted Institutions or Accrediting Agencies

The U.S. Department of Education (Department) has received inquiries from institutions of higher education and accrediting agencies regarding regulatory flexibilities that may be necessary in response to COVID-19 interruptions. Because of the highly unusual circumstances and challenges presented to the postsecondary education community by COVID-19, the Department provides the following guidance to accreditors, who should view this additional flexibility as a unique and temporary departure from the Department’s accreditation agency requirements.

In earlier COVID-19 information provided by the Department, we extended temporary flexibility to institutions to implement distance learning solutions to continue educating students in the event of campus interruptions or the unexpected return of students from travel abroad experiences. We similarly provided flexibility to accrediting agencies to waive routine regular distance learning review requirements and approval processes to allow institutions quickly to switch to distance learning so as to enable currently enrolled students to complete the current term.

As more campuses limit travel, reduce campus operations, or restrict visitors on campus, it may become difficult for accrediting agencies to perform site visits, including because the home institutions of site visitors have limited institutional travel. As a result, the Department announces the following temporary flexibilities to accrediting agencies to help them serve institutions and students through the period of COVID-19 interruption. The Department has determined that it is reasonable and prudent to permit on a temporary basis – but not require – accrediting agencies to perform virtual site visits during this period (even if their existing procedures do not provide for virtual visits). The agency board (or other decision-making body) should approve any change to policies governing virtual visits (or increased use of virtual visits) using the abbreviated process described at the end of this letter. If agencies implement virtual visits, they should follow-up with in-person visits to meet the statutory and regulatory requirements to perform regular on-site inspections. Virtual site visits should rely on an engaged, interactive format (e.g., telephonic meetings, video conference calls, and the like), rather than solely document reviews or exchanges of emails.
If an accreditor employs a virtual site visit, the agency must perform a follow-up, in-person visit to the campus (though not necessarily a full peer-review site visit) within a reasonable period of time following the virtual site visit. At its discretion, an accrediting agency may limit virtual site visits to institutions or programs that are otherwise in good standing or to institutions or programs that are engaged in renewal of accreditation, as opposed to those institutions or programs seeking an initial award of accreditation. It is the responsibility of the accreditation agency to determine if, and under what conditions, it would perform virtual site visits during this temporary flexibility period.

Moreover, during this period of COVID-19 interruption, the Department is permitting accreditors the flexibility to develop, adopt, modify, and implement temporary virtual site visit policies. With the approval of the agency’s board (or other decision-making body) during a telephonic or video conference meeting, accreditors may adopt or modify temporary virtual site visit policies without a public comment period. Because these policies would be temporary and arise from the unique set of circumstances and challenges presented by the COVID-19 interruption, this approval would not require a vote of the full membership of the accrediting agency. Should an agency desire to make a temporary virtual site visit policy or policy modification permanent after the period of COVID-19 interruption, it must adhere to applicable statutory and regulatory requirements.

The Department is also offering accrediting agencies the discretion to extend the term of accreditation, for a reasonable period of time during the COVID-19 interruption, for an institution that is undergoing renewal of accreditation and was scheduled to have a site visit during a COVID-19 interruption. In addition, during the COVID-19 interruption, accreditors may provide a good cause extension to institutions on a show-cause order or probation if the agency is unable to perform a required site visit or hold a hearing with representatives of the institution because of the COVID-19 interruption. This includes providing an additional good cause extension to an institution or program that has otherwise already been provided with the agency’s maximum allowable good cause extensions. The Department expects each agency to resume normal practices as soon as reasonably possible after the COVID-19 interruption has ended and will inform agencies of its expectations as the circumstances created by COVID-19 unfold.

Finally, the Department is aware that, in some instances, an accrediting agency may have scheduled a site visit of a program or institution such that the results of that site visit would inform an agency accreditation decision in time to ensure that students who graduate during the current or prior term will be considered to have graduated from an accredited program. The Department is reminding accrediting agencies that retroactive accreditation is permissible as long as the effective date of accreditation is no earlier than the date on which the institution or program accepted the program or agency as an applicant on the pathway to accreditation, or the date of a previous negative decision regarding an initial award of accreditation. If an agency typically has a retroactive accreditation policy that establishes the effective date as the date of a
site visit to the program or institution and that site visit has now been cancelled as a result of COVID-19, the effective date of the final decision could still be assigned based on the date of the scheduled site visit or an earlier date, but no earlier than the date on which the institution or program was accepted as an applicant on the pathway toward accreditation.

To allow the flexibility that the current COVID-19 situation requires, the Department is waiving the normal process by which accrediting agencies are required to develop, seek public comment, and enact new policies for the limited purpose of allowing agencies to implement the changes described above (and in the earlier distance education communication), so long as the policy changes are approved by the agency’s board (or other decision-making body). The agency may obtain this approval at a telephonic or videoconference meeting of the board; this approval would not require a public comment period or a vote of the full membership during this period of temporary flexibility. Should an agency desire to make a policy or policy modification permanent after the period of COVID-19 interruption, it must adhere to applicable statutory and regulatory requirements.

Agencies should record in writing and publish on their websites a decision to use the temporary flexibilities explained in this electronic announcement and include in its records the name of the school, a description of the waiver or extension, an explanation of the basis for granting the waiver or extension, the date on which the agency granted the waiver or extension, and a description of the suspended activity resulting from the waiver or extension. Agencies should also record in writing the vote of its board (or other decision-making body) when establishing a new or revised policy in response to circumstances created by COVID-19.

If you have any questions or concerns about the information provided in this electronic announcement, please contact the Department at COVID-19@ed.gov. Also, please visit our COVID-19 website (www.ed.gov/coronavirus) to monitor updates posted by the Department and to find links to information provided by other relevant Federal agencies, such as the Centers for Disease Control.

Thank you for continuing your work to ensure that students receive a quality education, including during this time when innovative solutions may be deployed by institutions rapidly to continue providing educational opportunities to their students.
# CODA Policies and Procedures Regarding Site Visit Process

## Evaluation and Operational Policies and Procedures

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I. SITE VISITS

The Commission on Dental Accreditation formally evaluates accredited programs at regular intervals. Comprehensive site visits based on a self-study are routinely conducted every seven years. Site visits of advanced dental education programs in oral and maxillofacial surgery are conducted at five year intervals.

Special site visits (which may be either focused or comprehensive in scope) are conducted when it is necessary for the Commission to review information about the program that can only be obtained or documented on-site. Information on special site visits is included elsewhere in this manual.

1. Overview And Accreditation Cycle: The Commission requires that each accredited program, or program seeking initial accreditation, conduct a self-analysis and submit a self-study report prior to its on-site review. Using the Commission’s self-study guide helps the program ensure that its self-study report addresses, assesses critically, and documents the degree of compliance with each of the accreditation standards and with the program’s own stated goals.

The Commission expects that one of the goals of a dental or dental-related educational program is to prepare qualified individuals in their respective disciplines. Accredited programs must design and implement their own outcomes measures to determine the degree to which stated goals and objectives are being met. Results of this ongoing and systematically documented assessment process must be used to evaluate the program’s effectiveness in meeting its goals, to improve program quality and to enhance student achievement.

All members of the visiting committee carefully review the self-study document prior to the on-site review. This initial assessment serves to identify areas where the program may not comply with the accreditation standards or to raise questions about information that is unclear. While on site, the visiting committee verifies the information provided in the self-study document and carefully assesses any unclear or problem areas. The verification process includes interviews with institutional personnel and review of program documentation. A recommendation is included in the report of the site visit when noncompliance with a standard is identified. If a particular standard is not addressed by the site visit report, the program is viewed as meeting that standard.

The site visit report, along with the institutional response to the report, serves as the Commission’s primary basis for accreditation decisions. The report also guides chief executive officers and administrators of educational institutions in determining the degree of the program’s compliance with the accreditation standards. The Commission, assisted by the visiting committees, identifies specific program deficiencies or areas of noncompliance with the standards, but it is the responsibility of the program to identify specific solutions or means of improvement.

2. Coordinated Site Visits: If an institution offers more than one dental education program, the Commission evaluates all programs during a single site visit whenever possible and may, at the program’s/institution’s request reduce the site visit date cycle to coordinate visitation to all programs at one time. Shared faculty, shared facilities and integrated curricula, as well as the time and expense
involved in preparing for a visit, are among the reasons for coordinated evaluations.

The Commission encourages the coordination of its evaluations with evaluations by regional and/or other nationally recognized accrediting associations. It will make every effort to coordinate its evaluations with those of other associations if requested to do so by an institution. The Commission has conducted simultaneous evaluations with regional accrediting associations such as the Commission on Colleges of the Southern Association of Colleges and Schools and other specialized agencies such as the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or with state accrediting agencies such as the State Education Department, the University of the State of New York Division of College and University Evaluation. If an institution wishes to coordinate accreditation activities, the Commission should be contacted well in advance of the projected time of the site visit.

Revised: 8/16; Reaffirmed: 8/19; 8/10

3. Institutional Review Process – Reminder Statement: The Commission on Dental Accreditation is recognized by the U.S. Department of Education (USDE) as an umbrella specialized accrediting agency for dental and dental-related disciplines. As a specialized accrediting agency, the Commission is responsible for the review of all dental, allied dental, and advanced dental educational programs. The Commission is also responsible for evaluating educational programs which are sponsored in a variety of educational settings, including hospitals. For this reason, when an institution sponsors multiple programs falling within the Commission’s accreditation purview, the institutional component is included as an integral part of the umbrella review process.

Although the Review Committees play a significant role in this broad-based review, the Commission has the final responsibility for ensuring that the impact of the programs on the sponsoring institution is considered.

Revised: 8/18; 7/97, 7/00; Reaffirmed: 8/19; 8/13; 8/10, 7/09, 1/03; CODA: 5/91:16, 1994

4. Policy On Cooperative Site Visits With Other Accreditors: The Commission encourages the coordination of its site visits with the accreditation reviews of other specialized or regional accrediting agencies. The Commission consults with institutional and program administrators to determine whether a coordinated visit can meet the accreditation needs of each agency involved in the visit. If so, a coordinated visit is scheduled. In order to protect the confidentiality of information gathered during the review, the cooperating agencies usually specify in advance the degree of access each will have to the other’s site visit documents and reports. Each visiting committee may develop its own report or certain sections of the report may meet the needs of the cooperating agencies.

The institution that sponsors the accredited program must request that a coordinated site visit be conducted. An offer to try to work cooperatively with other agencies is routinely included in the initial letter that announces an upcoming scheduled site visit by the Commission. If a request is received from the institution, the Commission contacts the other accrediting agencies. The agencies work together with the institution to attempt to develop a schedule or protocol that will meet the needs of both accrediting agencies and the institution.

The Commission requests the members of the visiting committees from other agencies sign the Commission’s Statement of Confidentiality in order to participate in interviews conducted by the Commission’s site visitors.
A reminder about the Commission’s willingness to conduct coordinated site visit is included periodically in the CODA Communicator e-newsletter.

Revised: 8/14; Reaffirmed: 8/19; 8/13; 8/10, 7/07, 7/01, 10/94, 6/92; CODA: 05/92:1, 2; 12/92:5

5. **Policy On Special Site Visits:** Special site visits are conducted when it is necessary for the Commission to review information about the program that can only be obtained or documented on-site. When necessary, special site visits are conducted to ensure the quality of the educational program, but are used selectively in order to avoid perceived harassment of programs. A special site visit may be either focused, limited to specified standards, or comprehensive, covering all accreditation standards. In making recommendations to the Commission for a special site visit, the Review Committee will indicate the specific standards or required accreditation policy in question. The Commission will communicate these concerns to the program in the letter transmitting the action related to a special site visit. If a comprehensive special visit will be conducted, the program must prepare a self-study prior to the visit. If a focused visit will be conducted, the program will be required to complete some portions of the self-study and/or to develop some other materials related to the specific standards or required policies that have been identified as areas of concern. With the exception of a special site visit due to falsification of information, all costs related to special site visits are borne by the program, including an administrative special focused site visit fee. (See Invoicing Process for Special Focused Site Visits)

The Commission may conduct a special site visit for any of the following reasons:

a. **Failure to document compliance:** A special site visit may be directed for an accredited program when, six (6) months prior to the time period allowed to achieve compliance through progress reports (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), the program has not adequately documented compliance with the accreditation standards. The special site visit will be focused on the recommendations contained in the site visit report. Recommendations for which supplemental information or documentation is submitted after the last progress report or special site visit report is reviewed by the appropriate Review Committee or the Commission and that in the Commission’s opinion requires on-site verification, shall be considered as not met for purposes of accreditation. Following the special site visit, if compliance is not demonstrated, the Commission will withdraw the program’s accreditation unless the Commission extends the period for achieving compliance for good cause.

b. **Change within a program:** A special site visit may be directed for an accredited program when a report of program change, review of annual survey data, or information received in other ways, indicates that changes in a program may have affected its ability to maintain compliance with the accreditation standards. The Commission may also request a special report from the involved program prior to conducting a special site visit. The Commission’s Policy on Reporting Program Changes in Accredited Programs found in Section V.C of this manual provides details.

c. **Investigating complaints:** A special site visit may be directed for an accredited program to investigate a complaint raising questions about the program’s compliance with the accreditation standards. The Commission’s Policy and Procedure Regarding Investigation of Complaints Against Educational Programs found in Section V.D of this manual provides details.

d. **Falsifying information:** A special site visit may be directed for an accredited program to investigate the possible intentional falsification of information provided to the Commission. The Commission’s policy on Integrity found in Section I.G provides details. The cost of such a special site visit is shared by the Commission and the program.

e. **Sites Where Educational Activity Occurs:** The Commission’s Policy Statement on Reporting and
Approval of Sites Where Educational Activity Occurs found in Section V.R provides details. 

f. Other reasons: A special site visit may, on occasion, be directed for an accredited program to respond to a request to the Commission from the chief executive officer or program administrator. The Commission may also direct that a focused site visit is necessary for just cause if it determines that a program may be unable to maintain compliance with the accreditation standards.

Revised: 8/19

**Invoicing Process for Special Focused Site Visits**

In advance of the special focused site visit, the program must remit payment for the Administrative Fee ($5,000 in 2020 and 2021) plus $1,500 per site visitor/staff attending visits up to two (2) days in length. Site visits that are three (3) or more days will be billed an additional $500 per site visitor/staff for each additional day; further, if additional airfare or transportation expenses are incurred, these will be assessed to the program. Failure to submit the special focused site visit fee in advance of the visit may result in a delay of the visit and additional rescheduling cost to the program, and may impact the program’s accreditation status. See Program Fee Policy.

Revised: 1/20; 8/19; 2/19; 2/18; 2/17; 8/16; 2/16; 8/14; 8/13; 1/00, 1/99, 1/98; Reaffirmed: 8/13; 8/10, 7/06; Adopted: 7/96

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**J. SITE VISITORS**

The Commission uses site visitors with education and practice expertise in the discipline or areas being evaluated to conduct its accreditation program. Nominations for site visitors are requested from national dental and dental-related organizations representing the areas affected by the accreditation process. Self-nominations are accepted. Site visitors are appointed by the Commission annually and may be re-appointed.

During the term of service as a Review Committee member, these individuals should not serve as site visitors for an actual accreditation site visit to an accredited or developing program, unless deemed necessary. Two instances when a review committee member could serve on a site visit include: 1) an inability to find a site visitor from the comprehensive site visitor list, or 2) when the review committee believes a member should attend a visit for consistency in the review process. This applies only to site visits that would be considered by the same review committee on which the site visitor is serving. Review committee members are prohibited from serving as independent consultants for mock accreditation purposes. These policies help avoid conflict of interest in the decision making process and minimize the need for recusals.

During the term of service as a commissioner, these individuals may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, site visitors serving on the Commission may not serve on a site visit team during their terms.

All other active site visitors who independently consult with educational programs accredited by CODA or applying for accreditation must identify all consulting roles to the Commission and must file with the Commission a letter of conflict acknowledgement signed by themselves and the institution/program with whom they consulted. All conflict of interest policies as noted elsewhere in this document apply. Contact the CODA office for the appropriate conflict of interest declaration form.
Prior to a site visit, a list of site visitors and other participants is reviewed by the institution/program for conflict of interest or any other potential problem. The program/institution being site visited will be permitted to remove individuals from the list if a conflict of interest, as described in the Commission’s Conflict of Interest Policy, can be demonstrated. Information concerning the conflict of interest must be provided in writing clearly stating the specifics of the conflict.

Site visitors are appointed by the Chair and approved by the institution’s administration, i.e. dental school dean or program director. The visiting committee conducts the site visit and prepares the report of the site visit findings for Commission action. The size and composition of a visiting committee varies with the number and kinds of educational programs offered by the institution. All visiting committees will include at least one person who is not a member of a Review Committee of the Commission or a Commission staff member. Two dental hygiene site visitors shall be assigned to dental school-sponsored dental hygiene site visits.

When appropriate, a generalist representative from a regional accrediting agency may be invited by the chief executive officer of an institution to participate in the site visit with the Commission’s visiting committee. A generalist advises, consults and participates fully in committee activities during a site visit. The generalist’s expenses are reimbursed by the institution. The generalist can help to ensure that the overall institutional perspective is considered while the specific programs are being reviewed.

The institution is encouraged to invite the state board of dentistry to send a current member to participate in the site visit. If invited, the current member of the state board receives the same background materials as other site visit committee members and participates in all site visit conferences and executive sessions. The state board of dentistry reimburses its member for expenses incurred during the site visit.

In addition to other participants, Commission staff member may participate on the visiting committee for training purposes. It is emphasized that site visitors are fact-finders, who report committee findings to the Commission. Only the Commission is authorized to take action affecting the accreditation status.

Revised: 8/19; 2/16; 8/14; 1/14; 1/03, 1/00, 7/97; Reaffirmed: 8/10, 7/09, 7/07, 7/06, 7/01; CODA: 07/96:10, 12/83:4

1. **Appointments:** All site visitor appointments are made annually for one year terms for a maximum of six consecutive years. Following the maximum appointment period of six consecutive years, the site visitor may reapply for appointment after one year. In exceptional circumstances the Review Committee may recommend that the Commission alter an individual’s term limits. Site visitors assist the Commission in a number of ways, including: developing accreditation standards, serving on special committees, and serving as site visitors on visits to predoctoral, advanced dental and allied dental education programs.

The Commission reviews nominations received from its communities of interest, including discipline-specific sponsoring organizations and certifying boards. Individuals may also self-nominate. In addition to the mandatory subject expertise, the Commission always requests nominations of potentially under-represented ethnic groups and women, and makes every effort to achieve a pool of site visitors with broad geographic diversity to help reduce site visit travel expenses.
Site visitors are appointed/reappointed annually and required to sign the Commission’s Conflict of Interest Statement, the Agreement of Confidentiality, the Copyright Assignment, Licensure Attestation, and the ADA’s Professional Conduct Policy and Prohibition Against Harassment. Site visitors must also complete annual training and will receive periodic updates on the Commission’s policies and procedures related to the Health Insurance Portability and Accountability Act (HIPAA). The Commission office stores these forms for seven (7) years. In addition, site visitors must comply with training requirements, the ADA’s travel policy and other CODA Rules and Regulations. The Commission may remove a site visitor for failing to comply with the Commission’s policies and procedures, continued, gross or willful neglect of the duties of a site visitor, or other just cause as determined by the Commission.

Subsequent to appointment/reappointment by the Commission, site visitors receive an appointment letter explaining the process for appointment, training, and scheduling of Commission site visitors.

Revised: 8/19; 8/18; 8/14; 7/08; Reaffirmed: 8/10, 1/98, 8/02; CODA: 07/94;9, 01/95:10

2. Criteria For Nomination Of Site Visitors: For predoctoral dental education programs, the Commission solicits nominations for site visitors from the American Dental Education Association to serve in five of six roles on dental education program site visits. The site visitor roles are Chair, Basic Science, Clinical Science, Curriculum, and Finance. Nominations for the sixth role, national licensure site visitor, are solicited from the American Association of Dental Boards.

For advanced dental education programs, the Commission solicits nominations for site visitors from the discipline-specific sponsoring organizations and their certifying boards.

For allied dental education programs, the American Dental Education Association is an additional source of nominations that augments, not supersedes, the nominations from the Commission’s other participating organizations, American Dental Assistants Association (ADAA), American Dental Hygienists’ Association (ADHA) and National Association of Dental Laboratories (NADL)

Revised: 8/18; 8/15; 8/14; 8/12; Reaffirmed: 8/19; 8/10, 7/07, 7/01; CODA: 05/93:6-7

The Commission requests all agencies nominating site visitors to consider regional distribution, gender and minority representation and previous experience as a site visitor. Although site visitors are nominated by a variety of sources, the Commission carefully reviews the nominations and appoints site visitors on the basis of need in particular areas of expertise. The pool of site visitors is utilized for on-site evaluations, for special consultations and for special or Review Committees.

All site visitors are appointed for a one-year term and may be re-appointed annually for a total of six consecutive years. Appointments are made at the Winter (January/February) Commission meeting and become effective with the close of the ADA annual session in the Fall.

Revised: 1/20; 8/19; 8/18; 8/14; 8/12, 7/09, 7/07, 7/01; Reaffirmed: 8/10; Adopted: 7/98

A. Predoctoral Dental Education: The accreditation of predoctoral dental education programs is conducted through the mechanism of a visiting committee. Membership on such visiting committees is general dentistry oriented rather than discipline or subject matter area oriented. The composition of such committees shall be comprised, insofar as possible, of site visitors having broad expertise in dental curriculum, basic sciences, clinical sciences, finance, national licensure (practitioner) and one Commission staff member. The evaluation visit is oriented to an assessment of the educational
program’s success in training competent general practitioners.

Although a basic science or clinical science site visitor may have training in a specific basic science or discipline-specific advanced dental education area, it is expected that when serving as a member of the core committee evaluating the predoctoral program, the site visitor serves as a general dentist. Further, it is expected that all findings, conclusions or recommendations that are to be included in the report must have the concurrence of the visiting committee team members to ensure that the report reflects the judgment of the entire visiting committee.

In appointing site visitors, the Commission takes into account a balance in geographic distribution as well as representation of the various types of educational settings and diversity. Because the Commission views the accreditation process as one of peer review, predoctoral dental education site visitors, with the exception of the national licensure site visitor, are affiliated with dental education programs.

The following are criteria for the six roles of predoctoral dental education site visitors:

Chair:
- Must be a current dean of a dental school or have served as dean within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission and as a previous site visitor.

Basic Science:
- Must be an individual who currently teaches one or more biomedical science courses to dental education students or has done so within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

Clinical Science:
- Must be a current clinical dean or an individual with extensive knowledge of and experience with the quality assurance process and overall clinic operations.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

Curriculum:
- Must be a current academic affairs dean or an individual with extensive knowledge and experience in curriculum management.
- Has served in the above capacity within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

Finance:
- Must be a current financial officer of a dental school or an individual with extensive knowledge of and experience with the business, finance and administration of a dental school.
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• Has served in the above capacity within the previous three (3) years.
• Should have accreditation experience through an affiliation with a dental education program accredited by the Commission or as a previous site visitor.

National Licensure:
• Should be a current clinical board examiner or have served in that capacity within the previous three (3) years.
• Should have an interest in the accreditation process.
  Revised: 8/18; 2/18; 2/16; 8/14; 1/99; Reaffirmed: 8/19; 8/10, 7/07, 7/01; CODA: 07/05, 05/77:4

B. Advanced Dental Education: In the disciplines of dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics, sponsoring organizations are advised that candidates recommended to serve as site visitors be board certified and/or have completed or participated in a CODA-accredited advanced dental education program in the discipline and must have experience in advanced dental education as teachers or administrators. Each applicable Review Committee will determine if board certification is required. Some sponsoring organizations have established additional criteria for their nominations to the Commission.

C. Allied Dental Education in Dental Hygiene: In appointing site visitors, the Commission takes into account a balance in geographic distribution, representation of the various types of educational settings, and diversity. Because the Commission views the accreditation process as one of peer review, the dental hygiene education site visitors are affiliated with dental hygiene education programs.

The following are criteria for selection of dental hygiene site visitors:
• a full-time or part-time appointment with a dental hygiene program accredited by the Commission on Dental Accreditation;
• a baccalaureate or higher degree;
• background in educational methodology;
• accreditation experience through an affiliation with a dental hygiene education program that has completed a site visit; and
• accreditation experience within the previous three (3) years.
  Revised: 8/18; 8/16; 8/14; Reaffirmed: 8/19; 8/10; Adopted: 7/09

D. Allied Dental Education in Dental Assisting: The following are criteria for selection of dental assisting site visitors:
• certification by the Dental Assisting National Board as a dental assistant;
• full-time or part-time appointment with a dental assisting program accredited by the Commission on Dental Accreditation;
• equivalent of three (3) years full-time dental assisting teaching experience;
• baccalaureate or higher degree;
• demonstrated knowledge of accreditation; and
• current background in educational methodology.
  Revised: 8/18; 8/16; 8/14; 2/13, 1/08, 1/98, 2/02; Reaffirmed: 8/19; 8/10, 7/08; CODA: 07/95:5
E. Allied Dental Education in Dental Laboratory Technology: The following are criteria for selection of dental laboratory technology site visitors:
   - background in all five (5) dental laboratory technology specialty areas: complete dentures, removable dentures, crown and bridge, dental ceramics, and orthodontics;
   - background in educational methodology
   - knowledge of the accreditation process and the Accreditation Standards for Dental Laboratory Technology Education Programs;
   - Certified Dental Technician (CDT) credential through the National Board of Certification (NBC); and
   - full or part-time appointment with a dental laboratory technology education program accredited by the Commission on Dental Accreditation or previous experience as a Commission on Dental Accreditation site visitor.

   Revised: 8/18; 8/14; Reaffirmed: 8/19; 8/10; Adopted: 07/09

F. Allied Dental Education in Dental Therapy: The following are criteria for selection of dental therapy site visitors:
   - a full-time or part-time appointment with a predoctoral dental or allied dental education program accredited by the Commission on Dental Accreditation or an accredited (or recognized) dental therapy program;
   - a baccalaureate or higher degree;
   - background in educational methodology;
   - accreditation experience through an affiliation with a dental therapy, allied, or predoctoral dental program that has completed a site visit;*
   - accreditation experience within the previous three (3) years;*
   - must either be a licensed dentist educator (general dentist) or licensed dental therapist educator; and
   - the “licensed dentist educator” may be predoctoral dental educator site visitors (i.e., a general dentist educator who serves as curriculum or clinical predoctoral site visitor) or allied dental educator site visitors.
   *

   *temporarily waived for dental therapist educator position until after CODA accredits dental therapy education programs

   Revised: 8/18; 8/16; Reaffirmed: 8/19; Adopted: 02/16

3. Policy Statement On Site Visitor Training: The Commission has a long history of a strong commitment to site visitor training and requires that all program evaluators receive training. Prior to participation, site visitors must demonstrate that they are knowledgeable about the Commission’s accreditation standards and its Evaluation and Operational Policies and Procedures. Initial and ongoing training takes place in several formats.

New site visitors must attend a two-day formal workshop that follows the format of an actual site visit. All new site visitors are directed to the Commission’s on-line training program and are required to successfully complete the training program and site visitor final assessment.

Site visitor update sessions take place at several dental-related meetings, such as the annual session of the American Dental Education Association (ADEA), the American Association of Oral and Maxillofacial Surgeons and the ADEA Allied Dental Program Directors’ Conference. The Commission may entertain requests from other organizations. Components from the workshop are sometimes presented at these
meetings; however, the primary purpose of the update sessions is to inform site visitors about recent Commission activities, revisions to standards and newly adopted policies and procedures.

Keeping costs in mind, the Commission continually explores new methods of providing initial and ongoing training to site visitors, as well as ensuring their ongoing competence and calibration. Methods being examined include on-line materials, virtual webinars (synchronous and/or asynchronous), broadcast e-mails and other self-instructional materials.

The Commission emphasizes its increased commitment to quality training for site visitors. While the Commission sponsors comprehensive training for new site visitors and provides updates for site visitors on a regular basis, all parent organizations are urged to provide support for CODA-sponsored training to augment the Commission’s programs. All active site visitors must complete mandatory annual web-based retraining in order to retain appointment.

Revised: 8/20; 8/19; 2/19; 8/14; 8/10, 7/06, 7/00, 1/98; Reaffirmed: 7/07, 7/01, 7/96; CODA: 01/94:9

4. Job Descriptions For Predoctoral Dental Education Visiting Committee Members:

A. Chair:
   • Will conduct a briefing session with the entire visiting committee relative to the philosophy of the Commission on the approach, purpose and methodology of the conduct of the site visit on the evening prior to the first day of the site visit;
   • Will be responsible for the continual reinforcement of the above concepts during the course of the site visit and for monitoring continually the conduct of the site visit;
   • Will brief visiting committee members as to their role as a fact-finding and reporting committee and the appropriate protocol during the course of the site visit; including what is expected of each member in terms of kinds of activities and relative to the report of findings and conclusions and recommendations, with adequate background rationale for making recommendations and enumerating strengths and weaknesses in the education program being evaluated;
   • Will lead all assigned conferences and executive sessions;
   • Will serve as liaison between the visiting committee members and the dental administration and the executive administrators of the institution;
   • Will make specific and special assignments to individual visiting committee members relative to evaluating and reporting on specific matters and sections of the site visit report, e.g. administrative organization, faculty, library facilities and resources, research program, facilities and equipment, admission process, hospital program(s), student achievement;
   • Will be responsible for ensuring that site visitors fully understand their responsibility for reporting adequately, but succinctly, in their area of expertise (finance, curriculum, basic sciences, clinical sciences and national licensure);
   • Will consult with the dental administration at regular intervals to discuss progress of the visit;
   • Will be responsible, during executive sessions with visiting committee members, for the separation of recommendations from suggestions—focusing upon the recommendations which are to be included in the site visit report which are considered to be major, critical and essential to the conduct of the education program(s); suggestions for program enhancement are to be included as part of the narrative of the report;
   • Will be responsible for the preparation of a written summary of the visiting committee’s
conclusions, findings, perceptions and observations of the program(s)’ in the form of suggestions and recommendations, as appropriate, for oral presentation during the exit interview with the Dean, and for presentation of an abbreviated summary during the exit interview with the institution’s executive administrators.

- Will assess institutional effectiveness including:
  - Assessment of the school’s mission statement;
  - Assessment and evaluation of the school’s planning, and achievement of defined goals related to education, patient care, research and service;
  - Assessment of the school’s outcomes assessment process; and
  - Evaluation of the school’s interaction with other components of higher education, health care education or health care delivery systems.

- Will assess the effectiveness of faculty and staff including:
  - Assessment of the number and distribution of faculty in meeting the school’s stated objectives;
  - Assessment of the school’s faculty development process;
  - Assessment of the school’s faculty governance;
  - Assessment of the school’s measurement of faculty performance in teaching, patient care, scholarship and service; and
  - Assessment of the school’s promotion and tenure process.

B. Financial Site Visitor: Will confer with the sponsoring institution’s chief financial officer(s) and the dental administration and its financial manager to assess the adequacy of the full spectrum of finance as it relates to the dental school including:

- Assessment of the operating budget and budgeting process;
- Assessment of all sources of revenue (state, federal, tuition and fees, practice plans, etc.);
- Evaluation of the maintenance of the facilities and learning resources to support the school’s mission and goals;
- Assessment of the school’s compliance with applicable regulations;
- Assessment of the resources for planned and/or future renovations and/or new construction; and
- Assessment of the school’s resources as they relate to its mission and goals.

C. Curriculum Site Visitor: Will examine the education program and the education support services including:

- Admissions
- Instruction
- Curriculum Management
- Behavioral Sciences
- Practice Management
- Ethics and Professionalism
- Information Management and Critical Thinking
- Student Services

D. Basic Science Site Visitor: Will work closely with curriculum site visitor to ensure consistency of evaluation and assessment. During the formal and informal evaluation of the basic sciences, the site visitor will conduct personal interviews with students, faculty and departmental Chairs and during the assessment will focus on:

- Biomedical Sciences
- Research Program
E. Clinical Sciences Site Visitor: Within the limitations imposed by the length of the site visit, will examine and evaluate the preclinical and clinical portions of the predoctoral dental education program and activities in terms of the details of what is occurring in these areas and assess the quality of the education and experiences provided to students to prepare them for dental practice. Will work closely with curriculum site visitor to ensure consistency of evaluation and assessment. During the formal and informal evaluation of the preclinical and clinical sciences, will conduct personal interviews with students, faculty and departmental chairs and during the assessment will focus upon:

- Clinical Sciences
- Patient Care Services
- During the formal and informal evaluation of the clinical program, will conduct personal interviews with students, faculty and departmental chairs and during the assessment will focus upon:
  - stated objectives;
  - adequacy of instruction;
  - appropriateness of subject matter;
  - intra/extra-mural experiences;
  - student clinic requirements;
  - student performance evaluation mechanisms;
  - sterilization of instruments;
  - patient care policies;
  - laboratory tests for patients;
  - patient physical examinations; and
  - clinic administration.

F. National Licensure (Practitioner) Site Visitor: Will serve in the same capacity as the clinical sciences site visitor on the visiting committee.

Revised: 8/14; 7/07; Reaffirmed: 8/19; 8/10, 7/05; Adopted: 7/96; CODA: 01/99:1

5. Job Description For Advanced Dental Education Site Visitors: Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery (Residency and Fellowship), Orthodontics and Dentofacial Orthopedics (Residency and Fellowship), Pediatric Dentistry, Periodontics, Prosthodontics (Combined and Maxillofacial), and Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, Orofacial Pain, and Dental Anesthesiology. Advanced dental education program site visitors will utilize the site visitors’ evaluation report form for their respective area, conduct personal interviews with Program Directors, faculty and students, and assess the advanced dental education program focusing upon:

- administration and staff;
- admissions procedures;
- physical facilities and equipment;
- didactic program (biomedical, lecture, seminar and conference program)
- clinical program;
- evaluation of residents;
- research activities and requirements;
- library resources;
- intra/extra-mural experiences;
- hospital program; and
- teaching conducted by residents.

An assessment of the strengths and weaknesses of the advanced dental education program is based upon the published accreditation standards for each respective program.

Revised: 8/18; 8/14; 7/07, 7/99, 7/00; Reaffirmed: 8/19; 8/10, 7/01; CODA: 11/87

6. **Job Description For Allied Dental Education Site Visitors:**

   **A. Site Visit Chair**
   - Will function as chair/staff representative of visiting committee of site visitors evaluating the allied dental education programs in dental assisting, dental hygiene, dental therapy and dental laboratory technology;
   - Will be responsible for the continual reinforcement of the Commission’s procedures to be used for the site visit and for monitoring continually the conduct of the visit;
   - Will brief site visitors as to their role as a fact finding and reporting committee and the appropriate protocol during the course of the site visit; including what is expected of each site visitor in terms of kinds of activities and relative to the report of findings and conclusions and recommendations, with adequate background rationale for making recommendations and enumerating strengths and weaknesses in the education program being evaluated;
   - Will chair all conferences and meetings of the allied dental visiting committee, as well as those which occur during the visiting committee’s executive sessions;
   - Will be responsible for maintaining closely the site visit evaluation schedule;
   - Will serve as liaison between the visiting committee and the allied dental visiting committee members;
   - Will make specific and special assignments to individual visiting committee members relative to evaluating and reporting on specific matters and sections of the site visit report, e.g. administrative organization, faculty, library facilities and resources, research program facilities and equipment, admissions process, hospital program(s), student achievement;
   - Will be responsible for ensuring that site visitors fully understand their responsibility for reporting adequately, but succinctly, in their area of expertise;
   - Will consult with the allied dental administration at regular intervals to discuss progress of the visit;
   - Will be responsible, during executive sessions with visiting committee members, for the separation of recommendations from suggestions – focusing upon the recommendations which are to be included in the site visit report which are considered major, critical and essential to the conduct of the education program(s). Suggestions for program enhancement are to be included as part of the narrative of the report; and
   - Will be responsible for the preparation of a written summary of the visiting committee’s conclusions, finding, perceptions and observations of program(s) strengths, weaknesses, recommendations and suggestions for oral presentation during the exit interview with the dean, and for presentation of an abbreviated summary during the exit interview with the institution’s executive administrators.

   **B. Dentist:** A dentist is also included, when at all possible, on site visits to dental assisting and dental hygiene programs in settings other than dental schools. An additional dentist site visitor will be added to dental school visiting committees when multiple programs are to be reviewed.
The role of the dentist team member during allied site visits includes the following responsibilities:

- Take notes during conferences;
- Conduct meeting with advisory committee, when applicable;
- Ensure confidentiality by waiting to begin the meeting until all affiliated school personnel have left the room;
- Introduce the visiting committee to the advisory committee members;
- Thank the members of the committee for meeting with the team and for their interest in and commitment to the specific allied program(s);
- Explain the purpose of the site visit;
- Discuss the Commission’s policy on confidentiality as it applies to the meeting and the entire site visit;
- Begin discussion of the following topics/questions:
  a. How often the committee meets and the purpose or goals of the committee
  b. Strengths/weaknesses of the students
  c. Specific current committee activities and future goals or anticipated activities
- Ensure that all of the questions in the Site Visit Evaluation Report form under Standard 1, Institutional Effectiveness, Community Resources are answered during the meeting;
- Assist Curriculum site visitor in review of science courses;
- Review clinical courses and clinical evaluation mechanisms;
- Review learning resources – library & audiovisual materials/equipment (It is usually most efficient for this review to be conducted by the dentist site visitor only.);
- Review documentation in the self-study prior to visit;
- Conduct preclinical, clinical, and/or laboratory observations (on/off campus) with Curriculum site visitor;
  a. Extended campus laboratory facilities
  b. Extramural clinical facilities
- Review equipment and instruments using Site Visit Evaluation Report Checklist under Standard 4, Educational Support Services;
- Formulate recommendations and suggestions; and
- After the visit, review and critique preliminary draft of the site visit report.

Revised: 2/16; 8/14; 7/07, 7/00, 7/99; Reaffirmed: 8/19; 8/10, 7/01; Adopted: 10/94, 11/87; CODA: 05/86:10

7. **Role Of Observers On A Site Visit:** Commissioners, Review Committee members, and public members of the Commission or Review Committees that have not participated as a site visitor are encouraged to participate on site visits as observers in order to become familiar with the accreditation process. The observer must not have a conflict of interest with the institution. This individual must be approved to participate in the site visit by the institution, receives all self-study materials from the institution and background information from the Commission prior to the site visit. This individual participates during all site visit conferences and executive sessions as a non-voting member of the site visit committee. As a participant of the site visit, it is expected that this individual will remain with the designated site visit team members at all times during the visit. The chairperson of the site visit committee has the right to excuse and/or exclude the observer from any or all aspects of the site visit for improper and/or unprofessional behavior.

Reaffirmed: 8/19; Adopted: 8/10
K. POLICY ON SILENT OBSERVERS ON SITE VISITS

In order to facilitate a better understanding of the accreditation and site visit processes, any dental education program scheduled for a site visit of its program, may request the opportunity to send one administrator or faculty member as a silent observer to a Commission site visit. Representatives of international programs may also participate as a silent observer on a Commission site visit. The silent observer visit will be scheduled one to two years before the scheduled site visit of the observer’s program. The program being observed has the right to approve the designated observer. Requests for a faculty member or administrator to observe the site visit of another program are managed according to when the observer’s site visit is scheduled. Requests for the opportunity to have a faculty member or administrator observe a site visit are made through a letter from the chief administrative officer (dean, chair, chief of dental service) of the program. While the observer may request to observe a specific site visit, Commission staff will make the final determination based upon the site visit schedule and availability of observation opportunities. Generally, a program is provided one opportunity to send an observer to a site visit. The observer’s program pays all expenses for such an observer.

The observer receives all self-study materials and is allowed to observe all interviews and meetings, but does not attend the briefing at the end of each day. The observer must remain silent during all sessions where university and/or program officials, faculty, staff or students are present at the site visit. The observer is encouraged to ask questions of the visiting committee during executive session meetings only but does not participate in decision-making discussions. As an observer of the site visit, it is expected that this individual will remain with the designated site visit team members at all times during the visit.

All observers must sign the Commission’s Agreement of Confidentiality prior to the site visit. The chair of the site visit committee has the right to excuse and/or exclude the observer from any or all aspects of the site visit for improper and/or unprofessional behavior. The chair’s decision to remove or exclude an observer from the site visit cannot be appealed.

A representative of the state dental society may attend a comprehensive dental school site visit as a silent observer, if requested by the society and approved by the institution.

Revised: 2/16; 8/14; 8/13; 2/13, 07/98:2, 01/94:2, 05/93:1-2, 12/92:3; Reaffirmed: 8/19; 8/10, 7/07, 7/01

L. POLICY ON STATE BOARD PARTICIPATION DURING SITE VISITS

It is the policy of the Commission on Dental Accreditation that the state board of dentistry is notified when an accreditation visit will be conducted in its jurisdiction. The Commission believes that state boards of dentistry have a legitimate interest in the accreditation process and, therefore, strongly urges institutions to invite a current member of the state board of dentistry to participate in Commission site visits. The Commission also encourages state boards of dentistry to accept invitations to participate in the site visit process.
If a state has a separate dental hygiene examining board, that board will be contacted when a dental hygiene program located in that state is site visited. In addition, the dental examining board for that state will be notified.

The following procedures are used in implementing this policy:

1. Correspondence will be directed to an institution notifying it of a pending accreditation visit and will include a copy of Commission policy on state board participation. The institution is urged to invite the state board to send a current member. The Commission copies the state board on this correspondence.

2. The institution notifies the Commission of its decision to invite/not invite a current member of the state board. If a current member of the state board is to be present, s/he will receive the same background information as other team members.

3. If it is the decision of the institution to invite a member of the state board, Commission staff will contact the state board and request the names of at least two of its current members to be representatives to the Commission.

4. The Commission provides the names of the two state board members, to the institution. The institution will be able to choose one of the state board members. If any board member is unacceptable to the institution, the Commission must be informed in writing.

5. The state board member, if authorized to participate in the site visit by the institution, receives the self-study document from the institution and background information from the Commission prior to the site visit.

6. The state board member must participate in all days of the site visit, including all site visit conferences and executive sessions.

7. In the event the chair of the site visit committee determines that a vote is necessary to make a recommendation to the Commission, only team members representing the Commission will be allowed to vote.

8. The state board reimburses its member for expenses incurred during the site visit.

The following statement was developed to assist state board members by clearly indicating their role while on-site with an accreditation team and what they may and may not report following a site visit. The statement is used on dental education, advanced dental education and allied dental education site visits.

The state board member participates in an accreditation site visit in order to develop a better understanding of the accreditation site visit process and its role in ensuring the competence of graduates for the protection of the public. The dental, advanced dental and allied dental education programs are evaluated utilizing the Commission's approved accreditation standards for each respective discipline.

The state board member is expected to be in attendance for the entire site visit, including all scheduled conferences and during executive sessions of the visiting committee. While on site the state board member:

- provides assistance in interpreting the state’s dental practice act and/or provides background on other issues related to dental practice and licensure within the state.
- on allied dental education visits: assists the team in assessing the practice needs of employer-dentists in the community and in reviewing those aspects of the program which may involve the delegation of expanded functions.
on dental school visits: functions primarily as a clinical site visitor working closely with the clinical specialist member(s) who evaluate the adequacy of the preclinical and clinical program(s) and the clinical competency of students.

Following the site visit, state board members may be asked to provide either a written or oral report to their boards. Questions frequently arise regarding what information can be included in those reports while honoring the Agreement of Confidentiality that was signed before the site visit. The following are some general guidelines:

- **What You May Share:**
  - Information about the Commission’s accreditation standards, process and policies.

- **What You May Not Share:**
  - The school’s self-study;
  - Previous site visit reports and correspondence provided to you as background information;
  - Information revealed by faculty or students/residents during interviews and conferences;
  - The verbal or written findings and recommendations of the visiting committee; and
  - Any other information provided in confidence during the conduct of an accreditation visit.

The Commission staff is available to answer any questions you may have before, during or after a site visit.

Revised: 7/09, 1/00; Reaffirmed: 8/19, 8/10, 7/07, 7/04, 7/01, 12/82, 5/81, 12/78, 12/75; Adopted: 8/86

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**M. SITE VISIT PROCEDURES**

The basic purpose of the site visit is to permit peers to assess a program’s compliance with the accreditation standards and with its own stated goals and objectives. Information provided in the self-study is confirmed, documentation is reviewed, interviews are conducted and the programs are observed by the visiting committee. Information related to the site visit is viewed as confidential. Therefore, no audio, video or other type of recording of the site visit is permitted. The Commission’s policy on confidentiality, elsewhere in this document, gives more specific information about the degree of confidentiality extended to various materials.

The Commission recognizes that there is considerable latitude in determining procedures and methodology for site visits. Experience has shown that the conference method for conducting a site visit is widely favored and effective. Conferences are scheduled with identified administrators, faculty and students at specified times.

In all cases, the recommendations of the dean or program director determine protocol to be followed during conferences with chief executive officers of the parent institution and/or their appointed representatives. Program administrators are excused during conferences scheduled with faculty members, students or other invitees.

In addition to formal scheduled conferences, committee members may informally discuss department and division programs with chairs and faculty members throughout the site visit. The visiting committee
chair will make every effort to schedule hearings with any individual or group of individuals wishing to present information about a program.

Executive sessions of the visiting committee are a critical part of the on-site evaluation process. These sessions are scheduled at intervals during the day and evening and provide time for the committee to meet privately to prepare its findings and recommendations.

Oral comments made by site visit team members during the course of the site visit are not to be construed as official site visit findings unless documented within the site visit report and may not be publicized. Further, publication of site visit team members’ names and/or contact information is prohibited.

Revised: 8/18; 2/16; Reaffirmed: 8/19; 8/10

1. Duration Of Site Visits: Predoctoral dental education program and initial accreditation (pre-enrollment) site visits are scheduled for 2.5 days. Advanced and allied dental education programs evaluated during a comprehensive dental school visit are 1.5 days.

Single-discipline advanced dental education program site visits scheduled outside of a comprehensive dental school visit are 1 day in length. Multi-discipline advanced dental education site visits conducted outside of a comprehensive dental school visit are 1.5 days in length. Initial accreditation (pre-enrollment) site visits are typically 1 day in length.

Allied dental education site visits scheduled outside of a comprehensive dental school visit are of varying length based on the number of programs to be evaluated. All single discipline visits are 1.75 days. All multiple visit site visits are 2.5 days. Initial accreditation (pre-enrollment) site visits are typically 1.5 days.

Additional time can be added to any educational program site visit if additional training sites will be evaluated or if other cause exists.

Revised: 8/18; 2/16; 8/14; 7/01; Reaffirmed: 8/19; 8/10, 7/07; CODA: 07/95:3

2. Final Conferences: It is the visiting committee’s responsibility to prepare and present an oral summary of its findings to the dean, chief of dental service, program director(s) and the institutional executives. Two separate conferences are scheduled at the end of every visit, one with the program director(s) and chief of dental service or dental dean and one with the chief executive officer(s) of the institution.

During these conferences, the committee presents the findings it will submit to the Commission. These findings address both program strengths and weaknesses. The committee also informs individuals in charge of the program(s) about the Commission’s procedures for processing and acting on the report. In keeping with the Commission’s policy on Public Disclosure and Confidentiality, these final conferences are not recorded on tape or by stenographer. Note taking, however, is permitted and encouraged.

Site visitors or any other participants are not authorized, under any circumstances, to disclose any information obtained during site visits. For more specific information, see the Commission’s Statement of Policy on Public Disclosure and Confidentiality.
3. **Rescheduling Dates Of Site Visits:** In extraordinary circumstances the Commission staff can reschedule the site visit if the program will be reviewed within the same calendar year. Commission staff can also reschedule the site visit to an earlier year to coincide with other programs at the institution. If the site visit would occur in a later year because of the rescheduling, the request must be considered and acted on by the Commission. In general, the Commission does not approve such requests, but it does review each request on a case-by-case basis. Should a site visit be changed the term of the accreditation will remain unchanged.

4. **Enrollment Requirement For Site Visits For Fully Developed Programs:** Site visit evaluations of dental, allied dental and advanced dental education programs will be conducted at the regularly established intervals, provided that students are enrolled in at least one year of the program. If no students are enrolled on the established date for the site visit, the visit will be conducted when students are enrolled, preferably in the latter part of the final year prior to graduation. (Refer to the Policy on Non-enrollment of First Year Students)

5. **Post-Site Visit Evaluation:** After each site visit, electronic evaluation forms are completed by the visited program and the participating site visitors to give the Commission feedback on the effectiveness of its processes and procedures. In addition, site visitors electronically evaluate their fellow site visitors and the visited programs electronically evaluate the individual site visitors.

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**D. CONFLICT OF INTEREST POLICY**

Evaluation policies and procedures used in the accreditation process provide a system of checks and balances regarding the fairness and impartiality in all aspects of the accreditation process. Central to the fairness of the procedural aspects of the Commission’s operations and the impartiality of its decision making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one’s duty to make decisions in the public’s interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be: 1) any relationship with an institution or program, or 2) a partiality or bias, either of which might interfere with objectivity in the accreditation review process. Procedures for selection of representatives of the Commission who participate in the evaluation process reinforce impartiality. These representatives include: Commissioners, Review Committee members, site visitors, and Commission staff.

In addition, procedures for institutional due process, as well as strict guidelines for all written documents and accreditation decisions, further reinforce adherence to fair accreditation practices. Every effort is
made to avoid conflict of interest, either from the point of view of an institution/program being reviewed or from the point of view of any person representing the Commission.

On occasion, current and former volunteers involved in the Commission’s accreditation process (site visitors, review committee members, commissioners) are requested to make presentations related to the Commission and its accreditation process at various meetings. In these cases, the volunteer must make it clear that the services are neither supported nor endorsed by the Commission on Dental Accreditation. Further, it must be made clear that the information provided is based only on experiences of the individual and not being provided on behalf of the Commission.

Revised: 8/15; 8/14; Reaffirmed: 8/18; 2/18; 8/12, 8/10

1. **Visiting Committee Members:** Conflicts of interest may be identified by either an institution/program, Commissioner, site visitor or Commission staff. An institution/program has the right to reject the assignment of any Commissioner, site visitor or Commission staff because of a possible or perceived conflict of interest. The Commission expects all programs, Commissioners and/or site visitors to notify the Commission office immediately if, for any reason, there may be a conflict of interest or the appearance of such a conflict.

All active site visitors who independently consult with educational programs accredited by CODA or applying for accreditation must identify all consulting roles to the Commission and must file with the Commission a letter of conflict acknowledgement signed by themselves and the institution/program with whom they consulted. All conflict of interest policies as noted elsewhere in this document apply. Contact the CODA office for the appropriate conflict of interest declaration form.

Conflicts of interest include, but are not limited to, a site visitor who:

- is a graduate of a program at the institution;
- has served on the program’s visiting committee within the last ten (10) years;
- has served as an independent consultant, employee or appointee of the institution;
- has a family member who is employed or affiliated with the institution;
- has a close professional or personal relationship with the institution/program or key personnel in the institution/program which would, from the standpoint of a reasonable person, create the appearance of a conflict;
- manifests a partiality that prevents objective consideration of a program for accreditation;
- is a former employee of the institution or program;
- previously applied for a position at the institution within the last five (5) years;
- is affiliated with an institution/program in the same state;
- is a resident of or owns property in the state; and/or
- is in the process of considering, interviewing and/or hiring key personnel at the institution.

Note: Because of the nature of their positions, a state board representative will be a resident of the state in which a program is located and may be a graduate of the institution/program being visited. These components of the policy do not apply for state board representatives, although the program retains the right to reject an individual’s assignment for other reasons.
If an institutional administrator, faculty member or site visitor has doubt as to whether or not a conflict of interest could exist, Commission staff should be consulted prior to the site visit. The Chair, Vice-Chair and a public member of the Commission, in consultation with Commission staff and legal counsel, may make a final determination about such conflicts.

Revised: 8/18; 2/18; 2/16; 8/14; 1/14; 2/13; 8/10; Reaffirmed: 8/12

2. Commissioners, Review Committee Members And Members Of The Appeal Board: The Commission firmly believes that conflict of interest or the appearance of a conflict of interest must be avoided in all situations in which accreditation recommendations or decisions are being made by Commissioners, Review Committee members, or members of the Appeal Board. No Commissioner, Review Committee member, or member of the Appeal Board should participate in any way in accrediting decisions in which he or she has a financial or personal interest or, because of an institutional or program association, has divided loyalties and/or has a conflict of interest on the outcome of the decision.

During the term of service as a Review Committee member, these individuals should not serve as site visitors for an actual accreditation site visit to an accredited or developing program, unless deemed necessary. Two instances when a review committee member could serve on a site visit include: 1) an inability to find a site visitor from the comprehensive site visitor list, or 2) when the review committee believes a member should attend a visit for consistency in the review process. This applies only to site visits that would be considered by the same review committee on which the site visitor is serving. Review committee members may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, review committee members may not serve as a site visitor for mock accreditation purposes. These policies help avoid conflict of interest in the decision making process and minimize the need for recusals.

During the term of service as a commissioner or appeal board member, these individuals may not independently consult with a CODA-accredited program or a program applying for CODA accreditation. In addition, Commissioners or appeal board may not serve on a site visit team during their terms. Areas of conflict of interest for Commissioners, Review Committee members and/or members of the Appeal Board include, but are not limited to:

- close professional or personal relationships or affiliation with the institution/program or key personnel in the institution/program which may create the appearance of a conflict;
- serving as an independent consultant or mock site visitor to the institution/program;
- being a graduate of the institution/program;
- being a current employee or appointee of the institution/program;
- previously applied for a position at the institution within the last five (5) years;
- being a current student at the institution/program;
- having a family member who is employed by or affiliated with the institution;
- manifesting a professional or personal interest at odds with the institution or program;
- key personnel of the institution/program having graduated from the program of the Commissioner, Review Committee member, or member of the Appeal Board;
- having served on the program’s visiting committee within the last ten (10) years; and/or
- no longer a current employee of the institution or program but having been employed there within the past ten (10) years.
To safeguard the objectivity of the Review Committees, conflict of interest determinations shall be made by the Chair of the Review Committee. If the Chair, in consultation with a public member, staff and legal counsel, determines that a Review Committee member has a conflict of interest in connection with a particular program, the Review Committee member will be instructed to not access the report either in advance of or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any committee member who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Commission, conflict of interest determinations shall be made by the Chair of the Commission. If the Chair, in consultation with a public member, staff and legal counsel, determines that a Commissioner has a conflict of interest in connection with a particular program, the Commissioner will be instructed to not access the report either in advance of or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any Commissioner who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Appeal Board, any member who has a conflict of interest in connection with a program filing an appeal must inform the Director of the Commission. The Appeal Board member will be instructed to not access the report for that program either in advance of or at the time of the meeting, and the individual must leave the room when the program is being discussed. If necessary, the respective representative organization will be contacted to identify a temporary replacement Appeal Board member.

Conflicts of interest for Commissioners, Review Committee members and members of the Appeal Board may also include being from the same state, but not the same program. The Commission is aware that being from the same state may not itself be a conflict; however, when residence within the same state is in addition to any of the items listed above, a conflict would exist. This provision refers to the concept of conflict of interest in the context of accreditation decisions. The prohibitions and limitations are not intended to exclude participation and decision-making in other areas, such as policy development and standard setting.

Commissioners are expected to evaluate each accreditation action, policy decision or standard adoption for the overall good of the public. The American Dental Association (ADA) Constitution and Bylaws limits the involvement of the members of the ADA, the American Dental Education Association and the American Association of Dental Boards in areas beyond the organization that appointed them. Although Commissioners are appointed by designated communities of interest, their duty of loyalty is first and foremost to the Commission. A conflict of interest exists when a Commissioner holds appointment as an officer in another organization within the Commission’s communities of interest. Therefore, a conflict of interest exists when a Commissioner or a Commissioner-designee provides simultaneous service to the Commission and an organization within the communities of interest. (Refer to Policy on Simultaneous Service)
3. **Commission Staff Members**: Although Commission on Dental Accreditation staff does not participate directly in decisions by volunteers regarding accreditation, they are in a position to influence the outcomes of the process. On the other hand, staff provides equity and consistency among site visits and guidance interpreting the Commission’s policies and procedures.

For these reasons, Commission staff adheres to the guidelines for site visitors, within the time limitations listed and with the exception of the state residency, including:

- graduation from a program at the institution within the last five years;
- service as a site visitor, employee or appointee of the institution within the last five years; and/or
- close personal or familial relationships with key personnel in the institution/program.

Revised: 8/14; 8/10, 7/09, 7/07, 7/00, 7/96, 1/95, 12/92; Reaffirmed: 8/18; 8/12, 1/03; Adopted: 1982

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**E. CONFIDENTIALITY POLICY**

All materials generated and received in the accreditation process are confidential. In all instances Protected Health Information (PHI), Personally Identifiable Information (PII) and student/resident/fellow identifying information must not be improperly disclosed. The Commission’s confidentiality policies apply to Commissioners, Review Committee members, members of the Appeal Board, and site visitors. Confidential materials are maintained to ensure the integrity of the institution/program and of the accreditation process, and may be shared by the Commission in instances related to USDE re-recognition or responding to state or federal legal requirements, as appropriate. Because of the confidential nature of the accreditation process, the Commission identifies three (3) points of contact with whom Commission staff is authorized to communicate, either in writing or verbally. These individuals are designated by the sponsoring institution and include the chief executive officer (university president/chancellor/provost or medical center director), the chief academic officer (dean/academic dean/chair/chief of dental service, etc.), and the program director. Commission staff is not authorized to discuss program-specific situations or share confidential material with any other individual(s).

Confidentiality applies without limitation, to the following:

**SELF-STUDY DOCUMENT**: At the discretion of the institution, the administration may either release information from this document to the public or keep it confidential. The Commission will not release the self-study document.

**SITE VISIT REPORT**: The preliminary draft of a site visit report is an unofficial document and remains confidential between the Commission and the institution’s executive officers and may not, under any circumstances, be released. Members of a visiting committee who review preliminary drafts of the report must consider the report as privileged information and must not discuss it or make its contents known to anyone, under any circumstances. Oral comments made by site visit team members during the course of the site visit are not to be construed as official site visit findings unless documented within the site visit report and may not be publicized. Further, publication of site visit team members’ names and/or contact information is prohibited. Reasons for assigning any non-adverse status other than full approval remain confidential between the institution and the Commission unless the institution wishes to release them. Public release of the final draft of the site visit report that is approved by the Commission is at the sole discretion of
the institution. If there is a point of contention about a specific section of the final site visit report and the institution elects to release the pertinent section to the public, the Commission reserves the right to make the entire site visit report public.

INSTITUTION’S RESPONSE TO A SITE VISIT REPORT: Release of this information is at the sole discretion of the institution. An institution’s response must not improperly disclose any Protected Health Information; however, if any such information is included in the response, such information will not be made public.

TRANSMITTAL LETTER OF ACCREDITATION NOTIFICATION: Information such as accreditation status granted and scheduled dates for submission of additional information is public information. However, release of other information or details is at the sole discretion of the institution and will not be disclosed by the Commission.

PROGRESS REPORT: The scheduled date for submission of progress reports is public information. Release of the content of a progress report is at the sole discretion of the institution. If there is a point of contention about a particular portion of the progress report and the institution elects to release the pertinent portion to the public, the Commission reserves the right to make public the entire progress report. Progress reports must not disclose Protected Health Information (PHI) or Personally Identifiable Information (PII).

SURVEYS: Routinely gathered data are used in the accreditation process and also provide a national data base of information about the accredited dental and dental-related educational programs. The Commission may release to the public any portion of survey data that is collected annually unless the terms of confidentiality for a specific section are clearly indicated on the survey instrument. Subsections of each survey instrument containing data elements which are confidential are clearly marked. Any data which may be reported from confidential subsections are published in a manner which does not allow identification of an individual institution/program.

EXIT INTERVIEWS: The final conference or exit interview between the site visit committee and the chief executive officer, dental dean, chief of dental service or the program director(s) is also confidential. Additional people may be included at the discretion of the institutional administration. The interview is a confidential summation of the preliminary findings, conclusions, recommendations and suggestions which will appear in the site visit report to the institution. This is a preliminary oral report and the preliminary written report is often only in draft stage at this point; therefore, this session may not be recorded in either audio or video format. Note taking is permitted and encouraged.

ON-SITE INTERVIEWS AND ORAL COMMUNICATIONS: In order to carry out their duties as on-site evaluators, visiting committee members must communicate freely with administrators, faculty, staff and students and any other appropriate individuals affiliated with an education program. As part of their on-site accreditation duties, committee members are expected to share with other team members pertinent and relevant information obtained during interviews. All oral communications occurring on-site, however, are confidential. Interviews may not be recorded in either audio or video format. Note taking is permitted and encouraged. When the site visit ends, team members may communicate orally, or in writing, only with Commission staff or other team members about any on-site interview or conversation. All questions related to any aspect of the site visit including oral communications must be referred to the Commission office.
MEETING MATERIALS/DISCUSSIONS: Background reports and informational materials related to accreditation matters are regularly prepared for review by the Commission and its Review Committees. These materials and all discussions related to accreditation matters routinely remain confidential. The Commission determines when, and the manner in which, newly adopted policy and informational reports will receive public distribution.

PROTECTED HEALTH INFORMATION: Patients’ protected health information, which includes any information that could identify an individual as a patient of the facility being site visited, may not be used by the site visitors, Review Committee members, or Commissioners for any purpose other than for evaluation of the program being reviewed on behalf of the Commission. Protected Health Information may not be disclosed to anyone other than Commissioners, Commission staff, Review Committee members or site visitors reviewing the program from which the Protected Health Information was received. Individual Protected Health Information should be redacted from Commission records whenever that information is not essential to the evaluation process. If a site visitor, Review Committee member, or Commissioner believes any Protected Health Information has been inappropriately used or disclosed, he/she should contact the Commission office.

MEETINGS: Policy portions of the Review Committee and Commission-meetings are open to observers, while accreditation actions are confidential and conducted in closed session. All deliberations of the Appeal Board are confidential and conducted in closed session.

NOTICE OF REASONS FOR ADVERSE ACTION: Notice of the reasons for which an adverse accreditation action (i.e. deny or withdraw) is taken is routinely provided to the Secretary of the U.S. Department of Education, any appropriate state agencies, and, upon request, to the public.

Revised: 8/20; 8/18; 2/16; 8/14; 1/05, 2/01, 7/00; Reaffirmed: 8/12, 8/10; Adopted: 7/94, 5/93

J. PROGRAM FEE POLICY

Programs accredited by the Commission pay an annual fee. The annual fee is doubled in the year of the program’s regular interval accreditation site visit. As there is some variation in fees for different disciplines based on actual accreditation costs, programs should contact the Commission office for specific information. Other than doubling of the annual fee during the site visit year, site visits are conducted without any additional charge to the institution and the Commission assumes all expenses incurred by its site visitors. However, accredited programs with multiple sites which must be site visited during a regular site visit and programs sponsored by the U.S. military in international locations are assessed a fee at the time of the site visit. The fee is established on a case-by-case basis, dependent upon the specific requirements to conduct the visit (e.g. additional site visitors, additional days, and additional travel time and expenses). Fees are also assessed to the program for the conduct of special focused site visits. (See Invoicing Process for Special Focused Site Visits in Policy on Special Site Visits). International dental education programs also pay an annual fee and site visit fees (See International Dental Education Site Visits). Expenses for representatives from the state board of dentistry or from other agencies, such as a regional accrediting agency, are not assumed by the Commission. Fee structures are evaluated annually by the Commission. The Commission office should be contacted for current information on fees.
An annual administrative fee is also applied to each program. Fees may also be associated with staff consulting services (See Staff Consulting Services, and International Policies and Procedures) administrative fees related to the Commission policy on protected health information and personally identifiable information (See Policy and Procedures Related to Compliance with the Health Insurance Portability and Accountability Act).

All institutions offering programs accredited by the Commission on Dental Accreditation are expected to adhere to the due date for payment of all fees for each accredited program sponsored by the institution. Written requests for an extension must specify a payment date no later than thirty (30) days beyond the initial due date. Failure to pay fees by the designated deadline is viewed as an institutional decision to no longer participate in the Commission’s accreditation program. Following appropriate reminder notice(s), if payment or a request for extension is not received, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting. Programs which have been discontinued or had accreditation withdrawn will not be issued a refund of accreditation fees.

Revised: 1/20; 2/19; 2/15; 8/14; 8/13; 7/08; Reaffirmed: 8/18; 8/13; 8/10, 7/07, 7/01, 7/95

B. APPLICATION FOR ACCREDITATION FOR FULLY OPERATIONAL PROGRAMS WITH ENROLLMENT AND WITHOUT ACCREDITATION

Those programs that have graduated at least one class of students/residents and are enrolling students/residents in every year of the program are considered fully operational. These programs will complete the self-study document and will be considered for the accreditation status of “approval with reporting requirements” or “approval without reporting requirements” following a comprehensive site visit (Please see procedures for the conduct of a comprehensive site visit). Students/Residents who are enrolled in the program at the time accreditation is granted, and who successfully complete the program, will be considered graduates of an accredited program. Students/Residents who graduated from the program prior to the granting of accreditation will not be considered graduates of an accredited program.

Because accreditation is voluntary, a program may withdraw its application for accreditation at any time prior to the Commission taking action regarding an accreditation status. When an accreditation status has been granted, the program has the right to ask that the status be discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of programs, application forms, deadlines for submission and accreditation standards. Program administrators and faculty are encouraged to consult with Commission staff during this initial process.

An application fee must be submitted with a program’s application for accreditation. Programs should contact the Commission office for the current fee schedule.

The following steps apply:
1. An application for accreditation is completed by the program and submitted to the Commission on
Dental Accreditation, along with appropriate documentation and application fee. The first opportunity for the Commission to consider the program, provided that the application is in order, could be 12 to 18 months following the application submission date.

2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet minimum requirements. The application is considered complete when the Criteria for Granting Accreditation have been addressed as part of the application process.

3. If it is determined that the Criteria for Granting Accreditation have been addressed, a site visit is scheduled four (4) to seven (7) months following completion of the application review.

4. If changes occur within the program between the date of submission of the application and scheduled site visit, the site visit may be delayed.

5. After the site visit has been conducted, the visiting committee submits a draft report to the Commission office.

6. Within four (4) to six (6) weeks following the site visit, the preliminary draft of the site visit report is transmitted to the institution for consideration and comment prior to review by the discipline-specific Review Committee and the Commission.

7. The visiting committee’s report and the institution’s response to the preliminary report are transmitted to the discipline-specific Review Committee for consideration at its meeting prior to the Commission meeting.

8. The Commission then considers the Review Committee’s report and takes action on the accreditation status.

9. The Commission’s action regarding accreditation status and the final site visit report are transmitted to the institution within thirty (30) days of the Commission’s meeting.

C. APPLICATION FOR INITIAL ACCREDITATION FOR DEVELOPING PROGRAMS

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 “developing.” The same review steps that apply for Application for Accreditation for Fully Operational Programs with Enrollment and Without Accreditation apply to Application for Initial Accreditation for Developing Programs.

The developing program must not enroll students/residents until initial accreditation status has been obtained. Once a program is granted “initial accreditation” status, a site visit will be conducted in the second year of programs that are four or more years in duration and again prior to the first class of students/residents graduating. Programs that are less than four (4) years in duration will be site visited again prior to the first class of students/residents graduating.

An institution which has made the decision to initiate and seek accreditation for a program that falls within the Commission on Dental Accreditation’s purview is required to submit an application for accreditation. “Initial accreditation” status may then be granted to programs which are developing, according to the accreditation standards.

Because accreditation is voluntary, a program may withdraw its application for accreditation at any time prior to the Commission taking action regarding an accreditation status. The initial accreditation status is granted based upon one or more site evaluation visit(s) and until the program is fully operational. When
an accreditation status has been granted, the program has the right to ask that the status be discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of programs, application forms, deadlines for submission and accreditation standards. Program administrators and faculty are encouraged to consult with Commission staff during this initial process.

An application fee must be submitted with a program’s application for initial accreditation. Programs should contact the Commission office for the current fee schedule.

The following steps apply:
1. An application for accreditation is completed by the program and submitted to the Commission on Dental Accreditation, along with appropriate documentation and application fee. The first opportunity for the Commission to consider the program, provided that the application is in order, could be 12 to 18 months following the application submission date.
2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet minimum requirements. The application is considered complete when the Criteria for Granting Accreditation have been addressed as part of the application process.
3. If it is determined that the Criteria for Granting Accreditation have been addressed, a site visit is scheduled four (4) to seven (7) months following completion of the application review.
4. If changes occur within the program between the date of submission of the application and scheduled site visit, the site visit may be delayed.
5. After the site visit has been conducted, the visiting committee submits a draft report to the Commission office.
6. Within four (4) to six (6) weeks following the site visit, the preliminary draft of the site visit report is transmitted to the institution for consideration and comment prior to review by the discipline-specific Review Committee and the Commission.
7. The visiting committee’s report and the institution’s response to the preliminary report are transmitted to the discipline-specific Review Committee for consideration at its meeting prior to the Commission meeting.
8. The Commission then considers the Review Committee’s report and takes action on the accreditation status.
9. The Commission’s action regarding accreditation status and the final site visit report are transmitted to the institution within thirty (30) days of the Commission’s meeting.

Revised: 8/16; 2/16; 8/13; 7/08, 8/02, 7/01; Reaffirmed: 8/18; 8/13; 8/11, 8/10

F. SELF-STUDY GENERAL INFORMATION

In preparation for a site visit, institutions are required to complete a self-study for each program being evaluated. A self-study involves an analysis of the program in terms of the accreditation standards and an assessment of the effectiveness of the entire educational program. It includes a review of the relevance of all its activities to its stated purposes and objectives and a realistic appraisal of its achievements and deficiencies. The self-study process permits a program to measure itself qualitatively prior to evaluation
by an on-site committee of peers in education and the profession. On-site evaluation assesses the degree to which the accreditation standards are met and assists the program in identifying strengths and weaknesses.

The self-study manual includes questions which require qualitative evaluation and analysis of the educational program. The intent of the self-study process is to identify program strengths and weaknesses. Latitude is permitted in interpreting questions to meet the specific needs of the program; however, Commission staff should be consulted if revisions are planned.

Visiting committee members review the completed self-study documents in preparation for conducting an on-site review. Any requests by committee members for additional materials relating to the on-site review are forwarded to the institution by the Commission staff, when staff attends the visit, or site visit chair. All such requests are compiled into one official communication from the Commission staff or site visit chair to the institution. Individual site visitors may not request additional material or information directly from an institution. The institution’s response serves as an addendum to the self-study document.

The sponsoring institution is required to forward a copy of the completed self-study document to each member of the visiting committee and to the Commission office no later than sixty (60) days prior to the scheduled site visit. If the self-study document is submitted with insufficient time for site visitor review, the visit may be canceled. Further, if an opportunity to reschedule the visit within the same calendar year is not available, the Commission will be informed. Failure to submit the self-study within the expected deadline could affect the accreditation status of the program.

Guidelines for preparing self-study documents for each discipline, including more specific information and instructions, and Electronic Submission Guidelines, are available upon request from the Commission office or on the Commission’s website.

Revised: 1/20; 8/19; 8/14; Reaffirmed: 8/10

G. PRE-VISIT GENERAL INFORMATION

The Commission proposes and confirms dates for the site visit, assists the institution with pre-visit plans and communicates with the visiting committee regarding transportation, hotel accommodations and the program’s accreditation history.

A site visit focuses only on the program(s) in operation at the time of the visit. The visiting committee will expect, however, to be apprised of any change in admissions, facilities, faculty, financial support or curriculum which is contemplated, but not yet implemented.

Although the Commission provides a suggested site visit schedule, the institution is responsible for preparing the actual schedule. Any necessary modifications to the schedule proposed by the institution are made prior to the visit either by Commission staff or by the staff representative assigned to the visiting committee. The schedule is also reviewed at the beginning of the visit to determine whether any other changes are indicated. The institution notifies all individuals associated with the institution, who are participating in the review, of the time and place of their scheduled conferences with the visiting committee.  

Reaffirmed: 8/19; 8/10
H. POLICY ON THIRD PARTY COMMENTS

The Commission currently publishes, in its accredited lists of programs, the year of the next site visit for each program it accredits. In addition, the Commission posts its spring and fall site visit announcements on the Site Visit Process and Schedule area of the Commission’s website for those programs being site visited in the current and next year. Special site visits and initial accreditation site visits for developing programs may be scheduled after the posting on the Commission’s website; thus, the specific dates of these site visits may not be available for publication. Parties interested in these specific dates (should they be established) are encouraged to contact the Commission office. The Commission will request written comments from interested parties on the CODA website.

The United States Department of Education (USDE) procedures require accrediting agencies to provide an opportunity for third-party comment, either in writing or at a public hearing (at the accrediting agencies’ discretion) with respect to institutions or programs scheduled for review. All comments must relate to accreditation standards for the discipline and required accreditation policies. In order to comply with the Department’s requirement on the use of third-party comment regarding program’s qualifications for accreditation or initial accreditation, the following procedures have been developed.

Those programs scheduled for regular review must solicit third-party comments through appropriate notification of communities of interest and the public such as faculty, students, program administrators, dental-related organizations, patients, and consumers at least ninety (90) days prior to their site visit. The notice should indicate the deadline of sixty (60) days for receipt of third-party comments in the Commission office and should stipulate that signed or unsigned comments will be accepted, that names and/or signatures will be removed from comments prior to forwarding them to the program, and that comments must pertain only to the standards for the particular program or policies and procedures used in the Commission’s accreditation process. The announcement may include language to indicate that a copy of the appropriate accreditation standards and/or the Commission’s policy on third-party comments may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611, or by calling 1/800-621-8099, extension 4653.

All comments submitted must pertain only to the standards relative to the particular program being reviewed or policies and procedures used in the accreditation process. Comments will be screened by Commission staff for relevancy. Signed or unsigned comments will be considered. For comments not relevant to these issues, the individual will be notified that the comment is not related to accreditation and, where appropriate, referred to the appropriate agency. For those individuals who are interested in submitting comments, requests may be made to the Commission office.

All relevant comments will have names and/or signatures removed and will then be referred to the program at least fifty (50) days prior to the site visit for review and response. A written response from the program should be provided to the Commission office and the visiting committee fifteen (15) days prior to the site visit. Adjustments may be necessary in the site visit schedule to allow discussion of comments with proper personnel. Negative comments received after the established deadline of sixty (60) days prior to the site visit will be handled as a complaint. Any unresolved issues related to the program’s compliance with the accreditation standards will be reviewed by the visiting committee while on-site.
Programs with the status of initial accreditation, and programs seeking initial accreditation must solicit comment through appropriate notification of communities of interest and the public such as faculty, students, program administrators, dental-related organizations, patients, and consumers utilizing the procedures noted above.

On occasion, programs may be scheduled for special focused or special comprehensive site visits and because of the urgency of the visit, solicitation of third-party comments within the ninety (90) day timeframe may not be possible. However, third party comments must be solicited at the time the program is notified of the Commission’s planned site visit, typically sixty (60) days in advance of the visit. In this case, the timeframe for solicitation of third-party comments will be shortened. The notice should indicate the deadline of thirty (30) days for receipt of third-party comments in the Commission office and should stipulate that signed or unsigned comments will be accepted, that names and/or signatures will be removed from comments prior to forwarding them to the program, and that comments must pertain only to the standards for the particular program or policies and procedures used in the Commission’s accreditation process. All relevant comments will have names and/or signatures removed and will then be referred to the program at least twenty (20) days prior to the site visit for review and response. A written response from the program should be provided to the Commission office and the visiting committee ten (10) days prior to the site visit. Adjustments may be necessary in the site visit schedule to allow discussion of comments with proper personnel. Any unresolved issues related to the program’s compliance with the accreditation standards will be reviewed by the visiting committee while on-site. Negative comments received after the established deadline of thirty (30) days prior to the site visit will be handled as a complaint.

Revised: 8/19; 8/18; 2/18; 2/16; 8/13; 8/12, 8/11, 7/09, 8/02, 1/97; Reaffirmed: 8/13; 8/10, 1/03; Adopted: 7/95

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C. REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes have a direct and significant impact on the program’s potential ability to comply with the accreditation standards. These changes tend to occur in the areas of finances, program administration, enrollment, curriculum and clinical/laboratory facilities, but may also occur in other areas. All program changes that could affect the ability of the program to comply with the Accreditation Standards must be reported to the Commission. When a change is planned, Commission staff should be consulted to determine reporting requirements. Reporting program changes in the Annual Survey does not preclude the requirement to report changes directly to the Commission. Failure to report and receive approval in advance of implementing the change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program’s accreditation status.
Advanced dental education programs must adhere to the Policy on Enrollment Increases in Advanced Dental Education Programs. In addition, programs adding off-campus sites must adhere to the Policy on Reporting and Approval of Sites Where Educational Activity Occurs. Guidelines for Reporting and Approval of Sites where Educational Activity Occurs are available from the Commission office. Guidelines for Requesting an Increase in Enrollment in a Predoctoral Dental Education Program and Guidelines for Reporting Enrollment Increases in Advanced Dental Education Programs are available from the Commission office.

On occasion, the Commission may learn of program changes which may impact the program’s ability to comply with accreditation standards or policy. In these situations, CODA will contact the sponsoring institution and program to determine whether reporting may be necessary. Failure to report and receive approval prior to the program change may result in further review by the Commission and/or a special site visit, and may jeopardize the program’s accreditation status.

The Commission’s Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breech of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

A Report of Program Change must document how the program will continue to meet accreditation standards. The Commission’s Guidelines for Reporting Program Changes are available on the Commission’s website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported by June 1 or December 1 and must be reviewed by the appropriate Review Committee and approved by the Commission prior to the implementation to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites not owned by the sponsoring institution used to meet accreditation standards or program requirements (See Guidelines on Reporting and Approval of Sites Where Educational Activity Occurs);
- Changes to Off-Campus Sites not owned by the sponsoring institution that impacts the use of the site (e.g. minor site to major site, or termination of enrollment at or discontinued use of major site);
- Transfer of sponsorship from one institution to another;
- Moving a program from one geographic site to another, including but not limited to geographic moves within the same institution;
- Program director qualifications not in compliance with the standards. In lieu of a CV, a copy of the new or acting program director’s completed BioSketch must be provided to Commission staff. Contact Commission Staff for the BioSketch template.
- Substantial increase in program enrollment as determined by preliminary review by the discipline-specific Review Committee Chair.
  - Requests for retroactive permanent increases in enrollment will not be considered. Requests for retroactive temporary increases in enrollment may be considered due to special circumstances on a case-by-case basis. Programs are reminded that resources must be maintained even when the full complement of students/residents is not enrolled in the
program. (see Policy on Enrollment Increases In Advanced Dental Education Programs and Predoctoral programs see Guidelines for Requesting an Increase in Enrollment in a Predoctoral Dental Education Program);

- Change in the nature of the program’s financial support that could affect the ability of the program to meet the standards;
- Curriculum changes that could affect the ability of the program to meet the standards;
- Reduction in faculty or support staff time commitment that could affect the ability of the program to meet the standards;
- Change in the required length of the program;
- Reduction of program dental facilities that could affect the ability of the program to meet the standards;
- Addition of advanced standing opportunity; and/or
- Expansion of a developing dental hygiene or assisting program which will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

The Commission recognizes that unexpected changes may occur. If an unexpected change occurs, it must be reported no more than 30 days following the occurrence. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster (See Policy/Guidelines on Interruption of Education). Failure to proactively plan for change will not be considered an unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that must be reported in writing at least thirty (30) days prior to the anticipated implementation of the change and are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:

- Establishment of Off-Campus Sites owned by the sponsoring institution used to meet accreditation standards or program requirements;
- Expansion or relocation of dental facilities within the same building;
- Change in program director. In lieu of a CV, a copy of the new or acting program director’s completed BioSketch must be provided to Commission staff. Contact Commission Staff for the BioSketch template.
- First-year non-enrollment. See Policy on Non Enrollment of First Year Students/Residents.
- Addition of distance education methods (see reporting requirements found in the Policy on Distance Education).

The Commission uses the following process when considering reports of program changes. Program administrators have the option of consulting with Commission staff at any time during this process.

1. A program administrator submits the report by June 1 or December 1.
2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by the
Commission.

3. Receipt of the report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review Committee and by the Commission at their next regularly scheduled meeting. Additional information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next site visit.

4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of program changes received from accredited educational programs.

- **Approve the report of program change:** If the Review Committee or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change(s) have been noted and will be reviewed at the next regularly-scheduled site visit to the program.

- **Approve the report of program change and request additional information:** If the Review Committees or Commission does not identify any concerns regarding the program’s compliance with the accreditation standards, but believes follow up reporting is required to ensure continued compliance with accreditation standards, additional information will be requested for review by the Commission. Additional information could occur through a supplemental report or a focused site visit.

- **Postpone action and continue the program’s accreditation status, but request additional information:** The transmittal letter will inform the institution that the report of program change has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request.

- **Postpone action and continue the program’s accreditation status pending conduct of a special site visit:** If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.

- **Deny the request:** If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for a program change. The institution will be advised that they may re-submit the request of program change with additional information if they choose. If the program change was submitted retroactively, and non-compliance is identified, the program’s accreditation status will be changed. The transmittal letter will inform the institution that the report of program change has been considered, but an area of non-compliance with the accreditation standards has been identified. The program’s accreditation status is changed and additional specific information regarding the identified area(s) of non-compliance will be requested for review by the Commission.
D. REQUESTS FOR TRANSFER OF SPONSORSHIP OF ACCREDITED PROGRAMS

The sponsorship of an accredited program may be transferred from one educational institution to another without affecting the accreditation status of the program, provided the accreditation standards continue to be met following the transfer. A request for transfer of sponsorship will be considered by the Commission if significant aspects of the program will remain unchanged following the transfer.

Critical factors that will be weighed in review of the transfer of sponsorship request include: administration, funding sources, curriculum, faculty, facilities, and patient volume. If most of these critical factors will be unchanged, then the Commission will consider the request for transfer of sponsorship of the program. If most of these factors will be significantly altered following the change in sponsorship, then the program cannot be considered as a continuation of the same program under different sponsorship. Rather, the program to be offered by the new sponsoring institution will be considered as a new program and will be required to complete the established application process for initial accreditation appropriate to the discipline. If the program is viewed as a new program, the accreditation status of the previous program will be discontinued at an appropriate time.

Information regarding the transfer of sponsorship and its effect on the program’s compliance with the accreditation standards must be submitted prior to implementation of the transfer. Written notice of the agreement to transfer sponsorship of the program must be provided to the Commission by both institutions; the new sponsor must explicitly indicate its willingness to accept responsibility for the transferred program. The information to be submitted must include the expected date of the transfer and the anticipated enrollment in each year of the program following the transfer. In addition, documentation must be submitted to demonstrate how the program will continue to meet the accreditation standards related to administration, financial support, curriculum, faculty and facilities. Any other changes that will occur in the program as a result of the transfer of sponsorship must also be explained and documented.

Programs anticipating a possible transfer of sponsorship are strongly encouraged to consult with Commission staff prior to submitting a request. The Commission has guidelines for preparing a request for transfer of sponsorship, to assist institutions in adequately explaining and documenting such changes.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of requests for transfer of sponsorship.

- **Approve the transfer of sponsorship:** If the Review Committee or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the program will be reviewed at the next regularly-scheduled site visit to the new sponsoring institution. If concerns have been identified that are not of such a nature as to require the submission of additional information immediately, the concerns may be cited in the transmittal letter; the institution will be advised that the concerns will be reviewed at the time of the next regularly-scheduled site visit.

- **Postpone action and continue the program’s accreditation status, but request additional information:**
This action may be taken only once following submission of the initial request. The transmittal letter will inform the institutions that Commission action has been postponed because concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institutions will be further advised that, if the additional information submitted does not satisfy the identified concerns, the Commission reserves the right to conduct a special focused site visit of the program at an appropriate time following implementation of the transfer, or to deny the request.

- **Postpone action and continue the program’s accreditation status pending conduct of a special site visit:** If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit to the new sponsoring institution will be conducted.

- **Deny the request for transfer:** If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for transfer of sponsorship. The institutions will be advised that they may re-submit the request with additional information if they choose.

Revised: 1/14, 8/10, 7/07, 7/97; Reaffirmed: 8/20; 8/15; 7/07, 7/01, 5/91, 12/82; CODA: 05/91:11

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### S. POLICY STATEMENT ON REPORTING AND APPROVAL OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

The Commission on Dental Accreditation recognizes that students/residents may gain educational experiences in a variety of settings and locations.

An accredited program may use one or more than one setting or location to support student/resident learning and meet Commission on Dental Accreditation standards and/or program requirements. The Commission expects programs to follow the EOPP guidelines and accreditation standards when developing, implementing and monitoring activity sites used to provide educational experiences.

**Reporting Requirements:**
The Commission on Dental Accreditation must be informed when a program accredited by the Commission plans to initiate educational experiences in new settings and locations. Off-Campus training sites that are owned by the sponsoring institution or where the sponsoring organization has legal responsibility and operational oversight do not need prior approval before utilization but must be reported to the Commission in accordance with the Policy on Reporting Program Changes in Accredited Programs.

<table>
<thead>
<tr>
<th>Reporting Requirements for Off-Campus Sites</th>
<th>Major Activity Sites</th>
<th>Minor Activity Sites</th>
<th>Supplemental Activity Sites*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
<th>Students/Residents <strong>required</strong> to complete an experience at this site to meet a program requirements or accreditation standards, and Competency assessments or comparable summative assessments performed at the site</th>
<th>Students/Residents <strong>required</strong> to complete an experience at this or another site to meet a program requirements or accreditation standards, and No competency assessments or comparable summative assessments performed at the site. Evaluation may occur.</th>
<th>Student/Resident chooses whether to visit the site outside of the educational program (e.g. volunteer mission trips, health fair, etc. not used to fulfill program or accreditation requirements).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Report Requirement</td>
<td>Report required by June 1 or December 1</td>
<td>Report required at least 30 days prior to planned implementation of educational activity site.</td>
<td>No report required.</td>
</tr>
<tr>
<td>Acknowledgement/Approval</td>
<td>Commission approval required prior to implementation of the educational activity site. Approval of the major activity sites required prior to recruiting students/residents for the site and initiating use of the site.</td>
<td>Commission acknowledgement of review at the program’s next site visit.</td>
<td>No approval required.</td>
</tr>
<tr>
<td>Site Visit(s) to Educational Activity Site</td>
<td>Commission may direct special focused site visit to review educational activity site prior to or after approval of the site. Commission may review site at future site visits.</td>
<td>Commission may visit educational activity site during program’s next site visit.</td>
<td>No site visit required.</td>
</tr>
</tbody>
</table>

*sites used for community service and service learning are exempt

The Commission must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all students/residents enrolled in an accredited program. Generally, only programs without reporting requirements will be approved to initiate educational experiences at major activity sites.
When the Commission has received notification that an institution plans to offer its accredited program at an off-campus educational activity site, the Commission may conduct a special focused site visit to each educational activity site where each student’s/resident’s educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, or if other cause exists for such a visit as determined by the Commission. There may be extenuating circumstances when a special review is necessary.

The program must report the rationale for adding an educational activity site and how that site affects the program’s goals, objectives, and outcomes. For example, program goals, objectives, and outcome measures may address institutional support, faculty support, curriculum, student didactic and clinical learning, research, and community service. The program must support the addition of an educational activity site with trends from pertinent areas of its outcomes assessment program that indicates the rationale for the additional site.

When conducting a review of the program, the Commission’s site visit team will identify the sites to be visited based upon educational experiences at the site (for example based upon length of training at the site, educational experience or evaluation/competencies achieved). After the initial visit or review, each educational activity site may be visited during the regularly scheduled CODA evaluation visit to the program.

**Discipline-specific Exemptions:**

The Commission recognizes that dental assisting and dental laboratory technology programs utilize numerous extramural private dental offices and laboratories to provide students with clinical/laboratory work experience. The program will provide a list of all currently used extramural sites in the self-study document. The Commission will then randomly select and visit facilities at the time of a site visit to the program. Prior Commission approval of these extramural dental office and laboratory sites will not be required.

The Commission recognizes that dental public health programs utilize numerous off-campus sites to provide students/residents with opportunities to conduct their supervised field experience. The program will provide a list of all currently used sites in the self-study document. The visiting committee will select and visit facilities during the site visit to the program to evaluate compliance with CODA accreditation standards. Prior Commission approval of these supervised field experience sites will not be required. Programs where 30% or more of the overall student/resident training occurs at off-campus site(s) must report the off-campus site(s) under the Commissions Policy Statement on Approval of Sites Where Educational Activity Occurs.

The Commission recognizes that advanced dental education programs in dental anesthesiology utilize numerous mobile ambulatory settings and rotations to provide residents with opportunities to gain required clinical experiences. The program will provide a list of all currently used settings and rotations in the self-study document. The visiting committee will randomly select and visit several settings and rotation locations during the site visit to the program to evaluate compliance with Commission on Dental Accreditation standards. Prior Commission approval of these settings and rotations will not be required.

For predoctoral dental education programs, when primary program faculty travel with student(s) to a site and competency is assessed, the site may be treated as a minor site for reporting purposes.
Expansion of a developing dental hygiene program and/or current or developing dental assisting program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

Fees Related to the Use of Educational Activity Sites:
All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to and educational activity site. The Commission office should be contacted for current information on fees.

Commission on Dental Accreditation Consideration of Educational Activity Sites:
The Commission uses the following process when considering reports for adding educational activity sites. Program administrators have the option of consulting with Commission staff at any time during this process.

1. Depending upon the type of educational activity site established, a program administrator submits either:
   (1) the major educational activity site report by June 1 or December 1 or (2) the minor educational activity site report at least thirty (30) days prior to planned implementation of educational activity site.
2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, whether the site is major or minor, the report is reviewed by the appropriate Review Committee for the discipline and by the Commission.
3. Receipt of the educational activity site report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review Committee and by the Commission at their next regularly scheduled meeting. Additional information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next site visit.
4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of addition of educational activity sites received from accredited educational programs.

- **Approve the addition of the educational activity site:** If the Review Committees or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change has been noted and will be reviewed at the next regularly-scheduled site visit to the program.
- **Approve the addition of the educational activity site and request additional information:** If the Review Committees or Commission does not identify any concerns regarding the program’s compliance with the accreditation standards, but believes follow up reporting is required to ensure continued compliance with accreditation standards, additional information will be requested for review by the Commission. Additional information could occur through a supplemental report or a focused site visit. Use of the educational site is permitted.
• **Postpone action and continue the program’s accreditation status, but request additional information:** The transmittal letter will inform the institution that the report of the addition of the educational activity site has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request. Use of the educational activity site is not permitted until Commission approval is granted.

• **Deny the request:** If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for the addition of educational activity sites. The institutions will be advised that they may re-submit the request with additional information if they choose.

Revised: 8/18; 8/17; Reaffirmed: 8/20; Adopted: 2/16 (Former Off-Campus Policy)

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**T. POLICY ON DISTANCE EDUCATION**

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

Distance education means education that uses one or more of the technologies listed below to deliver instruction to students who are separated from the instructor and to support regular and substantive interaction between the students and the instructor, either synchronously or asynchronously. The technologies may include:

- the internet;
- one-way and two-way transmissions through open broadcast, closed circuit, cable, microwave, broadband lines, fiber optics, satellite, or wireless communications devices;
- audio conferencing; and/or
- video cassettes, DVDs, and CD–ROMs, if the cassettes, DVDs, or CD–ROMs are used in a course in conjunction with any of the technologies listed above.

A program that is planning to implement the use of distance education methods must submit a report of program change (See Policy on Reporting Program Changes in Accredited Programs) and include evidence of the program’s compliance with the Student Identity Verification noted below. Upon review and Commission acknowledgement that the program has addressed all Student Identity Verification requirements, the use of distance education and the program’s compliance with the below noted items will be further reviewed at the time of the program’s next site visit.

Revised: 8/20; 8/10; Reaffirmed: 8/15

1. **Student Identity Verification Requirement For Programs That Have Distance Education Sites:** Programs that offer distance education must:

- have a processes in place through which the program establishes that the student who registers in a
distance education course or program is the same student who participates in and completes the course or program and receives the academic credit;
• verify the identity of a student who participates in class or coursework by using, at the option of the program, methods such as a secure login and pass code; proctored examinations; and/or new or other technologies and practices that are effective in verifying student identity;
• make clear in writing that processes are used that protect student privacy;
• notify students of any projected additional student charges associated with the verification of student identity at the time of registration or enrollment.

Revised: 8/20; Reaffirmed: 8/15; Adopted: 8/10

VI. COMPLAINTS

A. DEFINITION

A complaint is defined by the Commission on Dental Accreditation as one alleging that a Commission-accredited educational program, a program which has an application for initial accreditation pending, or the Commission may not be in substantial compliance with Commission standards or required accreditation procedures.

B. PROGRAM REQUIREMENTS AND PROCEDURES

NOTICE OF OPPORTUNITY TO FILE COMPLAINTS: In accord with the U.S. Department of Education’s Criteria and Procedures for Recognition of Accrediting Agencies, the Commission requires accredited programs to notify students of an opportunity to file complaints with the Commission.

Each program accredited by the Commission on Dental Accreditation must develop and implement a procedure to inform students of the mailing address and telephone number of the Commission on Dental Accreditation. The notice, to be distributed at regular intervals, but at least annually, must include but is not necessarily limited to the following language:

The Commission on Dental Accreditation will review complaints that relate to a program's compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission's policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 1-800-621-8099 extension 4653.

The accredited program must retain in its files information to document compliance with this policy so that it is available for review during the Commission's on-site reviews of the program.
REQUIRED RECORD OF COMPLAINTS: The program must maintain a record of student complaints received since the Commission’s last comprehensive review of the program.

At the time of a program’s regularly scheduled on-site evaluation, visiting committees evaluate the program’s compliance with the Commission’s policy on the Required Record of Complaints. The team reviews the areas identified in the program’s record of complaints during the site visit and includes findings in the draft site visit report and note at the final conference.

Revised: 2/13, 8/02, 1/9; Reaffirmed: 8/15; 8/10, 7/09, 7/08, 7/07, 7/04, 7/01, 7/96; CODA: 01/94:6 4

C. COMMISSION LOG OF COMPLAINTS

A log is maintained of all complaints received by the Commission. A central log related to each complaint is maintained in an electronic data base. Detailed notes of each complaint and its disposition are also maintained in individual program files.

Revised: 8/10, 7/06, 7/02, 7/00, 7/96; Reaffirmed: 8/15; CODA: 01/95:5

D. POLICY AND PROCEDURE REGARDING INVESTIGATION OF COMPLAINTS AGAINST EDUCATIONAL PROGRAMS

The following policy and procedures have been developed to handle the investigation of “formal” complaints and “anonymous” comments/complaints about an accredited program, or a program which has a current application for initial accreditation pending, which may not be in substantial compliance with Commission standards or established accreditation policies.

The Commission will consider formal, written, signed complaints using the procedure noted in the section entitled “Formal Complaints.” Unsigned comments/complaints will be considered “anonymous comments/complaints” and addressed as set forth in the section entitled “Anonymous Comments/Complaints.” Oral comments/complaints will not be considered.

**Formal Complaints**

A “formal” complaint is defined as a complaint filed in written (or electronic) form and signed by the complainant. This complaint should outline the specific policy, procedure or standard in question and rationale for the complaint including specific documentation or examples. Complainants who submit complaints verbally will receive direction to submit a formal complaint to the Commission in written, signed form following guidelines in the EOPP manual.

1. Investigative Procedures for Formal Complaints: Students, faculty, constituent dental societies, state boards of dentistry, patients, and other interested parties may submit an appropriate, signed, formal complaint to the Commission on Dental Accreditation regarding any Commission accredited dental, allied dental or advanced dental education program, or a program that has an application for initial accreditation pending. An appropriate complaint is one that directly addresses a program’s compliance with the Commission’s standards, policies and procedures. The Commission is interested in the continued improvement and sustained quality of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.
In accord with its responsibilities to determine compliance with accreditation standards, policies, and procedures, the Commission does not intervene in complaints as a mediator but maintains, at all times, an investigative role. This investigative approach to complaints does not require that the complainant be identified to the program.

The Commission, upon request, will take every reasonable precaution to prevent the identity of the complainant from being revealed to the program; however, the Commission cannot guarantee the confidentiality of the complainant.

The Commission strongly encourages attempts at informal or formal resolution through the program's or sponsoring institution's internal processes prior to initiating a formal complaint with the Commission. The following procedures have been established to manage complaints:

When an inquiry about filing a complaint is received by the Commission office, the inquirer is provided a copy of the Commission’s Evaluation and Operational Policies and Procedures Manual which includes the policies and procedures for filing a complaint and the appropriate accreditation standards document.

The initial screening is usually completed within thirty (30) days and is intended to ascertain that the potential complaint relates to a required accreditation policy or procedure (i.e. one contained in the Commission’s Evaluation and Operational Policies and Procedure Manual) or to one or more accreditation standard(s) or portion of a standard which have been or can be specifically identified by the complainant.

Written correspondence clearly outlines the options available to the individual. It is noted that the burden rests on the complainant to keep his/her identity confidential. If the complainant does not wish to reveal his/her identity to the accredited program, he/she must develop the complaint in such a manner as to prevent the identity from being evident. The complaint must be based on the accreditation standards or required accreditation procedures. Submission of documentation which supports the noncompliance is strongly encouraged.

When a complainant submits a written, signed statement describing the program’s noncompliance with specifically identified policy(ies), procedure(s) or standard(s), along with the appropriate documentation, the following procedure is followed:

1. The materials submitted are entered in the Commission’s database and the program’s file and reviewed by Commission staff. At this point, the complaint is the property of the Commission and may not be withdrawn by the complainant for the purposes of the Commission’s review.
2. Legal counsel, the Chair of the appropriate Review Committee, and the applicable Review Committee members may be consulted to assist in determining whether there is sufficient information to proceed.
3. If the complaint provides sufficient evidence of probable cause of noncompliance with the standards or required accreditation procedures, the complainant is so advised and the complaint is investigated using the procedures in the following section, formal complaints.
4. If the complaint does not provide sufficient evidence of probable cause of noncompliance with the standard(s) or required accreditation policy(ies), or procedure(s), the complainant is so advised. The complainant may elect:
   a. to revise and submit sufficient information to pursue a formal complaint; or
b. not to pursue the complaint. In that event, the decision will be so noted and no further action will be taken.

Initial investigation of a complaint may reveal that the Commission is already aware of the program’s noncompliance and is monitoring the program’s progress to demonstrate compliance. In this case, the complainant is notified that the Commission is currently addressing the noncompliance issues noted in the complaint. The complainant is informed of the program’s accreditation status and how long the program has been given to demonstrate compliance with the accreditation standards.

Revised: 2/18; 8/17; 1/14, 11/11; Reaffirmed: 8/15; 8/10

2. Formal Complaints: Formal complaints (as defined above) are investigated as follows:
1. The complainant is informed in writing of the anticipated review schedule.
2. The Commission informs the chief administrative officer (CAO) of the institution sponsoring the accredited program that the Commission has received information indicating that the program’s compliance with specific required accreditation policy(ies), procedure(s) or designated standard(s) has been questioned.
3. Program officials are asked to report on the program’s compliance with the required policy(ies), procedure(s) or standard(s) in question by a specific date, usually within thirty (30) days.
   a. For standard(s)-related complaints, the Commission uses the questions contained in the appropriate sections of the self-study to provide guidance on the compliance issues to be addressed in the report and on any documentation required to demonstrate compliance. Additional guidance on how to best demonstrate compliance may also be provided to the program.
   b. For policy(ies) or procedure(s)-related complaints, the Commission provides the program with the appropriate policy or procedural statement from the Commission’s Evaluation and Operational Policies and Procedures Manual. Additional guidance on how to best demonstrate compliance will be provided to the program. The Chair of the appropriate Review Committee and/or legal counsel may assist in developing this guidance.
4. Receipt of the program’s written compliance report, including documentation, is acknowledged.
5. The appropriate Review Committee and the Commission will investigate the issue(s) raised in the complaint and review the program’s written compliance report at the next regularly scheduled meeting. In the event that waiting until the next meeting would preclude a timely review, the appropriate Review Committee(s) will review the compliance report in a telephone conference call(s). The action recommended by the Review Committee(s) will be forwarded to the Commission for mail ballot approval in this later case.
6. The Commission may act on the compliance question(s) raised by the complaint by:
   a. determining that the program continues to comply with the policy(ies), procedure(s) or standard(s) in question and that no further action is required.
   b. determining that the program may not continue to comply with the policy(ies), procedure(s) or standard(s) in question and going on to determine whether the corrective action the program would take to come into full compliance could be documented and reported to the Commission in writing or would require an on-site review.
      i. If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
      ii. If by on-site review: The Commission will describe the scope and nature of the problem and
determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted. If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission's usual procedures for such site visits.

c. determining that a program does not comply with the policy(ies), procedure(s) or standards(s) in question and:
   i. changing a fully-operational program’s accreditation status to “approval with reporting requirements”
   ii. going on to determine whether the corrective action the program would take to come into full compliance could be documented and reported to the Commission in writing or would require an on-site review.
      • If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
      • If by on-site review: The Commission will describe the scope and nature of the problem and determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted. If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission's usual procedures for such site visits.

7. Within two weeks of its action on the results of its investigation, the Commission will also:
   a. notify the program of the results of the investigation.
   b. notify the complainant of the results of the investigation.
   c. record the action.

8. The compliance of programs applying for initial accreditation is assessed through a combination of written reports and on-site reviews.
   a. When the Commission receives a complaint regarding a program which has an application for initial accreditation pending, the Commission will satisfy itself about all issues of compliance addressed in the complaint as part of its process of reviewing the applicant program for initial accreditation.
   b. Complainants will be informed that the Commission does provide developing programs with a reasonable amount of time to come into full compliance with standards that are based on a certain amount of operational experience.

Revised: 8/17; 1/98; Reaffirmed: 8/15; 8/10, 7/09, 7/04; Adopted: 7/96

B. INTERNATIONAL PREDOCTORAL DENTAL EDUCATION SITE VISITS

Three types of site visits may be conducted to international dental education programs.

FOCUSED CONSULTATION VISIT: Focused, fee-based programmatic consultation services are available for programs requesting less than comprehensive consultation services or for programs that the
Standing Committee has determined would benefit from a focused consultation. Trained content experts will provide the consultation services.

In preparation for the consultation visit, the international dental school will prepare a written document describing its policies and procedures related to the focused topics. The written material will be submitted ninety (90) days prior to an on-site focused consultation visit. All documents and communications will be in English.

Two site visitors (Commission staff and/or volunteers) selected for their expertise in the focused topic areas will make up the visiting committee that provides the focused consultation services and carries out the visit. The trip may be seven days in length, allowing ample time for the committee to adjust to any time change and to access lower airfares. The program will receive a written report summarizing the review and recommendations within sixty (60) days.

COMPREHENSIVE CONSULTATION VISIT: A comprehensive, fee-based site visit with programmatic consultation by trained content experts regarding topics such as:

- Institutional effectiveness/outcomes assessment
- Curriculum content and scope
- Competency-based curriculum
- Faculty and staff qualifications and numbers
- Type and adequacy of facilities
- Patient care services and policies
- Student policies and services
- Research for both faculty and staff
- Readiness for accreditation
- Quality assurance
- Comprehensive patient care
- Relationship of dental school to the university and government
- Standards of care

In preparation for a comprehensive consultative site visit, the international dental schools will prepare a written document describing its policies and procedures related to the above topics. All documents and communications will be in English. Four site visitors (curriculum specialist, basic science specialist, clinician educator, and clinician practitioner representing the American Dental Association) and one Commission staff will make up the visiting committee that will conduct the PACV.

The visit will involve several interviews with the identified stakeholders of the international dental education program and the institution’s administration. Interviews will be conducted with the appropriate administrators, faculty, staff and students. The visiting committee will also provide consultation regarding the facilities. A written report summarizing the evaluation will be provided to the program within sixty (60) days.

ACCREDITATION SITE VISIT: The Commission’s accreditation service for international dental education programs is the same as the process and procedures of the accreditation program for U.S.-based dental education programs. The application process for accreditation of fully-operational international
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Programs will not be modified. For fully-operational programs, one site visit would occur upon application and, if successful, subsequent visits would occur on the usual seven-year cycle established for U.S. predoctoral dental education programs.

Programs that are successful in the PACV may submit an application for accreditation and an application fee for accreditation. The program will also be responsible for all site visit expenses (actual expenses) for all site visits during the application process and regular site visit schedule. International programs will pay an administrative fee of 25% of the total site visit cost to the program for coordination of each site visit. Accredited programs also pay an annual fee. All fees must be paid in advance in United States dollars. See CODA Policy on Fees and contact the Commission office for current fee schedule.

Commission site visitors will then be selected to evaluate the written application and determine whether the application is complete and the program is ready for an accreditation site visit. Once the Commission determines that the program has submitted sufficient information to determine the program’s potential for complying with the accreditation standards, a site visit will be scheduled.

A visiting committee consists of six (6) Commission trained volunteer site visitors and one Commission staff. The committee includes a chair, basic scientist, curriculum site visitor, clinical science site visitor, finance site visitor, and a national licensure site visitor.

The accreditation visit, following the process established for U.S.-based programs, will involve several interviews with the identified stakeholders of the international dental program and the institution’s administration. Interviews are conducted with the appropriate administrators, faculty, staff and students. The accreditation site visit committee also verifies that the written application accurately represents the program through multiple interviews, observations, on-site documentation review and facility inspection.

Following the site visit, the visiting committee writes a preliminary draft site visit report that will be considered by the Review Committee on Predoctoral Dental Education and the Commission. The Commission then determines whether to grant the program the appropriate accreditation status.

Revised: 8/16; 2/16; 8/14; 1/14; Reaffirmed: 8/10; Adopted: 7/06

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D. POLICY ON PLANNING AND IMPLEMENTING PRELIMINARY ACCREDITATION CONSULTATION VISIT (PACV) AND INTERNATIONAL ACCREDITATION SITE VISITS

The Commission on Dental Accreditation has developed the following policy and procedures for use in planning and implementing international Preliminary Accreditation Consultation Visit (PACV) and Commission accreditation site visits. (See the policy on Staff Consulting Services).

Prior to staff and volunteer travel, travel warnings from the US Department of State, US Department of Health and Human Services, and the Centers for Disease Control and Prevention will be continuously monitored. Additionally, the Commission will ensure there are no cultural restrictions or legal restrictions which would make PACV or accreditation site visits in any international location by Commission staff and volunteers problematic. Volunteers will be identified and invited to attend with the full knowledge of travel warnings. Prior to travel, the Commission Director in consultation with the Commission Chair will
determine whether CODA volunteers and staff require additional security, which would be the responsibility of the international dental education program to which the Commission is traveling.

The Commission reserves the right to change travel plans due to safety, health, or similar concerns, as warranted by the Commission Director in consultation with the Commission Chair. The Commission also reserves the right to cancel international travel when US State Department or other concerns discourage travel due to potential threats to safety or health (war, terrorism, health, etc.). All costs incurred by the Commission and/or its volunteers will be borne by the international program.

Site visits may be rescheduled within the same calendar year without prior approval by the full Commission. Site visits rescheduled in the following calendar year must be approved by the Commission (See Rescheduling Dates of Site Visits). Accreditation decisions for programs whose site visit has been rescheduled or cancelled due to circumstances beyond the control of the Commission and/or program will be made on a case-by-case basis.

Adopted: 8/17
REVIEW COMMITTEE FEEDBACK ON CONDUCTING VIRTUAL SITE VISITS

Special Meetings of the all CODA Review Committees, September 2020 and Special Meeting of the Commission, October 2020

<table>
<thead>
<tr>
<th>Predoctoral Dental Review Committee</th>
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<tr>
<td><strong>Dental Education:</strong> The PREDOC RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted on-site. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information. The PREDOC RC also believed that the program’s regular reaccreditation status should be based upon the virtual site visit, although the status may change if issues arise during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements.</td>
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The PREDOC RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences with faculty and administration
- Review and discussion of the electronic self-study, including all interviews associated with review of Accreditation Standards
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Interview with students selected to represent each class

The PREDOC RC believed the following components of the site visit must be conducted on-site:
- Tour of the facility, clinics, basic science areas, and educational activity sites
- Open session with students (large open session with all students)
- Follow-up interview with students selected to represent each class
- Clinic and student observations
- Introduction session with the program director
- Closing sessions with program director and administration
- Document review of sensitive and/or confidential information (i.e., those that might be subject to confidentiality, HIPAA or FERPA)

<table>
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<tr>
<th>Dental Therapy: The PREDOC RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted on-site. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information. The PREDOC RC also believed that the program’s regular reaccreditation status should be based upon the virtual site visit, although the status may change if issues arise during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements.</th>
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The PREDOC RC believed the following components of the site visit could be conducted virtually:

- Interviews and conferences with faculty and administration
- Review and discussion of the electronic self-study, including all interviews associated with review of Accreditation Standards
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Interview with students selected to represent each class

The PREDOC RC believed the following components of the site visit must be conducted on-site:

- Tour of the facility, clinics, basic science areas, and educational activity sites
- Open session with students (large open session with all students)
- Follow-up interview with students selected to represent each class
- Clinic and student observations
- Introduction session with the program director
- Closing sessions with program director and administration
- Document review of sensitive and/or confidential information (i.e., those that might be subject to confidentiality, HIPAA or FERPA)

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**Dental Assisting Review Committee**

**Dental Assisting:** The DA RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted on-site. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information. The DA RC also believed that the program’s regular reaccreditation status should be based upon the virtual site visit, although the status may change if issues arise during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements.

The DA RC believed the following components of the site visit could be conducted virtually:

- Introduction and exit session with the program director and administration
- Interviews and conferences with faculty and administration
- Review and discussion of the electronic self-study, including all interviews associated with review of Accreditation Standards
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Interview with students
- Tour of facilities with high speed action camera technology
- Tour of learning resources center
- Conference with the Advisory Committee
The DA RC believed the following components of the site visit must be conducted on-site:
- Chairside observations
- Tour of extramural facilities

### Dental Hygiene Review Committee

**Dental Hygiene:** The DH RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted on-site. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information. The DH RC also believed that the program’s regular reaccreditation status should be based upon the virtual site visit, although the status may change if issues arise during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements.

The DH RC believed the following components of the site visit could be conducted virtually:
- Introduction and exit session with the program director and administration
- Interviews and conferences with faculty and administration
- Review and discussion of the electronic self-study, including all interviews associated with review of Accreditation Standards
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Conference with the Advisory Committee

The DH RC believed the following components of the site visit must be conducted on-site:
- Tour of the facility, clinics, and educational activity sites
- Open session with students (large open session with all students)
- Clinic and student observations
- Document review of sensitive and/or confidential information (i.e., those that might be subject to confidentiality, HIPAA or FERPA)

### Dental Laboratory Technology Review Committee

**Dental Laboratory Technology:** The DLT RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted on-site. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information. The DLT RC also believed that the program’s regular reaccreditation status should be based upon the virtual site visit, although the status may change if issues arise during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements.

The DLT RC believed the following components of the site visit could be conducted virtually:
- Introduction and exit session with the program director and administration
- Interviews and conferences with faculty and administration
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- Review and discussion of the electronic self-study, including all interviews associated with review of Accreditation Standards
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Interview with students
- Tour of learning resources center
- Conference with the Advisory Committee

The DLT RC believed the following components of the site visit must be conducted on-site:
- Laboratory observations
- Tour of facilities
- Tour of extramural facilities

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<tr>
<th>Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Review Committee</th>
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</table>
| **Advanced Education in General Dentistry:** The AGDOO RC believed that, with the exception of program records, including patient records, all components of a site visit could be conducted virtually. Additionally, the AGDOO RC believed tours could be done virtually, but virtual tours may not be fully reflective of the facilities used by the programs.

The AGDOO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Facility tours

The AGDOO RC believed the following components of the site visit must be conducted on-site:
- Review of documentation, including patient records, because of HIPAA and privacy requirements

| General Practice Residency: | The AGDOO RC believed that, with the exception of program records, including patient records, all components of a site visit could be conducted virtually. Additionally, the AGDOO RC believed tours could be done virtually, but virtual tours may not be fully reflective of the facilities used by the programs.

The AGDOO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Facility tours

The AGDOO RC believed the following components of the site visit must be conducted on-site:
- Review of documentation, including patient records, because of HIPAA and privacy requirements |
**Dental Anesthesiology:** The AGDOO RC believed that, with the exception of program records, including patient records, all components of a site visit could conducted virtually. Additionally, the AGDOO RC believed tours could be done virtually, but virtual tours may not be fully reflective of the facilities used by the programs.

The AGDOO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Facility tours

The AGDOO RC believed the following components of the site visit must be conducted on-site:
- Review of documentation, including patient records, because of HIPAA and privacy requirements

**Oral Medicine:** The AGDOO RC believed that, with the exception of program records, including patient records, all components of a site visit could conducted virtually. Additionally, the AGDOO RC believed tours could be done virtually, but virtual tours may not be fully reflective of the facilities used by the programs.

The AGDOO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Facility tours

The AGDOO RC believed the following components of the site visit must be conducted on-site:
- Review of documentation, including patient records, because of HIPAA and privacy requirements

**Orofacial Pain:** The AGDOO RC believed that, with the exception of program records, including patient records, all components of a site visit could conducted virtually. Additionally, the AGDOO RC believed tours could be done virtually, but virtual tours may not be fully reflective of the facilities used by the programs.

The AGDOO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Facility tours

The AGDOO RC believed the following components of the site visit must be conducted on-site:
- Review of documentation, including patient records, because of HIPAA and privacy requirements
Dental Public Health Review Committee

The DPH RC believed that with appropriate technology and procedures, the entire site visit could be conducted virtually, especially in light of the fact there are no clinical records to review or clinical facilities inspect. The DPH RC also believed, if necessary, video and/or photographs could be provided in lieu of on-site tour. The DPH RC also believed the on-site evaluation should occur at whatever timeframe is required to meet Department of Education requirements.

The DPH RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Review of documentation that is not confidential and/or private
- Facility tours, using video and/or photographs, if appropriate

The DPH RC believed the following components of the site visit must be conducted on-site:
- Review of private and confidential files/records

Endodontics Review Committee

Endodontics: The ENDO RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements. Given the number of unknowns stemming from the ongoing pandemic, the Committee believed that site visits could be conducted almost entirely by virtual means. The ENDO RC also predicted that a largely virtual model could set a precedent for the future, although the design of an initial model may change over time.

The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information. The ENDO RC also believed that the standardization of how the technology is utilized would be important so as not to put any program at a disadvantage based on its technological capabilities. Further, security concerns such as prevention of recording of interviews must be carefully considered. The thorough preparation of site visitors in advance of a virtual site visit (e.g., reviewing documents, requesting additional information) was emphasized by the Committee through their discussion of how the self-study and the site visit are complementary, and that the site visit must remain a verification process.

The ENDO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences with faculty, administration, and students/residents
- Review and discussion of the electronic self-study, including all interviews associated with review of Accreditation Standards
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Facility tour by video; whether pre-recorded or live
• Inspection of facilities and instrumentation
• Chart/Record reviews (i.e., those that might be subject to confidentiality, HIPAA or FERPA)

The ENDO RC believed the following components of the site visit must be conducted on-site:
• Follow-up on issues identified through virtual visit

### Oral and Maxillofacial Pathology Review Committee

The OMP RC believed the Commission should conduct virtual site visits when possible and necessary during COVID-19. The OMP RC also believed that nearly all of the components of a site visit could be conducted virtually.

The OMP RC believed the following components of the site visit could be conducted virtually:
• Interviews with faculty and students/residents
• Review of program documentation and records as long as they are reviewed in a manner that maintains confidentiality.
• To the extent possible, facility tours and review of specimens

The OMP RC believed the following components of the site visit must be conducted on-site:
• Review of program documentation and records where confidentiality cannot be maintained
• Facility tours and review of specimens in situations where virtual review is not possible

### Oral and Maxillofacial Radiology Review Committee

The OMR RC agreed that nearly all components of a site visit could be conducted virtually, with the exception of facility tours. In addition, the OMR RC determined review of documentation could be conducted virtually if compliance with HIPAA and FERPA is assured.

The OMR RC believed the following components of the site visit could be conducted virtually:
• Interviews and conferences
• Review of documentation and patient charts, as long as compliance with HIPAA and FERPA are maintained

The OMR RC believed the following components of the site visit must be conducted on-site:
• Facility tours
• Review of documentation and patient charts if confidential and secure review cannot be assured through virtual site visit

The Committee also discussed the type of documentation and/or method of review that may require modification for components of the site visit that may be conducted virtually. The OMR RC discussed the importance of programs providing sufficient information in the self-
study for review prior to the site visit to ensure a more efficient on-site review. Further, the OMR RC believed CODA may want to look into future enhancements of the self-study process to include annual oversight and distributed review of portions of the self-study to occur over the 7-year cycle rather than every 7 years, which could result in review of the program as needed depending on the findings.

**Oral and Maxillofacial Surgery (Residency and Fellowship) Review Committee**

**Oral and Maxillofacial Surgery:** The OMS RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information, and understood that security, logistics, and other concerns will need to be addressed by the Commission. The Committee particularly noted the need to ensure the integrity of the review process and suggested the use of program waivers or attestations to the accuracy and completeness of the virtual site visit material and activity. The OMS RC fully supported the implementation of virtual site visits and viewed it as a necessity due to the evolving and uncertain nature of the pandemic impacting travel, personal preferences of volunteer site visitors, institutional limitations, and other factors.

The OMS RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences with faculty, administration, and residents; while preferred in-person, could be conducted virtually
- Review and discussion of the electronic self-study
- Review of on-site documents, which would require conversion to an electronic format and provided to the site visit team in advance of the visit
- Facility tours may be conducted through video; whether pre-recorded or live

The OMS RC believed the following components of the site visit must be conducted on-site:
- Follow-up on issues identified through virtual site visit
- Document review of sensitive and/or confidential information (i.e., those that might be subject to confidentiality, HIPAA)
- Facility tours are preferred in person, but could be conducted virtually as noted above

**Orthodontics and Dentofacial Orthopedics (Residency and Fellowship) Review Committee**

**Orthodontics and Dentofacial Orthopedics:** The ORTHO RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education (USDE) requirements. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of information.
Following discussion, the ORTHO RC noted that special focused site visits and initial accreditation site visits, should remain in-person only. The Committee believed that regularly scheduled site visits, with some adaptation, could be completed virtually in their entirety during COVID-19. Some elements, such as patient care activities, student/resident interviews, and facilities tours, are preferred to occur in-person but may be accommodated virtually with in-person follow-up at an appropriate time.

The ORTHO RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences with faculty, administration, and students/residents, although student/resident interviews are preferred in-person
- Facility tour (recorded or live), although preferred in-person
- Review and discussion of the electronic self-study
- Review of on-site documents

The ORTHO RC believed the following components of the site visit would best be conducted on-site:
- Follow-up to questions that could not be adequately addressed virtually
- Tour of the facilities
- Patient care activities
- Student/Resident interviews

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<thead>
<tr>
<th>Pediatric Dentistry Review Committee</th>
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<tr>
<td>The PED RC believed all components of a site visit could be conducted virtually, as long as the technology allows for confidential sessions and document portals are secure and password protected. The PED RC also discussed the length of the visit and the fact that site visits may need to be extended to ensure sufficient time for site visit team discussions and frequent breaks to avoid “screen” fatigue. Finally, the PED RC believed the follow up on-site visit should be conducted no more than 12 months following the virtual visit.</td>
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The PED RC believed the following components of the site visit could be conducted virtually:
- Interviews and conferences
- Documentation and patient chart review as long as confidentiality is maintained
- Facility tours

The PED RC believed the following components of the site visit must be conducted on-site:
- Documentation and patient chart reviews if confidentiality cannot be maintained
- Confirmation of findings of virtual site visit

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<tr>
<th>Periodontics Review Committee</th>
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<tr>
<td>Periodontics: The PERIO RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education</td>
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The PERIO RC believed that the Commission should conduct alternative (virtual) site visits wherever possible and necessary during COVID-19, recognizing that some components of the site visit must also be conducted during the on-site evaluation that is to occur within a reasonable time in accordance with United States Department of Education.
(USDE) requirements. The Committee noted that special care should be taken to ensure the confidentiality of the process and protection of personal and patient information. The PERIO RC also believed that the virtual process should include the allowance for a site visitor’s request for, and receipt of, additional information to demonstrate compliance with Accreditation Standards and CODA policies, a common occurrence during an in-person site visit.

Through discussion, the Committee believed that at least two thirds of the site visit could be conducted virtually, with follow-up and review of sensitive and/or confidential information to be completed on site. The PERIO RC also noted the value in physical inspection of clinic space, and related items, which could be part of the follow-up visit.

The PERIO RC believed that an initial accreditation visit could be even further streamlined through a virtual mechanism. While most site visits could be conducted virtually, the PERIO RC noted that the special focused site visit may need to remain in-person.

The PERIO RC believed the following components of the site visit could be conducted virtually:

- Interviews and conferences with faculty, administration, and students/residents
- Review and discussion of the electronic self-study
- Review of documents stated in self-study
- Clinic spaces, library, other appropriate facilities could be viewed by video

The PERIO RC believed the following components of the site visit must be conducted on-site:

- Document review of sensitive and/or confidential information (i.e., those that might be subject to confidentiality, HIPAA or FERPA), such as ambulatory records, hospital charts, operating room logs, program documentation and attending staff and student/resident files, periodontics program Methods of Evaluation, production reports, sedation logs, competency records, and other documentation not stated in self-study
- Follow-up tour of clinics and other related facilities

**Prosthodontics Review Committee**

The PROS RC believed that all components of a site visit could be conducted virtually with two exceptions: review of documentation that is considered private and confidential, and facility tours. Interviews could be conducted virtually, but the PROS RC noted additional time may be needed to allow for individual interviews in addition to group interviews. The PROS RC also believed as much information as possible should be provided to the site visit team in advance of the site visit to allow more time for other on-site activities. Finally, the PROS RC believed the on-site visit should be conducted no more than six (6) months after the virtual visit to ensure the findings and information gained virtually is current.

The PROS RC believed the following components of the site visit could be conducted virtually:

- Interviews and conferences
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- Review of program documentation that is not private and/or confidential

The PROS RC believed the following components of the site visit must be conducted on-site:
- Review of program documentation considered private and/or confidential
- Facility tours
TECHNOLOGY IMPLICATIONS FOR VIRTUAL SITE VISITS

Commission on Dental Accreditation Technology Needs

- Zoom Accounts – Currently CODA has three (3) accounts and each staff has Skype for Business; are more accounts needed? What if the program/institution does not permit use of Zoom?
- Computer and Webcam – All staff have laptop computers with webcam; Site Visitors must have access to a computer with webcam
- Internet – CODA and Site Visitors must have access to stable internet connections to support web-streaming
- Telephones – CODA staff have softphone on computer; Site Visitors may need access to telephone systems while working on computer
- ADA Connect - ADA Connect site may need to be expanded to develop more individual folders for confidential program upload of site visit materials. May need to determine capacity of site if program materials are retained in this location for an extended period of time (uploaded three months prior to site visit and held in this site until visit ends and report is generated).
- Other?

Educational Program Technology Needs

- Computers to run multiple concurrent interviews, with video capability (webcam) to focus on each interviewee
- Webcams (if not built into laptop)
- Stable internet connection
- Video equipment (pre-recorded or live) or still photo equipment for touring facilities
  - “high speed action camera technology” (DA RC Comment)
- Ability to utilize Zoom, per CODA system, or provide an alternative
- Ability to provide access to CODA and site visitors to examine “on-site” documents
- Other?

CODA Site Visitor Technology Needs

- Computer and Webcam; ability to review materials (paper or virtual) while conducting interviews
- Ability to access Zoom or another technology without firewall concerns
- Internet – Access to stable internet connections to support web-streaming
- Telephones –Site Visitors may need access to telephone systems while working on computer
- ADA Connect – ability to access confidential program upload of site visit materials.
- Other?
PROPOSED POLICY ON TEMPORARY USE OF ALTERNATIVE SITE VISIT METHODS

CODA Policy on Temporary Use of Alternative Site Visit Methods

On March 13, 2020, a national emergency was declared due to the COVID-19 pandemic. As a result of the continued impact on travel, the Commission on Dental Accreditation (CODA) has determined temporary use of alternative site visit (i.e., virtual or hybrid site visit) methods may be necessary to fulfill the Commission’s obligation to conduct accreditation site visits to programs that are currently accredited by, or apply for accreditation by, the Commission. The term of this policy shall be in effect upon CODA approval and until the termination date of the temporary flexibility granted through the United States Department of Education.

Alternative site visit methods **may be used** to conduct site visits to U.S.-based dental education programs seeking accreditation (applicant programs) as well as regular reaccreditation and special focused site visits, as applicable. The conduct of a site visit using alternative methods will be based on travel, health and safety concerns and/or restrictions in the geographic location(s) that may be visited by the Commission’s staff and volunteers, or for other reasons deemed appropriate by the Commission during the pandemic (for example, institutional, local, state, or federal directives).

Alternative site visit methods **may not be used** for any portion of the international accreditation process, including but not limited to the CODA Preliminary Accreditation Consultation Visit (PACV) process and the CODA predoctoral dental education international accreditation process.

Alternative site visits may be entirely virtual (all site visitors remote), or hybrid (at least one (1) on-site Commission site visitor in the discipline), as determined by the Commission in consultation with the program and site visit committee, and subject to the Commission’s final decision.

- Virtual site visits will require an on-site visit by a Commission site visit team (with 1-2 team members per discipline and, as necessary, Commission staff), as dictated by the Commission. The on-site visit to the educational program will occur within a period not to exceed 18 months following the conduct of a virtual site visit unless cause exists to conduct the visit earlier, subject to CODA’s site visit schedule and ongoing health, safety, and/or travel concerns and/or restrictions. During the in-person visit, the Commission reserves the right to review the portions of the program that could not be completed virtually (e.g. facility tours, clinic observations, educational activity site tours, confidential document reviews, patient record reviews, etc.) and any areas in which concerns were raised during the virtual site visit, or other standards, policies and/or procedures that may arise during the course of the in-person site visit.

- Hybrid site visits will be structured to include all components of the site visit process, with both virtual and on-site review of the program by Commission site visitors. As such, the Commission will view the hybrid site visit as equivalent to an on-site visit, with no secondary visit required based solely upon the methodology used to conduct the site visit.
Ad Hoc Alternative Site Visit Methods
Commission Only

- Following the virtual (followed by a later on-site visit) or hybrid site visit, the program’s next regular reaccreditation on-site visit will be scheduled seven (7) years following the date of the virtual or hybrid site visit in all disciplines except oral and maxillofacial surgery (residency and fellowship), which will be scheduled five (5) years following the date of the virtual or hybrid site visit. The Commission reserves the right to conduct an earlier visit to the program in accordance with Commission policies and procedures (e.g. special focused site visit, pre-graduation site visit).

Generally, for all alternative site visit methods, the Commission’s current policy and procedure related to the conduct of a site visit and Commission review of site visit reports, progress reports, and other due process noted in the Evaluation and Operational Policies and Procedures will apply.

The following principles apply to the temporary use of alternative site visit methods:
- The program will be issued a preliminary draft site visit report following the site visit, regardless of site visit format, in accordance with Commission policy. The preliminary draft site visit report will be provided to the Commission along with the program’s response, should one be submitted, and the Commission will make an accreditation decision based on this report.
- When Accreditation Standards are revised during the period in which the program is submitting progress reports for either the virtual, hybrid or in-person site visit, the program will be responsible for demonstrating compliance with the new standards. Further, identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.
- In order to conduct a virtual or hybrid site visit, the program must utilize the Commission’s meeting technology (i.e., Zoom), since the Commission will serve as host for the site visit. If the program cannot comply with use of CODA’s technology, the site visit will be delayed and the program must submit a formal request for extension of accreditation using the Report of Program Change, which will be considered by the Commission at its next regular meeting.
- All virtual/hybrid site visits will be conducted using the time zone of the program being visited, documenting all time zones using CODA’s site visit schedule template.
- Audio and/or video recording of the site visit is strictly prohibited.
- The Commission will dictate the portions of a site visit that will be conducted using alternative site visit methods.
  - The following applies to the conduct of a virtual-only site visit:
    - The Commission and its site visit team will dictate the final schedule of the site visit.
    - Tours of vacant facilities may be conducted virtually. However, all clinical observations and tours that may involve access to patients, will be conducted on-site only.
    - All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally
Identifiable Information (PII), FERPA or other confidential records will not be reviewed virtually.

- Student/Resident/Fellow interviews will be conducted virtually and on-site.
- All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.

- The following applies to the conduct of a hybrid site visit:
  - The Commission and its site visit team will dictate the final schedule of the site visit.
  - All clinical observations and tours that may involve access to patients, will be conducted by the on-site visitor only. Tours of vacant facilities may be conducted virtually for the entire visiting committee.
  - All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will be reviewed on-site only.
  - Student/Resident/Fellow interviews will be conducted virtually and on-site.
  - All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.

Adopted [insert date]
Site Visitor Manual for Alternative (Virtual or Hybrid) Site Visit Methods
## CODA Site Visitor Manual for Alternative (Virtual or Hybrid) Site Visit Methods

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CODA Policy on Temporary Use of Alternative Site Visit Methods

On March 13, 2020, a national emergency was declared due to the COVID-19 pandemic. As a result of the continued impact on travel, the Commission on Dental Accreditation (CODA) has determined temporary use of alternative site visit (i.e., virtual or hybrid site visit) methods may be necessary to fulfill the Commission’s obligation to conduct accreditation site visits to programs that are currently accredited by, or apply for accreditation by, the Commission. The term of this policy shall be in effect upon CODA approval and until the termination date of the temporary flexibility granted through the United States Department of Education.

Alternative site visit methods may be used to conduct site visits to U.S.-based dental education programs seeking accreditation (applicant programs) as well as regular reaccreditation and special focused site visits, as applicable. The conduct of a site visit using alternative methods will be based on travel, health and safety concerns and/or restrictions in the geographic location(s) that may be visited by the Commission’s staff and volunteers, or for other reasons deemed appropriate by the Commission during the pandemic (for example, institutional, local, state, or federal directives).

Alternative site visit methods may not be used for any portion of the international accreditation process, including but not limited to the CODA Preliminary Accreditation Consultation Visit (PACV) process and the CODA predoctoral dental education international accreditation process.

Alternative site visits may be entirely virtual (all site visitors remote), or hybrid (at least one (1) on-site Commission site visitor in the discipline), as determined by the Commission in consultation with the program and site visit committee, and subject to the Commission’s final decision.

- Virtual site visits will require an on-site visit by a Commission site visit team (with 1-2 team members per discipline and, as necessary, Commission staff), as dictated by the Commission. The on-site visit to the educational program will occur within a period not to exceed 18 months following the conduct of a virtual site visit unless cause exists to conduct the visit earlier, subject to CODA’s site visit schedule and ongoing health, safety, and/or travel concerns and/or restrictions. During the in-person visit, the Commission reserves the right to review the portions of the program that could not be completed virtually (e.g. facility tours, clinic observations, educational activity site tours, confidential document reviews, patient record reviews, etc.) and any areas in which concerns were raised during the virtual site visit, or other standards, policies and/or procedures that may arise during the course of the in-person site visit.

- Hybrid site visits will be structured to include all components of the site visit process, with both virtual and on-site review of the program by Commission site visitors. As such, the Commission will view the hybrid site visit as equivalent to an on-site visit, with no secondary visit required based solely upon the methodology used to conduct the site visit.

- Following the virtual (followed by a later on-site visit) or hybrid site visit, the program’s next regular reaccreditation on-site visit will be scheduled seven (7) years following the date of the virtual or hybrid site visit in all disciplines except oral and maxillofacial surgery (residency and fellowship), which will be scheduled five (5) years following the date of the virtual or hybrid site visit. The Commission reserves the right to conduct an earlier visit to the program in accordance with Commission policies and procedures (e.g. special focused site visit, pre-graduation site visit).

Generally, for all alternative site visit methods, the Commission’s current policy and procedure related to the conduct of a site visit and Commission review of site visit reports, progress reports, and other due process noted in the Evaluation and Operational Policies and Procedures will apply.

The following principles apply to the temporary use of alternative site visit methods:

- The program will be issued a preliminary draft site visit report following the site visit, regardless of site visit format, in accordance with Commission policy. The preliminary draft site visit report will be provided to the Commission along with the program’s response, should one be submitted, and the Commission will make an accreditation decision based on this report.

- When Accreditation Standards are revised during the period in which the program is submitting progress reports for either the virtual, hybrid or in-person site visit, the program will be responsible for demonstrating compliance with the new standards. Further, identification of new
deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

- In order to conduct a virtual or hybrid site visit, the program must utilize the Commission’s meeting technology (i.e., Zoom), since the Commission will serve as host for the site visit. If the program cannot comply with use of CODA’s technology, the site visit will be delayed and the program must submit a formal request for extension of accreditation using the Report of Program Change, which will be considered by the Commission at its next regular meeting.
- All virtual/hybrid site visits will be conducted using the time zone of the program being visited, documenting all time zones using CODA’s site visit schedule template.
- Audio and/or video recording of the site visit is strictly prohibited.
- The Commission will dictate the portions of a site visit that will be conducted using alternative site visit methods.
  - The following applies to the conduct of a virtual-only site visit:
    - The Commission and its site visit team will dictate the final schedule of the site visit.
    - Tours of vacant facilities may be conducted virtually. However, all clinical observations and tours that may involve access to patients, will be conducted on-site only.
    - All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will not be reviewed virtually.
    - Student/Resident/Fellow interviews will be conducted virtually and on-site.
    - All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.
  - The following applies to the conduct of a hybrid site visit:
    - The Commission and its site visit team will dictate the final schedule of the site visit.
    - All clinical observations and tours that may involve access to patients, will be conducted by the on-site visitor only. Tours of vacant facilities may be conducted virtually for the entire visiting committee.
    - All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will be reviewed on-site only.
    - Student/Resident/Fellow interviews will be conducted virtually and on-site.
    - All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.

Adopted [insert date]
INTRODUCTION TO THE ALTERNATIVE (VIRTUAL OR HYBRID) SITE VISIT PROCESS

The purpose of this manual is to provide Commission on Dental Accreditation (CODA) site visitors with guidance on the conduct of site visits using alternative site visit methods. Please carefully review the policy noted above, as well as the protocols noted below. The protocols below have been established to ensure consistency in the site visit process. All protocols must be followed, as written, unless another arrangement is made with the Commission Office.

Contact the Commission Office immediately should you have any questions or concerns.

By receiving this manual, the CODA site visitor affirms they have read the CODA Site Visitor Manual for Alternative Site Visits and agree to follow the guidelines in support of a virtual or hybrid site visit.

Site Visitor Expectations

The Commission appreciates the time and resources required to conduct an accreditation site visit. Use of alternative site visit methods will require additional dedication to ensure that the site visit process is a smooth one for both the CODA site visitor(s) and the educational program under review.

CODA site visitors are expected to dedicate their entire focus to the conduct of the accreditation site visit, regardless of the format used to conduct the visit. Therefore, a site visitor should only accept an assignment if they are able to dedicate uninterrupted time to all days of the site visit. The site visit schedule will not be modified to accommodate site visitors’ needs.

The CODA site visitor must:

- Have access to a quiet and private space to conduct the site visit. You must not be disturbed by co-workers, family, pets, or any other distractions during the site visit. Conducting CODA business in a public space is prohibited.
- Have access to secure and reliable internet throughout the site visit. You must not use public internet browsers when conducting CODA business. A personal or work, secure browser must be used.
- Have a desktop or laptop computer for use throughout the site visit.
- Have audio and camera functionality on the computer used for the site visit.
- Have the ability to utilize Zoom.
- Have the ability to dedicate time to conduct the entire visit, as scheduled.
- Represent the Commission in a professional manner:
  - Dress professionally (top and bottom)
  - Do not multi-task – no other distractions should be present
  - Silence phones and other interruptions
  - Keep focused on the conversation and engage in the discussion
  - Speak clearly and keep in mind video and voice delays

Site Visitor Technology Requirements

It is critical that a site visitor’s technology function properly throughout the site visit process. The program being site visited will host the site visit using its technology and will make CODA staff and site visitors the designated hosts and co-hosts of each session. Executive sessions for the site visit team must be set up with a different login that is only provided to CODA staff and site visitors, and the CODA staff and site visitors must be the host and co-hosts. Zoom technology is preferred. All site visitors must have the ability to utilize electronic business platforms when conducting CODA business.

The following protocols must be followed:

- The program will host all conferences using its technology; Zoom is preferred. Confidentiality is expected, and there must be no recording of any session.
• The site visitor must use a desktop or laptop computer for conferences, which includes:
  o A camera, which must be on at all times during the site visit
  o A microphone, which must be functional at all times during the site visit
  o A speaker, which must be functional at all times during the site visit
  o Use ear buds or headphones to limit background noise and ensure privacy
• The site visitor must have access to a secure internet connection using broadband wired or wireless networking (3G, 4G/LTE or 5G).
• The site visitor must have a backup technology plan, equipment/device.
• The site visitor must test their equipment prior to the site visit to ensure it is in working order.

**Program/Institution Technology Requirements**

• The program will host all conferences using its technology; Zoom is preferred. **Confidentiality is expected, and there must be no recording of any session.**
• Each individual who will meet with CODA site visitors must have audio and camera functionality on the computer used for the site visit.
• Video must be on at all times for all program representatives, including students/residents/fellows, faculty and staff. Picture placeholders or blank screens with names are not permitted. Anyone using this method will be removed from the meeting.
• If the site visit team or program encounter technology issues, CODA may use its discretion to schedule a second virtual or hybrid site visit or to delay the site visit until an in-person visit may be conducted.

**Conduct of Virtual Meetings**

The program will host all conferences using its technology; Zoom is preferred. The program will designate the Chair and at least one other site visitor and/or CODA staff as the host/co-host. At all times during the site visit, two or more CODA volunteers must be the co-host to ensure that a technology failure of the host does not terminate the virtual meeting.

• Ensure you are in a private meeting space without distractions.
• Become familiar with the meeting technology (see guide below)
• Video must be on at all times. Picture placeholders or blank screens with names are not permitted. Anyone using this method must be removed from the meeting.
• **DO NOT record any of the meetings. CODA prohibits the recording of meetings.**
• **DO NOT use the Chat feature. There is to be no chat during the site visit. Site visit team member discussions are to be reserved for Executive Sessions.**
• Use ear buds or headphones to limit background noise and ensure privacy
• All participants must use the videoconferencing feature. However, if internet goes down and the videoconferencing technology fails, the site visitor must immediately access the meeting using the telephone dial-in and may participate by audio only until internet is restored.
• Designate multiple co-hosts among the site visit team members for each videoconference session.
• Begin the initial meeting 15 minutes early to allow people to enter the virtual meeting and troubleshoot.
• At each session, once all attendees are present, the host/co-host must “lock” the meeting.

**Virtual Meeting Rooms:** There will be two (2) room types used during the site visit, as follows:

- Executive Session Room – to be used by the site visit team only, with a separate link for access.
- Meeting Room and Breakout Rooms – to be used by the site visit team and program representatives.

Both rooms will have breakout room functionality. Additionally, both rooms will have a waiting room and the site visit chair, site visit team members, and CODA staff will have to grant permission for individuals to enter.
Review of Self-Study and On-Site Program Documents

- The program is expected to upload to CODA’s E-Accreditation platform its Self-Study and any materials that would typically be reviewed on-site. It is the program’s obligation to ensure these materials adhere to CODA’s policies related to privacy and data security found at https://www.ada.org/en/coda/policies-and-guidelines/hipaa. If any member of the site visit team believes that prohibited information has been submitted, please notify the Commission staff immediately.
- CODA will provide the site visit team with the program’s Self-Study in the E-Accreditation platform. These materials will be securely deleted from the E-Accreditation platform following the site visit. The Self-Study will be retained in the program’s file, in accordance with CODA protocol.
- The program’s “on-site documentation” will be provided in a separate folder on the E-Accreditation platform. The program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file by CODA, unless necessary to document a site visit finding.
- All program and CODA site visit related materials must be securely disposed of from the site visitor’s personal device(s) immediately following the site visit, per CODA policy.

Conduct of the Site Visit**

It is important all site visitors be aware of the site visit schedule and meeting protocol in advance of the site visit. Please note site visits will occur based on the time zone of the program being visited, with notation of all time zones using CODA’s site visit schedule template.

** Also See Section on Conducting a Program Review Using Technology

Site Visit Schedule

- Programs must prepare a schedule that accounts for all time zones, to assist the site visit team. If the site visit team does not receive the appropriate schedule, contact the program through the Site Visit Chair or Commission Staff. (See Schedule Template below)
- The site visit schedule for a virtual or hybrid site visit must be consistent with the time spent for an on-site visit. Site Visits may not be shortened and may not be extended due to their virtual/hybrid format.
- There is to be no more than 15 program representatives at any interview session. Additional individuals will be difficult to manage.
- The site visit schedule must include all components noted in the site visit schedule template used for an on-site visit, with the following modifications:
  - There is to be no clinic observation when patients are present in the clinic. Real-time tours of vacant clinics and facilities are acceptable.
  - All students/residents/fellows (“students”) must be invited to the student interview session. If the total student population exceeds 20 students, separate the sessions to accommodate an equal amount of time for each year of the program with each session attended by 20 students. (For example, if there are 40 students total, 20 per class, there should be two (2) student sessions. If there are 80 students total, 40 per class, there should be four (4) sessions with two (2) sessions per class.) Student sessions for all disciplines under CODA’s purview will also occur at the second (in-person) site visit.
  - For dental school site visits, the student session will be limited to the structured meeting with class representatives. Student sessions will also occur at the second (in-person) site visit.
The Site Visit Schedule must be provided by the program using the following format:

Day X: Day, Date

<table>
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<tr>
<th>Subject of Conferences</th>
<th>Names and Titles of Individuals Meeting with Committee</th>
<th>Room Link</th>
<th>Pacific Time</th>
<th>Mountain Time</th>
<th>Central Time</th>
<th>Eastern Time</th>
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<td>Interview with Administration (CEO/CAO/Program Director)</td>
<td>First and Last Name, CEO First and Last Name, CAO First and Last Name, Program Director</td>
<td>Meeting Technology Link</td>
<td>6:00 – 6:30am</td>
<td>7:00 – 7:30am</td>
<td>8:00 – 8:30am</td>
<td>9:00 – 9:30am</td>
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**Before the Site Visit**
- Ensure your technology is operable and reliable, and that you will have a confidential place to conduct the site visit.
- Ensure you have access to and have reviewed the program’s Self-Study, On-Site Documentation, and the Site Visit Schedule, via the CODA E-Accreditation portal.
- Communicate with the site visit team members, as usual, noting any additional information that the program should upload to the E-Accreditation portal.
- Coordinate and prepare for the first Executive Session with the site visit team.
- Review the Site Visit Schedule. The site visit schedule for a virtual/hybrid site visit must be consistent with the time spent for an on-site visit. Site Visits may not be shortened and may not be extended due to their virtual or hybrid format.

**During the Site Visit**
- Start the Executive Session (first site visit meeting) at least 15 minutes ahead of schedule to ensure all technical difficulties are addressed.
- Prior to each interview, ask each individual to announce their name and role, just like in-person meetings. Keep the schedule handy to reference individuals who should be in attendance at each session.
- Remove any individual who is not visible or should not be in attendance during each session.
- At the start of each interview session, remind all attendees that there must be no recording of the CODA meetings.
- All site visitors must fully engage in interviews, allowing for question and answer to each standard that must be addressed. Remember there may be audio delays, so speak clearly and pause between questions. Do not speak while others are speaking.
- Ask questions as you would for an in-person visit, to help guide the process of program review given the virtual or hybrid format.
- Remember, the program may provide aggregate information that comports with CODA’s privacy and data security policy found at [https://www.ada.org/en/coda/policies-and-guidelines/hipaa](https://www.ada.org/en/coda/policies-and-guidelines/hipaa).
- All Accreditation Standards must be reviewed regardless of the format of the site visit (in-person, virtual, or hybrid), and documentation to support compliance must conform to CODA’s privacy and data security requirements.
  - There will be no review of PHI, PII, Student/Resident/Fellow Files or other confidential records using technology; these type of records may be reviewed on-site only. The
program must demonstrate compliance with all Accreditation Standards providing aggregate data when needed.

- Facility tour will be pre-recorded and may be supplemented with a “real-time / live” virtual tour during the site visit. Real-time / Live tours must be to facility spaces in which no patients are present.
  - For the “real-time / live” tour, the site visitors may want to have a general walk-through of the vacant facility, looking at clinical space, laboratory space, student/resident/fellow space, office space, and other areas, as applicable. The site visit team may want to ask the program to open instrument draws or demonstrate emergency equipment is in place, etc.

- In lieu of a visit to sites where educational activity occurs, the site visit team should request educational site faculty/attending staff be available for interviews. Tour of educational activity sites can occur as noted above for facility tours.

- Conduct Executive Sessions at regular intervals throughout the site visit.
- Develop a single Site Visitor Evaluation Report of findings to submit to the Commission by the site visit Chair. The SVER must be complete and must address the program’s compliance with all Accreditation Standards, as would be expected for an in-person site visit.
- Provide an exit session in which you provide the verbal final findings of the site visit. There is no recording of this session.
- All other protocols, policies and procedures of the Commission apply to the conduct of virtual or hybrid site visits.

**After the Site Visit**

- Regardless of the site visit format, all CODA protocols apply for the submission of the site visit team’s Site Visitor Evaluation Report and review of the Preliminary Draft Site Visit Report.
- Do not engage in any further communication with the program following the site visit.
- All program and CODA site visit related materials must be securely disposed of from the site visitor’s personal device(s) immediately following the site visit, per CODA policy.
# COMMISION ON DENTAL ACCREDITATION
## STAFF LIST

CODA Direct Dial: 312-440-EXT.

211 E. Chicago Avenue, Suite 1900, Chicago, IL 60611

<table>
<thead>
<tr>
<th>Directors</th>
<th>Ext.</th>
<th>Email</th>
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<tr>
<td>Dr. Sherin Tooks, Director</td>
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<td><a href="mailto:tookss@ada.org">tookss@ada.org</a></td>
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<tr>
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<td>Ms. Peggy Soeldner 2788 <a href="mailto:soeldnem@ada.org">soeldnem@ada.org</a> General Practice Residency &lt;GPR&gt;, Adv. Education in Gen. Dent. &lt;AEGD&gt;, Oral Med., Dental Anesthesiology; Orofacial Pain</td>
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<td>Mr. Gregg Marquardt 2705 <a href="mailto:marquardtg@ada.org">marquardtg@ada.org</a> Communication and Technology Strategies</td>
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<tr>
<th>Site Visit Coordinator Predoc/Advanced</th>
<th>Site Visit Coordinator Allied Dental Board Contact</th>
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</thead>
<tbody>
<tr>
<td>Ms. Kelsey Loveless 2675 <a href="mailto:lovelessk@ada.org">lovelessk@ada.org</a></td>
<td>Ms. Bernadette Molina 2668 <a href="mailto:molinab@ada.org">molinab@ada.org</a></td>
</tr>
</tbody>
</table>
Conducting a Program Review Using Technology

CODA’s preferred meeting platform is Zoom; however, the program will utilize the platform of its choosing. The program is expected to provide clear user instructions for their technology platform, as well as software access, and ongoing IT support to the CODA site visit team and CODA staff for duration of the site visit.

Prior to the Site Visit:

- Download the program documents and any other materials you intend to reference before your meeting begins. CODA's E-Accreditation Portal and other software systems may not permit access during a video conference. Make sure you have all the materials on your computer desktop in advance of the meeting. Create a Folder called “CODA Site Visit” and place items in this folder so that they can be easily and securely destroyed immediately following the site visit. Remember, the computer used for CODA business must be encrypted, must not back-up to cloud storage, and must auto-lock following 15 minutes of inactivity.

  Consider how you want to refer to these materials during the meeting. Options include:
  - Shrink the size of the videoconference screen (do not “leave the meeting”) and open the downloaded documents. You can enlarge the videoconference screen at any time.
  - Print out portions of the materials which you want to consult. Remember, these must be secured as they are confidential.
  - Use another device to refer to the meeting materials book. For example, your laptop or I-Pad for videoconference and your desktop for the downloaded material.
  - “Extend” your desktop if you are using multiple monitors.

- Test your internet and computer systems well in advance of the site visit. See elsewhere for additional technology requirements.

- Ensure the program has provided you with a quick-reference guide for using the program’s virtual meeting technology. Ensure that you have the ability to access and test the technology prior to the site visit; enlist the program’s IT staff should assistance be needed.

During the Site Visit:

- All videoconference meetings are confidential; recording via any method is strictly prohibited.

- Mute your microphone unless you are speaking.

- The Chat function must be disabled. No chatting will be permitted during CODA site visits.

- Protocols for videoconference meeting conduct are discussed elsewhere in this manual.
Zoom Instructions for Site Visitors
(If Program will Utilize Zoom)

Training materials and documentation
Zoom offers free live and interactive training courses. If you can’t attend one of the live sessions they also offer recorded versions of the training. These sessions are typically around 60 minutes long.

If you want to watch recorded training, start by watching the 30 minute Getting Started with Zoom video. https://livetraining.zoom.us/recording/play/F_BDBIJ-EndygEj16xL9flGaFwnvYvZw7CM2VEjW0BxAfFvCBYCQVvl7IhfL4uJ?continueMode=true

Then continue with the 60 minute Zoom Meetings Training video. https://livetraining.zoom.us/recording/play/48IlOfofCsCX-SIWKxxkHTv7JoPMeoGH-1uaDcY-P68pX-PU36fJT3FjkiWYkBvl?continueMode=true

Zoom also has short video tutorials on a variety of topics. These videos are 1 to 2 minutes long. They are a good reminder of how to do something after you’ve experienced the regular training.

Join a Zoom Meeting
https://www.youtube.com/embed/vFhAEoCF7jg?rel=0&autoplay=1&cc_load_policy=1

Zoom Meeting Controls - Introduction
https://www.youtube.com/embed/4w_pRMBEALE?rel=0&autoplay=1&cc_load_policy=1

How to Participate in a Zoom Meeting:

In your site visit schedule, click “Join Zoom Meeting:”

Join Zoom Meeting
https://zoom.us/j/833914312

Meeting ID: 833 914 312

Click “Open Zoom Meetings:”

https://zoom.us wants to open this application.

[Open Zoom Meetings] [Cancel]
Type your first and last name and click “Join:”

Join the audio one of three ways – By computer:

By calling the system:

Or by having the system call you:
The Zoom interface will look like this:

A. Show meeting information (meeting ID, Host, meeting URL)
B. Choose meeting view (Gallery vs Speaker view). Gallery view shows up to 49 participant’s video. Speaker view shows larger video of current speaker.
C. Microphone and Camera options (be SURE your mic is unmuted AND your computer speaker is on); the camera must also be on at all times
D. Participant’s information and options – all participants must include first and last name
E. Share content, chat and record settings (chat and record must not be used)
F. Exit meeting
Program Manual for Alternative (Virtual or Hybrid) Site Visit Methods

Adopted by CODA [insert date]
Commission on Dental Accreditation  
Program Manual for Alternative (Virtual or Hybrid) Site Visit Methods

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CODA Policy on Temporary Use of Alternative Site Visit Methods

On March 13, 2020, a national emergency was declared due to the COVID-19 pandemic. As a result of the continued impact on travel, the Commission on Dental Accreditation (CODA) has determined temporary use of alternative site visit (i.e., virtual or hybrid site visit) methods may be necessary to fulfill the Commission’s obligation to conduct accreditation site visits to programs that are currently accredited by, or apply for accreditation by, the Commission. The term of this policy shall be in effect upon CODA approval and until the termination date of the temporary flexibility granted through the United States Department of Education.

Alternative site visit methods may be used to conduct site visits to U.S.-based dental education programs seeking accreditation (applicant programs) as well as regular reaccreditation and special focused site visits, as applicable. The conduct of a site visit using alternative methods will be based on travel, health and safety concerns and/or restrictions in the geographic location(s) that may be visited by the Commission’s staff and volunteers, or for other reasons deemed appropriate by the Commission during the pandemic (for example, institutional, local, state, or federal directives).

Alternative site visit methods may not be used for any portion of the international accreditation process, including but not limited to the CODA Preliminary Accreditation Consultation Visit (PACV) process and the CODA predoctoral dental education international accreditation process.

Alternative site visits may be entirely virtual (all site visitors remote), or hybrid (at least one (1) on-site Commission site visitor in the discipline), as determined by the Commission in consultation with the program and site visit committee, and subject to the Commission’s final decision.

- Virtual site visits will require an on-site visit by a Commission site visit team (with 1-2 team members per discipline and, as necessary, Commission staff), as dictated by the Commission. The on-site visit to the educational program will occur within a period not to exceed 18 months following the conduct of a virtual site visit unless cause exists to conduct the visit earlier, subject to CODA’s site visit schedule and ongoing health, safety, and/or travel concerns and/or restrictions. During the in-person visit, the Commission reserves the right to review the portions of the program that could not be completed virtually (e.g. facility tours, clinic observations, educational activity site tours, confidential document reviews, patient record reviews, etc.) and any areas in which concerns were raised during the virtual site visit, or other standards, policies and/or procedures that may arise during the course of the in-person site visit.

- Hybrid site visits will be structured to include all components of the site visit process, with both virtual and on-site review of the program by Commission site visitors. As such, the Commission will view the hybrid site visit as equivalent to an on-site visit, with no secondary visit required based solely upon the methodology used to conduct the site visit.

- Following the virtual (followed by a later on-site visit) or hybrid site visit, the program’s next regular reaccreditation on-site visit will be scheduled seven (7) years following the date of the virtual or hybrid site visit in all disciplines except oral and maxillofacial surgery (residency and fellowship), which will be scheduled five (5) years following the date of the virtual or hybrid site visit. The Commission reserves the right to conduct an earlier visit to the program in accordance with Commission policies and procedures (e.g. special focused site visit, pre-graduation site visit).

Generally, for all alternative site visit methods, the Commission’s current policy and procedure related to the conduct of a site visit and Commission review of site visit reports, progress reports, and other due process noted in the Evaluation and Operational Policies and Procedures will apply.

The following principles apply to the temporary use of alternative site visit methods:

- The program will be issued a preliminary draft site visit report following the site visit, regardless of site visit format, in accordance with Commission policy. The preliminary draft site visit report will be provided to the Commission along with the program’s response, should one be submitted, and the Commission will make an accreditation decision based on this report.

- When Accreditation Standards are revised during the period in which the program is submitting progress reports for either the virtual, hybrid or in-person site visit, the program will be responsible for demonstrating compliance with the new standards. Further, identification of new
deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

- In order to conduct a virtual or hybrid site visit, the program must utilize the Commission’s meeting technology (i.e., Zoom), since the Commission will serve as host for the site visit. If the program cannot comply with use of CODA’s technology, the site visit will be delayed and the program must submit a formal request for extension of accreditation using the Report of Program Change, which will be considered by the Commission at its next regular meeting.

- All virtual/hybrid site visits will be conducted using the time zone of the program being visited, documenting all time zones using CODA’s site visit schedule template.

- Audio and/or video recording of the site visit is strictly prohibited.

- The Commission will dictate the portions of a site visit that will be conducted using alternative site visit methods.
  - The following applies to the conduct of a virtual-only site visit:
    - The Commission and its site visit team will dictate the final schedule of the site visit.
    - Tours of vacant facilities may be conducted virtually. However, all clinical observations and tours that may involve access to patients, will be conducted on-site only.
    - All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will not be reviewed virtually.
    - Student/Resident/Fellow interviews will be conducted virtually and on-site.
    - All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.

  - The following applies to the conduct of a hybrid site visit:
    - The Commission and its site visit team will dictate the final schedule of the site visit.
    - All clinical observations and tours that may involve access to patients, will be conducted by the on-site visitor only. Tours of vacant facilities may be conducted virtually for the entire visiting committee.
    - All program information must be provided to the site visitors in aggregate form and must conform to CODA’s privacy and data security policy. Documents that include Protected Health Information (PHI), Personally Identifiable Information (PII), FERPA or other confidential records will be reviewed on-site only.
    - Student/Resident/Fellow interviews will be conducted virtually and on-site.
    - All typical “on-site documentation” will be provided to the site visit committee and Commission in advance of the site visit, and must be limited to the essential documents to demonstrate a program’s compliance. The on-site documents will be uploaded to CODA’s electronic accreditation portal along with the program’s self-study. Following the site visit, the program’s “on-site documentation” will be securely destroyed and will not be retained in the program’s accreditation file, unless necessary to document a site visit finding.

Adopted [insert date]
INTRODUCTION TO THE ALTERNATIVE (VIRTUAL OR HYBRID) SITE VISIT PROCESS

The purpose of this manual is to provide dental, advanced dental, and allied dental education programs that are accredited by the Commission on Dental Accreditation (CODA) and those programs seeking accreditation with guidance on the conduct of site visits using alternative site visit methods. Please carefully review the policy noted above, as well as the protocols noted below. The protocols below have been established to ensure consistency in the site visit process. All protocols must be followed, as written, unless another arrangement is made with the Commission Office.

Contact the Commission Office immediately should you have any questions or concerns.

An “Alternative Site Visit Program Agreement” must be submitted to CODA acknowledging that the dental, allied dental, or advanced dental education program has read the CODA Program Manual for Alternative Site Visits and agrees to follow the guidelines in support of a virtual or hybrid site visit. The program director, chief academic officer, and chief executive officer of the institution must sign the agreement and return it to the CODA office in advance of the site visit. Failure to return a signed Alternative Site Visit Program Agreement could delay the program’s site visit and may affect the program’s accreditation status. Electronic signature are acceptable during the COVID-19 pandemic.

Program/Institution Technology Requirements

It is critical that the program’s technology function properly throughout the site visit process. The program being site visited will host the site visit using its technology and will make CODA staff and site visitors the designated hosts and co-hosts of each session. Executive sessions for the site visit team must be set up with a different login that is only provided to CODA staff and site visitors, and the CODA staff and site visitors must be the host and co-hosts. Zoom technology is preferred. All program/institutional representatives must have the ability to utilize electronic business platforms related to the conduct of a virtual or hybrid site visit.

The Commission appreciates the time and resources required to conduct an accreditation site visit. Use of alternative site visit methods will require additional dedication to ensure that the site visit process is a smooth one for both the CODA site visitor(s) and the educational program under review.

The following are expected:

- The program will host all conferences using its technology; Zoom is preferred. **Confidentiality is expected, and there must be no recording of any session.**
- Prior to the site visit, provide the CODA site visitors and staff a quick-reference guide for using your program’s virtual meeting technology. Ensure that each site visitor has the ability to access and test the technology prior to the site visit; enlist your IT staff should assistance be needed.
- Each individual who will meet with CODA site visitors must have audio and camera functionality on the computer used during the site visit.
- Video must be on at all times for all program representatives, including students/residents/fellows, faculty and staff. Picture placeholders or blank screens with names are not permitted. Anyone using this method will be removed from the meeting.
- The program must have an IT personnel available at all times during the site visit to assist with troubleshooting.
- If the site visit team or program encounter technology issues, CODA may use its discretion to schedule a second virtual or hybrid site visit or to delay the site visit until an in-person visit may be conducted.
Conduct of Virtual Meetings
The program will host all conferences using its technology; Zoom is preferred. The program will designate the Chair and at least one other site visitor and/or CODA staff as the host/co-host. The Host/Co-Host will remove individuals who are not identified as attendees during an interview session.

The Commission requests that program personal ensure the following:

- Secure a private meeting space without distractions.
- Become familiar with the meeting technology (see guide below)
- Video must be on at all times. Picture placeholders or blank screens with names are not permitted. Anyone using this method will be removed from the meeting.
- **DO NOT** record any of the meetings. CODA prohibits the recording of meetings.
  - The program has an obligation to inform all individuals meeting with the site visit team of this requirement.
- **DO NOT** use the Chat feature. There is to be no chat during the site visit. This feature must be disabled.
- First and last names must be used to identify each program representative within the virtual meeting platform. Initials, partial names, or other identifiers will result in an individual being removed from the interview session.
- In advance of the site visit, the program must provide the site visit schedule which identifies the names of each individual attending the interview sessions.
- Use ear buds or headphones to limit background noise and ensure privacy.
- All participants must use the videoconferencing feature. However, if internet goes down and the videoconferencing technology fails, the program personnel must immediately access the meeting using a telephone dial-in and may participate by audio only until internet is restored.
- Program personnel must to arrive to the virtual meeting five (5) minutes prior to the start time. Program personnel will enter a waiting room and be admitted to the meeting at the appropriate time.
- At each session, once all attendees are present, the host/co-host will “lock” the meeting.

The Self-Study and On-Site Program Documents

- The program is expected to upload to CODA’s E-Accreditation platform its Self-Study and any materials that would typically be reviewed on-site. The site visit team will access the program’s materials through CODA’s E-Accreditation platform.
- All Accreditation Standards will be assessed for compliance during the virtual/hybrid site visit, along with the program’s compliance with applicable policies and procedures as is the case during an on-site evaluation. The program is responsible for demonstrating compliance while ensuring confidentiality and compliance with privacy regulations.
- **It is the program’s obligation and responsibility to ensure all submitted (uploaded) materials adhere to CODA’s policies related to privacy and data security found at** [https://www.ada.org/en/coda/policies-and-guidelines/hipaa](https://www.ada.org/en/coda/policies-and-guidelines/hipaa). **Information that may be subject to FERPA or other expectations of confidentiality must not be uploaded to the CODA E-platform nor provided to the site visit team in any other manner.**
- **All program information, as applicable, must be submitted in aggregate form to ensure the confidentiality of information. Student/Resident/Fellow names, and all patient and individual identifiers (as noted in the policy linked above) must be removed from the submission.**
- **As a reminder – CODA site visit teams must not access HIPAA protected information or personally identifiable information (PII) when off-site from the program’s facility.**
- The program’s “On-Site Documentation” must be provided in a separate folder on the E-Accreditation platform. The program’s “On-Site Documentation” will be securely destroyed and will not be retained in the program’s accreditation file by CODA, unless necessary to document a site visit finding.
- **All program documentation must be organized and concise. The program must only submit information that is directly demonstrative of its compliance with the Accreditation Standards.**
CODA will provide the site visit team with the program’s Self-Study in the E-Accreditation platform. These materials will be securely deleted from the E-Accreditation platform following the site visit. The Self-Study and related documents will be retained in the program’s file, in accordance with CODA protocol.

**Conduct of the Site Visit**
It is critical the site visit team receive the site visit schedule of conferences in advance of the site visit. Please note site visits will occur based on the time zone of the program being visited, with notation of all time zones using CODA’s site visit schedule template.

**Site Visit Schedule**
- Programs must prepare a schedule that accounts for all time zones, to assist the site visit team. (See Schedule Template below)
- The site visit schedule for a virtual/hybrid site visit must be consistent with the time spent for an on-site visit. Site Visits may not be shortened and may not be extended due to their virtual or hybrid format.
- There is to be no more than 15 program representatives at any interview session. Additional individuals will be difficult to manage. Only those individuals with direct involvement in the specific area of the program under review should attend that portion of the site visit.
- The site visit schedule must include all components noted in the site visit schedule template used for an on-site visit, with the following modifications:
  - There is to be no clinic observation when patients are present in the clinic. Real-time tours of vacant clinics and facilities are acceptable.
  - All students/residents/fellows (“students”) must be invited to the student interview session. If the total student population exceeds 20 students, separate the sessions to accommodate an equal amount of time for each year of the program with each session attended by 20 students. *(For example, if there are 40 students total, 20 per class, there should be two (2) student sessions. If there are 80 students total, 40 per class, there should be four (4) sessions with two (2) sessions per class.)* Student sessions for all disciplines under CODA’s purview will also occur at the second (in-person) site visit.
  - For dental school site visits, the student session will be limited to the structured meeting with class representatives. Student sessions will also occur at the second (in-person) site visit.

The Site Visit Schedule must be provided by the program using the following format:

**Day X: Day, Date**

<table>
<thead>
<tr>
<th>Subject of Conferences</th>
<th>Names and Titles of Individuals Meeting with Committee</th>
<th>Room Link</th>
<th>Pacific Time</th>
<th>Mountain Time</th>
<th>Central Time</th>
<th>Eastern Time</th>
</tr>
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<tbody>
<tr>
<td>Interview with Administration (CEO/CAO/Program Director)</td>
<td>First and Last Name, CEO First and Last Name, CAO First and Last Name, Program Director</td>
<td>Meeting Technology Link</td>
<td>6:00 – 6:30am</td>
<td>7:00 – 7:30am</td>
<td>8:00 – 8:30am</td>
<td>9:00 – 9:30am</td>
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**Before the Site Visit**

- Ensure all program representatives' technology is operable and reliable, and that they will have a confidential place to conduct the site visit.
- Upload the program’s Self-Study, On-Site Documentation, and the Site Visit Schedule, via the CODA E-Accreditation portal in accordance with CODA requirements.
- Ensure all program representatives are aware of their assigned interview times and meeting access.
- Remind all attendees that there must be no recording of the CODA meetings. Additionally, individuals must log into the virtual meeting using first and last name. Cameras must be on at all times.
- Communicate with the site visit team Chair or CODA Staff, as usual, noting any additional information that the program should upload to the E-Accreditation portal at the site visit team’s request.

**During the Site Visit**

- Ensure that program representatives arrive five (5) minutes ahead of schedule to each interview session.
- Maintain ongoing access to IT support to ensure all technical difficulties are addressed.
- The program may provide aggregate information that comports with CODA’s privacy and data security policy found at [https://www.ada.org/en/coda/policies-and-guidelines/hipaa](https://www.ada.org/en/coda/policies-and-guidelines/hipaa).
- All Accreditation Standards will be reviewed regardless of the format of the site visit (in-person, virtual, or hybrid), and documentation to support compliance must conform to CODA’s privacy and data security requirements.
  - There will be no review of PHI, PII, Student/Resident/Fellow Files or other confidential records using technology; these type of records may be reviewed on-site only. The program must demonstrate compliance with all Accreditation Standards providing aggregate data when needed.
  - Facility tour will be pre-recorded and may be supplemented with a “real-time / live” virtual tour during the site visit. Real-time / Live tours must be to facility spaces in which no patients are present.
    - For the “real-time / live” tour, the site visitors may want to have a general walk-through of the vacant facility, looking at clinical space, laboratory space, student/resident/fellow space, office space, and other areas, as applicable. The site visit team may want to ask the program to open instrument draws or demonstrate emergency equipment is in place, etc.
  - In lieu of a visit to sites where educational activity occurs, the site visit team should request educational site faculty/attending staff be available for interviews. Tour of educational activity sites can occur as noted above for facility tours.
- Answer questions and reference supporting documentary evidence to demonstrate the program’s compliance with all Accreditation Standards and applicable policies and procedures.
- Attend the exit session in which the program will receive a verbal report of final site visit findings. There is no recording of this session or any other CODA site visit session.
- All other protocols, policies and procedures of the Commission apply to the conduct of virtual or hybrid site visits.

**After the Site Visit**

- The program will receive the Preliminary Draft Site Visit Report in accordance with CODA policies and procedures.
- The program will receive an electronic post site visit survey.
- Do not engage in any further communication with the program following the site visit. If questions arise, contact the Commission office.
## COMMISSION ON DENTAL ACCREDITATION
### STAFF LIST
CODA Direct Dial: 312-440-EXT.
211 E. Chicago Avenue, Suite 1900, Chicago, IL 60611

<table>
<thead>
<tr>
<th>Managers</th>
<th>Senior Project Assistants</th>
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<tbody>
<tr>
<td>Dr. Sherin Tooks, Director</td>
<td>2940 [<a href="mailto:tookss@ada.org">tookss@ada.org</a>]</td>
</tr>
<tr>
<td>Ms. Marjorie Hooper, Coordinator, CODA Operations</td>
<td>4653 [<a href="mailto:hooperm@ada.org">hooperm@ada.org</a>]</td>
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### Office of the Director / CODA Operations / International Predoctoral

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<tr>
<td>Ms. Dawn Herman</td>
<td>2721 Mr. Eric Wiig</td>
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<td>Ms. Jennifer Snow</td>
<td>2714 Mr. Christopher Castaneda</td>
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<tr>
<td>VACANT (Michelle Smith)</td>
<td>2695 Mr. Daniel Sloyan</td>
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<td>Ms. Michelle Smith</td>
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<th>Senior Project Assistants</th>
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<tr>
<td>Ms. Jennifer Snow</td>
<td>2714 Mr. Christopher Castaneda</td>
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<th>Managers</th>
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<tr>
<td>VACANT (Michelle Smith)</td>
<td>2695 Mr. Daniel Sloyan</td>
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<th>Managers</th>
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<td>Ms. Michelle Smith</td>
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<th>Managers</th>
<th>Senior Project Assistants</th>
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<td>Mr. Gregg Marquardt</td>
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<tr>
<th>Site Visit Coordinator Predoc/Advanced</th>
<th>Site Visit Coordinator Allied Dental Board Contact</th>
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<tr>
<td>Ms. Kelsey Loveless</td>
<td>2675 Ms. Bernadette Molina</td>
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Conducting a Program Review Using Technology

CODA’s preferred meeting platform is Zoom; however, the program will utilize the platform of its choosing. The program is expected to provide clear user instructions for their technology platform, as well as software access, and ongoing IT support to the CODA site visit team and CODA staff for duration of the site visit.

Prior to the Site Visit:

- Consider how you want to refer to program materials during the meeting. Remember, your camera must be on at all times.

- Test your internet and computer systems well in advance of the site visit. See elsewhere for additional technology requirements.

- Provide the CODA site visitors and staff a quick-reference guide for using your program’s virtual meeting technology. Ensure that each site visitor has the ability to access and test the technology prior to the site visit; enlist your IT staff should assistance be needed.

During the Site Visit:

- All videoconference meetings are confidential; recording via any method is strictly prohibited.

- Mute your microphone unless you are speaking.

- The Chat function must be disabled. No chatting will be permitted during CODA site visits.

- Protocols for videoconference meeting conduct are discussed elsewhere in this manual.
Zoom Instructions for Programs
(If Program will Utilize Zoom)

Training materials and documentation
Zoom offers free live and interactive training courses. If you can’t attend one of the live sessions they also offer recorded versions of the training. These sessions are typically around 60 minutes long.

If you want to watch recorded training, start by watching the 30 minute Getting Started with Zoom video.
https://livetraining.zoom.us/recording/play/F_BDBtJ-EndygEj16xL9fIGaFwnvYvZw7CM2VEjJWoBxAtFvCBYCQVxl7IHF4uJ?continueMode=true

Then continue with the 60 minute Zoom Meetings Training video.
https://livetraining.zoom.us/recording/play/48IlOfofCstX-SiWKxxHTv7JoPMeoGH-1uaDcY-P6BpX-PU36JriiWYkBvlt?continueMode=true

Zoom also has short video tutorials on a variety of topics. These videos are 1 to 2 minutes long. They are a good reminder of how to do something after you’ve experienced the regular training.

Join a Zoom Meeting
https://www.youtube.com/embed/vFhAEOCF7ig?rel=0&autoplay=1&cc_load_policy=1

Zoom Meeting Controls - Introduction
https://www.youtube.com/embed/4w_pRMBEALE?rel=0&autoplay=1&cc_load_policy=1

How to Participate in a Zoom Meeting:

In your site visit schedule, click “Join Zoom Meeting:”

Join Zoom Meeting
https://zoom.us/j/833914312

Meeting ID: 833 914 312

Click “Open Zoom Meetings:”
Type your first and last name and click “Join:”

Join the audio one of three ways – By computer:

By calling the system:

Or by having the system call you:
The Zoom interface will look like this:

A. Show meeting information (meeting ID, Host, meeting URL)
B. Choose meeting view (Gallery vs Speaker view). Gallery view shows up to 49 participant’s video. Speaker view shows larger video of current speaker.
C. Microphone and Camera options (be SURE your mic is unmuted AND your computer speaker is on); the camera must also be on at all times
D. Participant’s information and options – all participants must include first and last name
E. Share content, chat and record settings (chat and record must not be used)
F. Exit meeting
Alternative Site Visit Program Agreement

The ____________________________ (Discipline Type) program sponsored by the ____________________________ (Institution Name) understands and agrees to abide by the Commission on Dental Accreditation (CODA) Policy on Temporary Use of Alternative Site Visit Methods and the policies and procedures related to the conduct of alternative site visits as documented within the CODA Program Manual for Alternative (Virtual or Hybrid) Site Visit Methods, as these policies and procedures relate to the CODA site visit review of the program for the purpose of evaluation of an application for accreditation (application site visit), conduct of a special focused site visit, or conduct of a reaccreditation site visit. By signing the agreement the program agrees to all policies and procedures in the aforementioned documents, including but not limited to the following:

- The site visit must be confidential; no portion of the visit will be recorded beyond the program’s pre-recorded facility tour.
- The program will submit information within the Commission’s E-Accreditation portal, and all information will comply with the Commission’s privacy and data security policies and procedures.
- A virtual site visit will be followed by an in-person site visit as directed by CODA policy.
- The findings of the virtual or hybrid site visit will be reported to the program within the preliminary draft site visit report following the site visit, regardless of site visit format, in accordance with Commission policy. The preliminary draft site visit report will be provided to the Commission along with the program’s response, should one be submitted, and the Commission will make an accreditation decision based on this report.
- Following the virtual (followed by a later on-site visit) or hybrid site visit, the program’s next regular reaccreditation on-site visit will be scheduled seven (7) years following the date of the virtual or hybrid site visit in all disciplines except oral and maxillofacial surgery (residency and fellowship), which will be scheduled five (5) years following the date of the virtual or hybrid site visit. The Commission reserves the right to conduct an earlier visit to the program in accordance with Commission policies and procedures (e.g. special focused site visit, pre-graduation site visit).

As the individuals representing and responsible for the dental education program, we agree to the terms of this agreement and will not challenge the results of the site visit or the Commission on Dental Accreditation’s decisions based on the site visit format or findings unless under CODA’s current policies and procedures for due process.

If the program is co-sponsored, this table must be submitted for each program sponsor.

<table>
<thead>
<tr>
<th>Institution Name*:</th>
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<td>Street Address: (do not list P.O. Boxes)</td>
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</tr>
<tr>
<td>Chief Executive Officer</td>
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<tr>
<td>Chief Administrative Officer</td>
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<td>Program Director</td>
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CONSIDERATION OF A REQUEST FROM THE COMMISSION ON DENTAL ACCREDITATION OF CANADA FOR REVIEW OF ORAL MEDICINE STANDARDS FOR POTENTIAL INCLUSION IN THE RECIPROCAL AGREEMENT BETWEEN THE COMMISSION ON DENTAL ACCREDITATION AND COMMISSION ON DENTAL ACCREDITATION OF CANADA

**Background:** On December 17, 2020, the Commission on Dental Accreditation (CODA) received a letter from the Commission on Dental Accreditation of Canada (CDAC) requesting that the CODA and the CDAC initiate a process of review of the CDAC’s Accreditation Requirements for Oral Medicine and Pathology Programs to determine if the CDAC Standards are comparable to the CODA Accreditation Standards for Advanced Dental Education Programs in Oral Medicine, for inclusion of Oral Medicine in the reciprocal agreement between the CODA and the CDAC (Appendix 1). Upon receipt of the CDAC request, and in accordance with policy, the Chair of the Commission on Dental Accreditation directed that the request be considered by the Commission at its next regularly scheduled meeting.

The Commission’s policy on Reciprocal Agreement with the Commission on Dental Accreditation of Canada, found in CODA’s Evaluation and Operational Policies and Procedures (EOPP), is found in Appendix 2.

**Summary:** The Commission is requested to consider the Commission on Dental Accreditation of Canada request (Appendix 1) and CODA’s policies and procedures (Appendix 2). The Commission may take action on the CDAC’s request, or the Commission may direct further review of this request by standing or ad hoc committee(s) of the Commission.

**Commission Action:**

Prepared by: Dr. Sherin Tooks
December 17, 2020

Dr. Sherin Tooks  
Director  
Commission on Dental Accreditation (CODA)  
211 East Chicago Avenue  
Suite 1900  
Chicago Illinois  
60611-2678

Dear Dr. Tooks,

Thank you for meeting with me and Ms. Callan and your executive on December 1. It was a very good dialogue; one we should consider conducting more frequently as matters arise from the pandemic and best practices for accreditation during these times.

Pursuant to our brief discussion regarding the process to include the specialty of Oral Medicine as part of our reciprocal agreement. We are formally requesting that CODA and CDAC begin the process for the review of the accreditation requirements/standards to determine if they are comparable in nature and if including Oral Medicine as part of our reciprocal agreement is achievable.

Kind regards,

[Signature]

Dr. Amarjit Rihal, DMD  
Chair, CDAC

c. Lee Callan
Accreditation Requirements For
Oral Medicine and Pathology Programs

Effective January 1, 2001
Updated November 30, 2004
Updated November 30, 2005
Updated November 30, 2006
Updated November 30, 2007
Updated November 30, 2008
Updated November 30, 2010
Updated November 30, 2012
Updated November 30, 2013
Updated November 30, 2014

Oral medicine and pathology is the branch and specialty of dentistry concerned with the diagnosis, nature and primarily non-surgical management of oral, maxillofacial and temporomandibular diseases and disorders, including dental management of patients with medical complications. Oral medicine and oral pathology are two applied components of this specialty.
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Accreditation Requirements  
Oral Medicine and Pathology  

The Commission on Dental Accreditation of Canada  

The Commission on Dental Accreditation of Canada (CDAC) is a partnership with membership from the public and organizations representing oral health care professionals, educators who prepare them and regulators responsible for their competence and continuing safe practice. CDAC, in consultation with its partners, develops and approves requirements for educational programs preparing dentists, dental specialists, dental interns/residents, dental hygienists and dental assistants. CDAC also develops and approves requirements or standards for institutional dental services. CDAC reviews educational programs and dental services by means of structured, on-site visits following receipt of submissions presenting detailed information in the required format. Programs and services meeting or exceeding the requirements are granted accredited status.

Vision  

Quality educational programs and health facilities through accreditation.

Mission  

The CDAC evaluates oral health educational programs and health facilities to determine eligibility for and grant accreditation.

Basic Process  

The starting point within accreditation is CDAC’s development, approval and ongoing revision of accreditation requirements. Educational programs and dental services are invited to apply for review against current requirements. Programs applying submit detailed documentation outlining evidence addressing the accreditation requirements. A survey visit is then arranged, and an accreditation survey team conducts interviews with faculty members, residents and other stakeholders, to secure additional information. This process clarifies issues arising from the submission and generally verifies that the documentation reflects the program or service. The survey team submits a report to CDAC. CDAC then determines the eligibility of the program or service for accreditation.

Responsibilities of Accredited Programs or Services  

Programs or services invite CDAC to conduct a review to assess eligibility for accreditation. Once initially accredited, CDAC notifies programs or services when reassessment is required in order to maintain accredited status.

Programs or services must submit reports to CDAC as requested following an accreditation survey. Programs or services must also, on their own initiative, inform CDAC, in writing, of any significant
changes, completed or pending, in supporting facilities, resources, faculty member complement, curriculum or structure.

CDAC requires the cooperation of programs in studies related to the improvement of the accreditation process. Educational programs are expected to cooperate in completing CDAC’s Annual Program Review.

Clarification of Terms

Particular attention should be paid to the wording of each requirement. For example, a requirement may take the form of either a "must" or a "should" statement. There is a significant difference between the two. "Must" statements reflect the importance of a particular requirement. CDAC defines the terms as follows:

**Must; Shall; CDAC expects;**  
These words or phrases indicate requirements that are **essential or mandatory**.

**Should:**  
This word implies that compliance with the requirement is highly desirable.

**May or Could:**  
These words imply freedom or liberty to follow a suggested alternative to the requirement.

Levels of Knowledge

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

**Understanding:** Adequate knowledge with the ability to apply.

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

**Exposed:** The level of skill attained by observation of / or participation in a particular activity.

Curriculum Approach

Competency Based Education (CBE), Evidence Based Education (EBE) and Outcomes Based Education (OBE) are terms applied to educational programs which build curriculum, student learning experiences, and evaluation methods from documents that describe the knowledge, skills and values that a student must possess to graduate. These documents include descriptions of the competencies required of an entry-level dental specialist.
Programs preparing health practitioners must also include consideration of the cognitive (foundation knowledge), the affective (values associated with professional responsibility) and psychomotor (preclinical and clinical). These abilities may be expressed through competencies or learning outcomes.

The accreditation process reviews how individual competencies are taught and evaluated and how the program ensures that each and every graduate has achieved every competency. This principle is the foundation of the accreditation process.

**Respect For Educational Innovation And Autonomy**

CDAC strives to ensure that its accreditation requirements and processes do not constrain innovation or program autonomy. The expertise of educators in the development and implementation of educational programs, curriculum and learning experiences is fully acknowledged. For this reason, CDAC places its emphasis upon assessment of the program’s ability to meet its stated objectives and outcomes.
0.0 Program Information

0.1 Provide the following information:

   a. Name of Institution
   b. Mailing and website addresses
   c. Telephone and fax numbers, email address(es) and the name of the survey visit coordinator
   d. Name of President or Chief Executive Officer along with telephone number
   e. Name of Dean or Director along with telephone number
   f. Name of Program Head or equivalent along with telephone number
   g. Date program was established
   h. Provincial authority under which the institution operates
   i. Program length
   j. Name of the Privacy Officer and the position job description

0.2 List the Recommendations that resulted from the last accreditation survey report and describe how they have been addressed.

0.3 If the CDAC accredited dental specialty program has established a Dental Specialty Assessment and Training Programs (DSATP) for dental specialists from non-accredited programs to be eligible for certification and licensure in Canada (either “onsite” or at an affiliated institution) the program must provide the documentation requested in Appendix A.

1.0 Institutional Structure

Requirement

1.1 CDAC requires that an advanced or dental specialty program must be sponsored by a faculty/school/college of dentistry located within a university which is properly chartered and licensed to operate and offer instruction leading to a degree, diploma or certificate. All other educational programs offered by the university eligible for accreditation by CDAC must be accredited. A hospital that provides a major component of an advanced dental education program must have its dental service accredited by CDAC. It is expected that the position of the program in the administrative structure will be consistent with that of other comparable programs within the institution. There must be provision for direct communication between the program and the parent institution regarding decisions that directly affect the program. Faculty members should have the opportunity to participate on university committees.

Documentation Required
a. Attach as an appendix, the senior organizational chart of the university (include the names of the individuals currently holding these positions).
b. Attach as an appendix, an organizational chart of the program.
c. Attach as an appendix, the terms of reference for the decision making body that oversees the program.
d. Attach as an appendix, a list of all educational programs, eligible for accreditation by CDAC.
e. Attach as an appendix, a list of university committees in which faculty members participate.

Requirement

1.2 The program must define its own mission statement, consistent with that of the parent institution, the faculty/school/college of dentistry or faculty of graduate studies.

Documentation Required

Provide a copy of the mission statement or equivalent for the parent institution and a copy of the mission statement or equivalent for the program.

Requirement

1.3 Specific program objectives and outcomes must be consistent with the mission statement.

Documentation Required

Provide a copy of the program’s objectives and outcomes.

Requirement

1.4 The parent institution must recognize the unique costs involved in dental education. Documentation must be submitted providing revenue and expense data for the program.

Documentation Required

a. Describe the procedures used in determining the budget of the program.
b. Attach as an appendix, a copy of the current program budget including details of revenues and expenditures.
c. Describe any significant changes in the budget over the past five (5) years.
d. Comment on the adequacy of the present budget.
e. Describe the process for the replacement of old/or the purchase of new equipment and resources.
f. Describe the process and rationale used to establish clinic fees, if applicable.
 Requirement

1.5 The program must establish structures and processes for ongoing planning, evaluation and improvement of the quality of the program. Membership and terms of reference for committees must be established and published, recognizing that the parent institution has ultimate responsibility and authority. Committees should include representatives from the specialty program, residents and, where appropriate, qualified individuals from the parent institution and the profession.

Documentation Required

Describe the committee structures and processes that provide for ongoing planning, evaluation and improvement of program quality. Attach as an appendix, the membership, terms of reference and frequency of meetings of these committees.

 Requirement

1.6 The program must evaluate the degree to which its objectives and outcomes are being met through a formal process. Results of this process must be used to improve program quality.

Documentation Required

Describe the process(es) used to evaluate the program relative to its stated objectives and outcomes and identify how this process is used to improve program quality.

 Requirement

1.7 The parent institution may seek financial support from external sources. External contracts must not compromise the program’s stated objectives and outcomes or restrict the research requirements established by the parent institution. To eliminate any perception of bias or breach of ethics that may be a consequence of accepting and administering such funds, the parent institution must involve program administration and maintain transparency in relation to the process to seek external funding sources and any conditions attached to the acceptance of such funds. External funding must not determine the selection of residents, design and content of the curriculum, choice of techniques and materials used in teaching and the appointment of academic or administrative staff.

Documentation Required

Describe the impact of external funding on resident selection, program curriculum, the selection of teaching materials and academic appointments.
2.0 Educational Program

2.1.0 Admissions

Requirement

2.1.1 Admission must be based on specific selection criteria, which must be established and published prior to the consideration of applicants. The criteria must be readily available to advisors and applicants, and be applied equitably during the selection process. The program must be involved in establishing these criteria. Selection criteria should encourage recruitment of a diverse resident population with appropriate academic preparation and aptitude.

Documentation Required

a. Describe the admissions process.
b. Identify the individual(s) primarily responsible for admissions.
c. Attach as an appendix, the application information provided to potential applicants.

Requirement

2.1.2 An admissions committee must be established to select candidates for admission to the program. This committee should include representatives from the program as well as other individuals who are qualified to define and evaluate admissions procedures and criteria.

A candidate’s previous academic performance should not be the sole criterion for admission. Admissions committees should consider non-academic criteria in the overall assessment of applicants for admission. The process should employ tests and measurements designed to select residents who have the capacity for success in the program. For applicants whose primary language is not the language of instruction in the institution, language proficiency should be considered in the admissions process.

Documentation Required

a. Describe the role of the admissions committee. Include the membership and terms of reference for this committee.
b. Identify the language proficiency examination used for applicants whose primary language is not the one of instruction and describe how it is used in the admissions process.
c. Describe any changes to the admissions process since the last accreditation visit.
d. Describe the selection interview used in the admissions process.
Requirement

2.1.3 CDAC encourages participation in, and the development of, mechanisms and studies designed to retain residents.

Documentation Required

Provide data for the last five (5) years regarding resident attrition and the reasons for withdrawal or dismissal.

Requirement

2.1.4 It is recognized that a resident may transfer, with credit, from one accredited program to another. If the program accepts such transfer residents, the program must ensure that transfer residents are admitted into the appropriate year to permit the residents to meet program outcomes.

Documentation Required

If the program accepts transfer residents from other accredited programs, attach as an appendix, the established criteria used for the admission of transfer residents.

Requirement

2.1.5 The assessment criteria for residents admitted with advanced standing based on credit for courses taken at a non-accredited program must be consistent with the admission requirements.

Documentation Required

If the program accepts advanced standing residents from non-accredited programs, attach as an appendix, the criteria for admission.

Requirement

2.1.6 The number of residents enrolled in the program must be proportionate to the resources available. These resources include adequate physical facilities, faculty members and support staff and availability of patients.

Documentation Required

a. Using the format below as a guide, indicate the current number of residents enrolled in the programs at the institution.
2.2.0 Curriculum Management

Requirement

2.2.1 The program must have a written plan for the ongoing review and evaluation of the curriculum, which includes:

a. Defined outcomes of the program.
b. A mechanism for input from faculty members, residents, administrators, the curriculum committee and other appropriate sources.
c. A mechanism for the evaluation of all courses describing how they contribute to the program outcomes.
d. A mechanism to ensure the incorporation of evidence-based practice and emerging information.

Documentation Required

Describe the program’s curriculum management plan including:

a. The ongoing curriculum review and evaluation process used by the program.
b. How input is obtained from faculty members, residents, administrators, the curriculum committee and other appropriate sources.
c. How decisions involving curriculum are made; and how the program ensures that curriculum decisions are consistent with the program’s stated objectives and outcomes.
d. The process used to implement curriculum revisions.
e. The mechanism used to incorporate evidence-based practice and emerging information.
f. Copies of minutes of the curriculum committee or equivalent and resident evaluation of instruction must be available on site.

**Requirement**

2.2.2 Written documentation of the curriculum must be provided to residents at the beginning of each course. This documentation must include course descriptions, content outlines, course objectives and outcomes, learning activities and evaluation procedures.

**Documentation Required**

Describe when residents receive written information and what type of information is provided to residents about the courses.

**Requirement**

2.2.3 Teaching methods and resident learning activities must be effectively integrated and coordinated so that residents’ educational experiences are comprehensive and promote their ability to demonstrate decision-making and critical thinking skills.

**Documentation Required**

Provide a concise description of the teaching methods and learning activities used in the program.

**Requirement**

2.2.4 A process must be established to ensure that residents meet the published and distributed cognitive, affective and psychomotor (preclinical and clinical) objectives and outcomes. Institutional due process policies with respect to academic standards must be followed.

**Documentation Required**

Provide a copy of the program’s academic and due process policies.

**Requirement**

2.2.5 CDAC recognizes that extramural educational experiences and internal rotations to specific disciplines and other health related settings are essential and are required to complement the existing core program within the institution. Scheduling must be done to ensure that resident progress within the core program is not compromised by these experiences and rotations.

**Documentation Required**
2.2.5 Describe the types of extramural experiences and internal rotations established and how they are scheduled.

2.3.0 Curriculum Content

Requirements 2.3.1-2.3.11

2.3.1 CDAC recognizes that there may be various patterns for advanced or specialty education. An oral medicine and pathology program must be a minimum of four (4) consecutive academic years. A program in either oral medicine or oral pathology, must be a minimum of three (3) consecutive academic years. The oral medicine and pathology program consists of a common core curriculum based on knowledge necessary for competence in both oral medicine and oral pathology. The program is supplemented by education and experience in the subjects and practice appropriate to each specialty.

2.3.2 The graduate/postgraduate program provides advanced education experience beyond the undergraduate level. It is expected therefore that courses will be taught at a greater depth and breadth than in the undergraduate curriculum. Basic, clinical and behavioural science instruction must be integrated and of sufficient scope, timeliness, quality and emphasis to ensure that graduates meet the program’s stated objectives and outcomes. Particular attention must be given to the interrelationship of subjects, especially to the application of the basic sciences to the clinical subjects, so that the program comprises a related body of knowledge rather than a collection of individual and separate subjects. Graduates must be prepared to assume a level of professional responsibility appropriate to a postdoctoral educational program, within the scope of practice of the specialty. Graduates must understand their responsibility to the referring practitioner and patient, with emphasis on professional courtesy and communication.

2.3.3 The basic, clinical and behavioural sciences, although taught in the undergraduate years, are constantly evolving and residents must be made aware of recent advances in order to better understand the fundamentals of practice.

2.3.4 Basic and clinical sciences instruction must be designed to be relevant to the specialty discipline and to the clinical management of the patient, including a variety of clinical experiences. Emphasis must be placed upon thoroughness of patient evaluation and accuracy in diagnosis, treatment planning, and in the treatment of both routine and complex cases. Program instruction may consist of formal courses and/or seminars, conferences, reading assignments, hospital rounds and assignments in the laboratories, which are carefully organized. The objectives and content, if presented in this fashion, must be reviewed by the program director to avoid deficiencies and/or unnecessary repetition.
2.3.5 Consultation with members of other specialty areas of dental practice and offering of joint seminars is encouraged. Assignment of residents to other graduate/postgraduate clinics or private practice should be fostered so that they may observe modes of treatment related to their field.

2.3.6 Participation in teaching is a learning experience for the resident as it enhances the ability to organize and evaluate material and communicate information to others. The resident must be assigned to teach in the institution’s programs and encouraged to participate in table clinics, seminars, demonstrations, or lectures. Participation as both clinician and resident in the institution’s continuing dental education program is also recommended. However, this participation must not interfere with the core graduate/postgraduate program.

2.3.7 The program must ensure resident participation in a research experience related to the specialty of oral medicine and pathology either in a clinical or laboratory research topic as both an investigator and author.

2.3.8 The program must ensure that the resident is able to write a scholarly paper to a standard for publication in a peer reviewed journal.

Basic Sciences

2.3.9 Instruction in the basic sciences must:

a. Provide comprehension in greater scope and depth than achieved in undergraduate education with particular emphasis on fundamental principles and recent advances related to the specialty.
b. Emphasize the interrelationships among the basic sciences and correlate them with clinical practice.
c. Permit the resident to develop the capacity for objective analysis and critical evaluation of the scientific literature.

Clinical Sciences

2.3.10 Instruction in the clinical sciences must:

a. Enhance the resident’s diagnostic acumen and clinical judgment in the diagnosis and planning of treatment for conditions more complex than those encountered in the undergraduate experience.
b. Provide advanced clinical experience in the management of conditions appropriate to the field of specialization.
c. Emphasize the need for basing clinical judgments on evidence-based medicine and dentistry, where available.
d. Ensure that treatment in the field of specialization is appropriately related to the dental and general needs of the patient.
Specialty Program

2.3.11 The following list, although not exhaustive, represents content areas which the CDAC expects to find in the program:

Common Core Program

Biomedical Sciences

Knowledge of the basic medical sciences is a prerequisite to advanced education in oral medicine and pathology. The program must provide opportunities for residents to apply basic medical science knowledge. The recognition, diagnosis, and treatment of diseases require an understanding of anatomy, physiology, pathophysiology, pathology, pharmacology and pharmacoatherapeutics, neurosciences, immunology, microbiology, genetics, behavioural science, and physical medicine. Knowledge of epidemiology, biostatistics, and critical analysis of medical and dental literature is important in the practice of oral medicine and pathology.

Preparation for Oral Medicine and Pathology

Instruction in oral medicine and pathology must provide knowledge at the in-depth level to provide the didactic foundation for oral medicine and pathology: physiology and pathophysiology of orofacial structures, neuroscience, internal medicine, oral cytology diagnosis and procedures, anatomic pathology, dermatologic, forensic, chemical and haematologic pathology, interpretation of radiographs and other advanced imaging techniques and surgical oral pathology.

Clinical Program

Oral Medicine and Pathology Core Program

Residents in oral pathology and oral medicine are required to develop competency in the clinical diagnosis and primarily non-surgical management of patients with oral, maxillofacial and temporomandibular diseases and disorders, including orofacial pain, sensory, and motor disorders.

Experiences with a variety of imaging techniques for diagnostic purposes must be provided. Residents must have the opportunity to interpret an adequate volume of radiographs to understand the radiographic features of disease. Residents must have exposure to seminars on radiographic interpretation and to materials on file, to assure knowledge and experience.

Residents in oral pathology and oral medicine are required to develop competency to:

1. Diagnose and manage patients with oral mucosal disease.
2. Diagnose and manage patients with orofacial disorders arising from ageing, systemic disease, and medical therapies.
3. Diagnose and manage patients with non-surgical disorders of the salivary glands.
4. Diagnose and provide consultation regarding patients with diseases of the jaws requiring surgical therapy.
5. Discuss and present treatment plans with patients and make recommendations based on a critical review of the literature.
6. Instruct students on oral medicine/oral pathology topics.

**Oral Pathology Requirements**

Oral pathology residents must assume initial responsibility for reports and diagnosis on an adequate volume of diagnostic and surgical specimens of sufficient variety to achieve competency in surgical pathology. Oral pathology residents must become competent drafting pathology laboratory reports and have adequate exposure to sufficient seminar material, special collections, exchange slides, and file material to achieve competency to diagnose unusual difficult lesions. The oral pathology diagnosis laboratory service must organize regular conferences and/or seminars to review cases.

Clinical competency is required in the diagnosis and treatment of oral mucosal disorders, oral manifestations of systemic disease, and the non-surgical management of salivary gland disease. Residents must also achieve competence in the diagnosis of oral and maxillofacial diseases and disorders where the treatment is primarily surgical and not within the scope of oral medicine and pathology (e.g., tumours of bone and salivary glands).

The program must provide for residency-level training in anatomic pathology as part of an active hospital-based pathology department or other accredited laboratory facility. Experience in surgical pathology including dermatopathology and hematopathology must be provided. Residents must obtain experience with autopsy pathology through participation as a prosector and by review of a sufficient volume of archival autopsy material.

The program must provide experiences in an accredited clinical pathology program. This training may include medical microbiology, immunology, hematology and molecular pathology.

Residents in oral pathology are required to develop competency to prescribe, direct personnel as required, and interpret laboratory tests for the tissue diagnosis of orofacial disease.

**Oral Medicine Requirements**

Oral medicine residents must have opportunities to acquire sufficient knowledge of surgical pathology to ensure full understanding of the pathobiology of the diseases they diagnose and treat.
Clinical competency is required in the diagnosis and treatment of orofacial pain and temporomandibular disorders and oral/dental management of the complex medical patient. Clinical training may be achieved by participation in clinical care in university and hospital-based dental services that are specifically organized to diagnose and treat these disorders.

Extensive knowledge and experience of applied pharmacology and therapeutics is required, particularly in relation to the management of chronic pain and the dangers of addiction, control of infection and the treatment of mucosal disorders.

The program must provide experiences in the managing of patients with oral diseases.

Residents in oral medicine are required to develop competency to:

1. Diagnose and manage patients with orofacial pain, and other neurosensory disorders.
2. Provide oral/dental management of patients with complex medical conditions that compromise oral tissues and affect dental treatment.

Documentation Required Requirements 2.3.1-2.3.11

a. Attach as an appendix, the timetables of each year of the program or the schedule of resident rotations/seminars.

b. Attach as an appendix, a list of all courses/rotations, by year and semester/term, offered by the program. For example:

<table>
<thead>
<tr>
<th>Course</th>
<th>Year</th>
<th>Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dent 101</td>
<td>I</td>
<td>Fall</td>
</tr>
</tbody>
</table>

c. Attach as an appendix course outlines for all courses in the program. The course outline must include:

1. Course title, number and academic year offered
2. Number of: lecture hours, laboratory hours, clinic hours, seminar hours, other instruction hours and total course hours
3. Academic unit responsible for the course
4. Names of instructors
5. Course objectives and outcomes
6. Content outline
7. Evaluation procedures
8. Required texts and materials
9. Instructor/resident ratios in the course (e.g. lectures, laboratory, clinic and seminar sessions)

d. Attach as an appendix, a document, which shows the relationship between course
content and the program’s objectives and outcomes, including the oral medicine and pathology competencies.

2.4.0 Preparation for Practice

Requirement

2.4.1 A graduate of the program must be capable of meeting the dental health needs of the public as a specialist in oral medicine and pathology. Sufficient opportunity for the development of competency in the specialty of oral medicine and pathology must be provided. There must be a sufficient supply of patients with disorders requiring a wide variety of oral medicine and pathology services in order to provide adequate clinical experience. Accordingly, the graduate must be capable of diagnosing and treating oral disease as defined by the scope of the specialty.

Oral medicine and pathology education must include experiences in medical disciplines, specifically pathology and medicine, divisions of dermatology and dermatopathology, otolaryngology, and hematology oncology and radiation-oncology. Experiences with general medicine, internal medicine, neurology, physical therapy, rehabilitative medicine, and a pain clinic (if available) are also suggested.

Clinical experiences must be such as to produce a graduate who can assume the level of professional responsibility appropriate to the specialty practice of oral medicine and pathology and provide those services usually provided in the practice of oral medicine and pathology.

Documentation Required

a. Describe how the program manages patient assignment.
b. Describe how resident’s clinical experiences are monitored.
c. Describe how the program ensures that each resident is provided with sufficient experiences to develop competency within the contemporary scope of oral medicine and pathology practice.

Requirement

2.4.2 An appropriate patient pool must be available to permit residents to demonstrate competency in the management of oral mucosal disease; disorders arising from ageing, systemic disease and medical therapies; diseases of the jaw bones; benign and malignant tumours; salivary gland diseases; orofacial pain and neurosensory disorders; temporomandibular disorders; medically complex patients. The availability of such experiences must be monitored to ensure adequate experiences for each resident. An ongoing record of the number and variety of clinical experiences accomplished by each resident must be maintained.
Documentation Required

a. Provide evidence that the patient pool available for educational purposes is sufficient to allow residents to develop competency within the scope of the oral medicine and pathology practice.
b. Describe the strategies that have been implemented to ensure that residents have sufficient patient experiences.
c. Identify any areas where a shortage of patients may exist. Describe the strategies that have been implemented to address these areas.

Requirement

2.4.3 Residents must have opportunities to work with other health care professionals.

Documentation Required

Describe the opportunities available to oral medicine and pathology residents to gain experience working with physicians and other health professionals.

2.5.0 Evaluation

Requirement

2.5.1 Reliable and valid systems of resident evaluation must exist and be applied. Processes must be defined which ensure that residents are individually evaluated in terms of their achievement of the program’s stated objectives and outcomes. These evaluation systems must be the basis for judgments that govern resident promotion and graduation.

Documentation Required

a. Describe the resident evaluation system(s).
b. Describe how the program ensures that residents are evaluated in terms of their achievement of the program’s stated objectives and outcomes including the oral medicine and pathology competencies.
c. Describe how residents receive formative evaluation.
d. Describe how residents are involved in providing feedback regarding the evaluation system.

e. Attach as an appendix, the results of the Canadian National Dental Specialty Examinations, administered by the RCDC, for graduates of the program since the last accreditation survey visit.
3.0 Administration, Faculty and Faculty Development

3.1.0 Program Administration

Requirement

3.1.1 The dean or director of the faculty/school/college of dentistry must be an individual who has the educational background, professional experience, authority and responsibility necessary to fulfill program objectives and outcomes.

Documentation Required

Attach as an appendix, the job description of the dean or director of the faculty/school/college of dentistry.

Program Director

Requirement

3.1.2 For the purposes of the accreditation documentation CDAC regards the program director as the individual with responsibility and authority for the clinical academic program. A program director appointed after January 1, 2007 who has not previously served as a program director* must hold Fellowship in the Royal College of Dentists of Canada (RCDC) or have completed the National Dental Specialty Examination (NDSE) within two (2) years of their appointment.

The program director must be a recognized licensed/registered specialist in oral pathology, oral medicine, or both and have the professional experience, authority and responsibility necessary to fulfill the program objectives and outcomes. Program directors completing the NDSE are encouraged to apply for Fellowship in the RCDC.

The program director must have the necessary time to oversee program administration, operation, supervision, evaluation, and revision. Teaching contact hours must not compromise the ability to fulfill these obligations.

Documentation Required

a. Attach as an appendix, a brief curriculum vitae and a copy of the job description for the program director.

b. Attach as an appendix, the teaching contact hours of the program director and the teaching contact hours of other faculty members in the discipline.

* Please note the statement “who have not previously served as Program Directors” refers to
programs directors of accredited dental specialty programs.

Requirement

3.1.3 When a new program is being planned, the program director or equivalent should be appointed in advance of the program starting date to allow time for developing curriculum, recruiting faculty, preparing facilities, ordering equipment, making clinical program arrangements and establishing admission procedures.

Documentation Required

If the program is a new program, identify when the program director was appointed.

3.2.0 Faculty and Faculty Development

Requirement

3.2.1 The professional education of the faculty members, their preparation and experience for clinical practice, teaching and research must be adequate to meet the stated objectives and outcomes of the program. There must be mechanisms for the appointment, review and reappointment of faculty members, including those with administrative positions. One (1) or more program faculty members must be Fellows of the Royal College of Dentists of Canada (RCDC) in oral medicine and/or oral pathology.

Documentation Required

a) List alphabetically the names of all full-time, half-time, and part-time faculty members teaching in the specialty program.
b) Provide on site current curricula vitae of these faculty members.
c) Attach as an appendix, the mechanisms for the appointment, review, and reappointment of full-time faculty members, including those with administrative positions.
d) Describe the review and appointment/reappointment process for half-time and part-time faculty members.
e) Identify the number of program faculty members who hold Fellowship in the RCDC.

Requirement

3.2.2 The number and distribution of faculty members must be sufficient to meet the program’s stated objectives and outcomes. Resident contact time must allow the faculty members sufficient time for:

a. Teaching preparation.
b. Resident evaluation and counselling.
c. Development of subject content and appropriate evaluation criteria.
d. Program development and review.
e. Professional development.

Documentation Required

Comment on the adequacy of the faculty member complement to meet the program’s stated objectives and outcomes. Identify specific areas where there is insufficient coverage and the strategies implemented to address these areas.

Requirement

3.2.3 An appropriate balance of faculty member involvement in teaching, research, scholarly activity, and service must exist.

Documentation Required

Describe how the balance of faculty member expectations and involvement in teaching, research, scholarly activity, and service is established.

Requirement

3.2.4 A process must be in place for faculty evaluation that measures the performance of faculty members relative to their expectations and involvement in teaching, research, scholarship and service.

Documentation Required

Describe the process in place for evaluation of faculty member performance.

Requirement

3.2.5 The faculty to resident ratios must be adequate to ensure that neither resident learning nor the health and safety of patients is compromised.

Documentation Required

Comment on the adequacy of faculty/resident ratios in each of the following areas: microscopic and radiological teaching, research supervision, laboratory, clinic and seminar sessions.

Requirement

3.2.6 Faculty members must be involved in continuing professional development. The program must show evidence of an ongoing faculty development plan.
**Documentation Required**

a. Describe the professional development opportunities available to faculty members.
b. Describe the budget support available for professional development opportunities.
c. Describe how faculty members are supported or encouraged in these initiatives.

**Requirement**

3.2.7 There must be opportunities for faculty members to meet on a regular basis to discuss program issues.

**Documentation Required**

Outline how often faculty meetings are held and provide (on-site) copies of the minutes for the last two (2) years.

**Requirement**

3.2.8 The program must have a process to calibrate faculty members with respect to the consistent evaluation of residents.

**Documentation Required**

Describe the program’s calibration activities and the strategies implemented to measure the effectiveness of these activities.

### 4.0 Educational Support and Services

#### 4.1.0 Physical Facilities

**Requirement**

4.1.1 Physical facilities and equipment must be adequate to support the didactic, laboratory and clinical objectives of the program. The adequacy of facilities will be evaluated in relation to availability and resident enrollment. If other programs utilize the same facilities, the program must provide evidence that the existing facilities are sufficient to meet the needs of the program.

**Documentation Required**

a. Attach as an appendix, a floor plan of the program facilities, including the number and capacity of lecture rooms, clinics, laboratory facilities, and locker space. Identify any areas in which there is insufficient space.
b. Specify the number of dental units available for the program using the following format:
   1. Units with radiology facilities
   2. Units without radiology facilities
   3. Total units
   4. Number of units shared with other programs
   5. Number of units used by oral medicine and pathology only

**Requirement**

4.1.2 Didactic, clinical, and other program facilities should ideally be located in reasonable physical proximity to one another.

**Documentation Required**

a. Describe where all teaching, clinical and research activities and instruction occur.
b. Describe how clinical facilities are shared with other programs, if applicable.
c. Identify areas of the physical facilities that should be improved in order to enhance the program.

**Requirement**

4.1.3 It may be necessary in some instances for the program to use an off-campus facility. Specific requirements for administration, faculty members, facilities, patients and instruction must be identified. Policies and procedures for operation of any off-campus clinical facility must be consistent with the objectives/outcomes of the program. A formal agreement between the educational institution and any agency or institution providing the off-campus facility must be negotiated and confirmed in writing. Such agreement(s) must include clearly defined provisions for renewing and terminating the agreement to ensure program continuity. The program administrator must retain authority and responsibility for instructional requirements and assignment of residents.

**Documentation Required**

a. Describe off-campus resident clinical experiences and include information on the location, arrangements for supervision, evaluation, length of time each resident is assigned and the types of patients and the treatment provided.
b. Provide a list of the affiliation agreements between the institution and any agency or site where residents receive off-site experiences.

**Requirement**

4.1.4 Adequate space must be available for faculty members and secretarial and clinical support staff. The location and size of offices should be conducive to the effective use of faculty and staff time and program resources for teaching preparation and resident counselling. Space
must be available for storage of office, clinical, research and laboratory supplies and equipment, instructional media and resident, patient and program records.

Documentation Required

Describe the office and storage space and comment on the adequacy.

Requirement

4.1.5 The institution must make provision for the acquisition and/or replacement of clinical and laboratory equipment, supplies, reference materials and teaching aids.

Documentation Required

Describe the program’s plan for the repair and/or replacement of clinical and laboratory equipment, supplies, reference materials and teaching aids.

4.2.0 Learning Resources

Requirement

4.2.1 A professionally administered library must be available. The library must be accessible to both residents and faculty members during and after scheduled hours of instruction and/or via electronic format.

Documentation Required

Please describe the library and its adequacy with respect to the program.

a. Identify the individual(s) and their qualifications who administer the library that supports the program.

b. Have available onsite a complete list of the currently held dental related journals and library holdings.

c. Comment on resident access to the library resources.

d. Describe resident access to electronic journals.

Requirement

4.2.2 The library must be responsive to and supportive of the teaching and research activities of the program. CDAC encourages development and use of computerized/electronic methods of information retrieval.

Documentation Required
a) Describe the ways in which the library is responsive and supportive of the teaching and research activities of the program (e.g. acquisition process for books and journals).
b) Describe how the faculty members promote resident use of available library resources.

Requirement

4.2.3 Residents and faculty members must have access to electronic and other multimedia resources.

Documentation Required

Describe how the program provides access to electronic and other multimedia resources.

4.3.0 Didactic and Clinical Support

Requirement

4.3.1 Resident learning must not be compromised by an over-reliance on residents to provide institutional service, clinical productivity solely to enhance revenue, teaching and/or research, which cannot be justified as an educational requirement of the program. Teaching clinics must provide the necessary supplies and equipment required for patient comfort and safety.

Documentation Required

Describe resident obligations to provide instructional, treatment and/or support services within the program. Provide evidence that there are adequate documented protocols to ensure resident and patient safety.

Requirement

4.3.2 Sufficient qualified support personnel must be assigned to the program to support both instruction and patient care. Adequate administrative, secretarial, clerical and other support staff must be available to assist faculty members and residents to meet program objectives and outcomes. Adequate maintenance and custodial staff must be available.

Documentation Required

Describe the number and types of support staff assigned to the program and comment on adequacy.
4.4.0 Resident Issues

Requirement

4.4.1 Residents must have rights, responsibilities, and privileges comparable with those of other residents at the institution.

Policies must exist concerning resident representation on appropriate committees.

The program must have methods to identify and address resident concerns.

Documentation Required

a. Provide copies of documentation supplied to residents describing their rights, responsibilities, and privileges. Comment on the adequacy of facilities available for resident use (i.e. learning resources, lounge, cafeteria, washrooms, lockers, health clinic, day care, etc.).

b. Attach as an appendix, policies concerning resident representation on appropriate committees.

c. Describe the process(es) in place to identify and address resident concerns.

Requirement

4.4.2 There must be an institutional policy which provides for due process for residents with respect to grievances.

Documentation Required

Describe or attach as an appendix, the institution policy that provides for due process if a resident has a grievance.

Requirement

4.4.3 Residents must have an opportunity to participate in the evaluation of the teaching effectiveness of faculty members.

Documentation Required

Describe resident participation in the evaluation of the teaching effectiveness of faculty members.
4.4.4 Resident membership and participation in provincial/national dental and dental specialty professional organizations should be encouraged.

*Documentation Required*

Describe how resident membership and participation in provincial/national dental and dental specialty professional organizations is encouraged.

*Requirement*

4.4.5 Counselling and health services must be available to all residents.

*Documentation Required*

Describe how residents access counselling and health services.

*Requirement*

4.4.6 Prior to admission, residents should receive information concerning expected costs of the program. This information should include estimates of living expenses and educational fees.

*Documentation Required*

Describe how residents are provided with information related to the costs of graduate education and provide, as an appendix, a copy of the information provided to residents.

5.0 Clinic Administration

5.1.0 Clinic Operations

*Requirement*

5.1.1 There must be an individual identified as responsible for patient relations, clinical care and clinic administration of the graduate oral medicine and pathology clinic. This director of clinics or equivalent must have access to relevant faculty decision-making groups and should have appropriate committee appointments. This individual must have effective working relationships with other administrators.

*Documentation Required*
Identify the director of the graduate oral medicine and pathology clinic or equivalent at the institution and attach his/her job description. Describe his/her access to relevant faculty decision-making groups. Describe how he/she has effective working relationships with other administrators.

**Requirement**

5.1.2 Patient treatment records must be comprehensive and adequate for teaching purposes.

*Documentation Required*

Provide as an appendix, a copy or screen shot of a blank patient treatment record.

Provide confirmation that patient authorization for his/her chart to be reviewed as part of the accreditation process has been obtained.

5.2.0 **Health and Safety Provisions**

*Requirement*

5.2.1 Written policies and procedures relating to quality assurance to ensure the safe use of ionizing radiation must be in place and be compliant with applicable regulations for radiation hygiene and protection. Mechanisms must be in place to monitor compliance of these policies and protocols by faculty members, staff, and residents. The design and construction of radiology facilities must provide adequate protection from ionizing radiation for the patient, operator and others in close proximity. The program must ensure that it is in compliance with provincial and federal regulations relating to radiation protection. Where provincial or federal regulations are not in force, the program must show evidence that radiography equipment is routinely inspected to ensure the safe use of ionizing radiation, and that the radiology facilities are designed in such a way to ensure that occupational and public exposure is not in excess of the current recommendations of the International Commission on Radiological Protection (ICRP).

In addition, the program must identify a radiation protection officer and have in place a quality assurance program that includes daily monitoring of radiographic quality.

Radiographs must be prescribed based on the specific needs of the patient taking into account the existence of any current radiographs. Radiographs must be exposed solely for diagnostic purposes, not to achieve instructional objectives.

*Documentation Required*
a. Attach as an appendix, a copy of the job description of the radiation protection officer.
b. Provide on-site copies of policies and protocols related to the prescription of radiographs.
c. Provide an on-site a copy of the quality assurance program used at the institution.
d. Provide on-site reports of the radiation safety inspections undertaken since the last accreditation survey.

Requirement

5.2.2 Policies and/or protocols must exist relating to Fire and Safety Procedures, Hazardous Materials and Waste Management, Infection Control and Medical Emergency Procedures. Such policies and/or protocols must be consistent with related elements of the didactic program, related regulation, legislation, and bylaws of the various jurisdictions and must be readily available for faculty members, staff and residents. Mechanisms must be in place to monitor compliance of these policies and protocols by faculty members, staff and residents.

Documentation Required

Provide as an appendix, copies of the policies and/or protocols outlined in 5.2.2. Describe how these policies and/or protocols are monitored for faculty members, staff and residents.

Requirement

5.2.3 Residents, faculty members and appropriate staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, tuberculosis and hepatitis B prior to contact with patients and/or infectious objects or materials in an effort to minimize the risk to patients and dental personnel. All individuals who provide patient care must follow standards of risk management.

Documentation Required

Describe steps that are taken to encourage immunization of residents, faculty members, and staff against infectious diseases prior to contact with patients.

Requirement

5.2.4 The program should develop (or adopt provincial policies if applicable) and implement policies and procedures related to individuals who have bloodborne infectious disease(s).

Documentation Required

Provide a copy of the institution’s policies and procedures related to faculty members, staff and residents who have bloodborne infectious disease(s).
5.2.5 Residents, faculty members and staff involved with the direct provision of patient care must be certified in basic life support procedures.

*Documentation Required*

Provide documentation that identifies the process used to monitor that all faculty members, staff, and residents are certified in basic life support.

### 5.3.0 Patient Care and Quality Assurance

**Requirement**

5.3.1 Policies and/or protocols must exist relating to the following:

- a. Audit of Patient Care
- b. Collection of Patient Fees
- c. Confidentiality of Patient Information
- d. Consultative Protocols
- e. Informed Consent
- f. Patient Assignment
- g. Patient Continuing and Recall Care
- h. Patient Records
- i. Professional Decorum

Such policies and protocols must be written, consistent with related elements of the didactic program, and readily available for the residents, staff, and faculty members. Mechanisms must be in place to monitor compliance of these policies and protocols by faculty members, staff and residents.

*Documentation Required*

Provide as an appendix, copies of the policies and/or protocols outlined in 5.3.1. Describe how these policies and/or protocols are monitored for faculty members, staff and residents.

**Requirement**

5.3.2 The program must have policies and mechanisms in place that provide quality assurance and education for patients about their specialty care and related treatment needs. Patients accepted for dental specialty care must be advised of the scope of care available at the facility and be appropriately referred for procedures that cannot be provided by the specialty program.
The primacy of total dental care for the patient must be well established in the management of the clinical program, assuring that the rights and best dental interests of the patient are protected. The quality assurance process should ensure that the following are in place:

a. Primary responsibility for total patient care is formally assigned and documented to a single resident.
b. Patient-centred, comprehensive care, continuing and recall care.
c. An ongoing review of a representative sample of patients/patient care records.
d. Mechanisms to determine the cause of treatment deficiencies.
e. Patient review policies, procedures, outcomes and corrective measures.
f. Adverse or ineffective outcomes are subject to routine review.

**Documentation Required**

Describe quality assurance mechanisms in place within the program. Provide evidence that the quality assurance program supports ongoing improvement in comprehensive patient care.

**Requirement**

5.3.3 Treatment undertaken by residents prior to advancement and graduation must be reasonably expected to be beneficial for the health and care of patients.

**Documentation Required**

Describe mechanisms that ensure that resident education requirements are beneficial for the health and care of patients.

### 6.0 Research and Scholarly Activities

**Requirement**

6.1 There must be an appropriate commitment to research activity by faculty members teaching in the oral medicine and pathology program. This responsibility must also involve residents and should have the support of the parent university with respect to finances and facilities. An appropriate balance of faculty member involvement between teaching and research must exist so that the quality of the program is not compromised. Investigations leading to the improvement of the educational program should be included in such research activities.

CDAC believes that there are many worthy research projects, particularly of a clinical or educational nature, which could be undertaken without major funding from external agencies.
Documentation Required

a. Identify the research and scholarly activity requirements for residents and identify if a thesis/major paper is required.
b. Attach as an appendix, a list of the research projects/scientific papers that have been completed by faculty members and graduate residents since the last accreditation survey visit, identifying the name of the investigator and the name, title and affiliation of the staff supervisor.
c. Attach as an appendix, a list of research affiliations and support mechanisms of the program since the last accreditation survey visit.

7.0 Program Relationships

7.1.0 Relationships with Other Educational Programs

Requirement

7.1.1 Where other health science programs and/or baccalaureate/graduate/postgraduate educational programs exist efforts should be made to integrate the didactic and clinical aspects of these programs wherever possible and/or appropriate, in order to foster effective working relationships.

Documentation Required

Describe the program’s relationships with other health sciences educational programs that permit residents to develop multidisciplinary working relationships, as appropriate, with other programs and residents.

Requirement

7.1.2 CDAC recognizes the potential value of faculty-based continuing education programs. Such programs should develop resident awareness and appreciation of the necessity for continuing education as a professional responsibility. The demands of continuing education programs must not be allowed to jeopardize the quality of the program.

Documentation Required

Describe how resident awareness and appreciation of the benefits of a faculty-based continuing education program are fostered. Describe how faculty members provide and/or participate in continuing education programs.
7.2.0 Relationships with Health Care Facilities and Other Health Care Agencies

Requirement

7.2.1 The program must have a functional relationship with at least one (1) hospital with a dental service approved by CDAC. This relationship must afford the resident the opportunity to learn protocols, observe working relationships with other health professionals and to provide patient care while participating in the management of the health and social problems of the hospital patient.

Documentation Required

Describe the relationship between the program and area hospitals that have a dental service approved by CDAC. Describe the opportunities for the residents and attach a schedule of their activities.

Requirement

7.2.2 The program should also develop functional relationships with other institutional health care facilities, community health programs and health departments to establish an environment which prepares residents to provide care for patients in such health care facilities.

Documentation Required

Describe relationships between the program and other institutional health care facilities, community health programs and health departments. Describe how these relationships establish an environment, which prepares residents to provide care for patients in such facilities.

7.3.0 Relationships with Regulatory Authorities and Dental Organizations

Requirement

7.3.1 Residents must be made aware of the regulatory framework for both dental and specialty practice and of the distinct role of regulatory authorities, provincial/national dental organizations. Faculty members should be encouraged to accept positions of responsibility in such organizations and their contribution should be supported and recognized by the program.

Documentation Required

a. Describe how residents are made aware of the role of regulatory authorities.

b. Describe how residents are made aware of the role of provincial/national dental and
dental specialty organizations.
c. Describe how faculty members participate in positions in these organizations and how their contributions are supported and recognized by the program.
APPENDIX A  Dental Specialty Assessment and Training Program

Accredited dental specialty programs offering a Dental Specialty Assessment and Training Program (DSATP) for dental specialists who graduated from non-accredited programs will be assessed by CDAC. The dental specialty program and the DSATP for dental specialists who graduated from non-accredited programs will be assessed by CDAC conjointly. The accredited dental specialty program will provide the customary documentation in response to the accreditation requirements for the specific dental specialty program; and specific additional information will be requested for the DSATP. CDAC will review the accredited dental specialty program’s educational approach preparing DSATP candidates.

Introduction

CDAC accredited dental specialty programs may admit dental specialists who graduated from non-accredited programs for assessment and additional education and training. CDAC requires that an accredited dental specialty program offering a DSATP be responsible for the assessment of candidates and all educational components of the program. Accredited dental specialty programs may enter into an affiliation agreement with other Dental Faculties/Schools of Dentistry to provide aspects of the DSATP program. However, the certificate of completion of the DSATP must be granted to successful candidates by the Faculty/School of Dentistry accredited dental specialty program.

The Faculty/School of Dentistry offering a DSATP must advise accepted candidates that Institutional policies and regulations apply to them as candidates in the program and that they have the same rights and responsibilities as other residents in the Institution.

The following documentation in relation to CDAC requirements must be provided.

Documentation Required

A1  Institutional Structure

A1.1 Identify the sponsoring Faculty/School of Dentistry and the accredited dental specialty program(s) admitting dental specialists who graduated from non-accredited programs to assess their eligibility for the DSATP.

A1.2 In the event of an affiliation with another Faculty/School of Dentistry; the accredited dental specialty program must provide a copy of the affiliation agreement(s).

A1.3 Identify all sites and affiliated institutions where candidates receive instruction.
A2 Admission to the Dental Specialty Assessment and Training Program

A2.1 Verify that all applicants have completed the Dental Specialty Core Knowledge Exam (DSCKE) as a requirement for admission.

A2.2 Describe the admissions process for applicants to be admitted to the DSTAP.

A2.3 Describe how the applicant’s skills in the specific dental specialty are assessed prior to admission into the DSATP.

A2.4 Complete the following chart for DSATP candidates for the past five (5) years.

<table>
<thead>
<tr>
<th>Number of candidates who applied to the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of applicants admitted.</td>
</tr>
<tr>
<td>Number of candidates who successfully completed the program.</td>
</tr>
<tr>
<td>Number of candidates who passed the NDSE.</td>
</tr>
</tbody>
</table>

A3 Curriculum

A3.1 Describe, with examples, the process used to develop a customized plan for educational experiences for a candidate.

A3.2 Provide an example of a customized educational program. On site, provide further examples of customized educational programs including a description of the ongoing evaluation of the program and any required modifications.

A4 Candidate Evaluation

A4.1 Describe the process to determine that a candidate has successfully completed the customized plan for educational experiences and is eligible to be awarded the certificate of completion.
A5 Resources

A5.1 Identify the faculty members involved in the DSATP, and indicate whether they have a Faculty appointment and have the appropriate qualifications and experiences necessary to teach the candidates in the program.

A5.2 Provide evidence that there is sufficient faculty member coverage to provide the individualized program for each candidate.

A5.3 Demonstrate that the appropriate resources, physical facilities, support staff, and patients are available to offer the program.
POLICY ON RECIPROCAL AGREEMENT WITH THE COMMISSION ON DENTAL ACCREDITATION OF CANADA FROM THE COMMISSION ON DENTAL ACCREDITATION EVALUATION AND OPERATIONAL POLICIES AND PROCEDURES

F. RECIPROCAL AGREEMENT WITH THE COMMISSION ON DENTAL ACCREDITATION OF CANADA

The reciprocal accreditation arrangement between the Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada (CDAC) has been maintained and expanded since its adoption in 1956. Under the reciprocal agreement, each Commission recognizes the accreditation of educational programs in specified categories accredited by the other agency. Under this arrangement, the Commissions agree that the educational programs accredited by the other agency are equivalent to their own and no further education is required for eligibility for licensure. Commissioners and staff of the accrediting agencies will regularly attend the meetings of the other agency and its standing committees. In addition, Commissioners and/or staff will participate annually in at least one site visit conducted by the other agency. The Commissions believe that this cross-participation is important in maintaining an understanding of the accreditation processes in each country and in ensuring that the accreditation processes in each country continue to be equivalent.

The following educational programs are included in the scope of the reciprocal agreement.

- Predoctoral dental education
- Dental hygiene
- Level II dental assisting
- Advanced dental education programs in dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics.

The following statement is found in the “Find a Program” section of the CODA website:

Canadian Programs
By reciprocal agreement, programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation. However, individuals attending dental programs in one country and planning to practice in another country should carefully investigate the requirements of the licensing jurisdiction where they wish to practice.

By reciprocal agreement, predoctoral dental education, level II dental assisting, dental hygiene, and advanced dental education programs in dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics that are accredited by the Commission on Dental Accreditation Canada are recognized by the Commission on Dental Accreditation.

Revised: 8/18; 8/17; 2/15; 7/91; Reaffirmed: 8/12, 8/10, 7/07, 1/03, 7/01; CODA: 1/97:03, 1/94:4-5
REPORT OF THE STANDING COMMITTEE ON NOMINATIONS

**Background:** An ongoing responsibility of the Standing Committee on Nominations (Nominations Committee) includes recommendations to the Commission of qualified nominations to vacant positions on Review Committees and, in the case of consumer/public members, to vacant positions on Review Committees and the Commission on Dental Accreditation (CODA). Based upon review of position qualifications and submitted nominations, the Committee submits recommendations to the Commission for appointment of individuals.

In December 2020, Commission staff were notified of Dr. Farah Masood’s immediate resignation as the representative of the American Board of Oral and Maxillofacial Radiologists (ABOMR) on the Oral and Maxillofacial Radiology Education Review Committee (OMR RC) of the Commission. Without an alternate appointee, the Commission requested the ABOMR to submit nominees. The appointee will complete the remainder of Dr. Masood’s term and will be eligible for a second term since less than 50% of the term remains.

**February 4, 2021 Mail Ballot:** The following are members of the Nominations Committee: Dr. James Katancik, chair, Dr. John Agar, Dr. Christopher Hasty, Dr. Barbara Krieg-Menning, Ms. Martha McCaslin, Dr. Carol Anne Murdoch-Kinch, Dr. William Nelson, and Dr. Marybeth Shaffer.

Via Mail Ballot, the Standing Committee considered the Criteria for Commission and Review Committee Members and the Policy on Simultaneous Service (Appendix 1), nominee qualifications, and upcoming vacancies on Review Committees (Appendix 2). The nominee that is not appointed may serve as the alternate. Via mail ballot, closing on February 4, 2021, the Committee recommends the Commission appoint the following individual:

**Nomination Committee Recommendation:** It is recommended that the Commission on Dental Accreditation appoint the following individual, nominated by the certifying board, to the relevant review committee to fill a discipline-specific vacancy:

American Board of Oral and Maxillofacial Radiologists nominee (one (1) vacancy) for the Review Committee on Oral and Maxillofacial Radiology Education (OMR RC):
- Dr. K.C. Chan
  Alternate: Dr. S. Thomas Deahl

**Commission Action:**

Prepared by: Dr. Sherin Took
MISSION

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. Adopted August 5, 2016

REVIEW COMMITTEE COMPOSITION & CRITERIA FOR NOMINATION

Composition

Predoctoral Education Review Committee (9 members)
1 discipline-specific Commissioner appointed by American Dental Education Association
1 public member
3 dental educators who are involved with a predoctoral dental education program (two must be general dentists)
1 general dentist (One of whom is a practitioner
1 non-general* dentist (dentist and the other an educator)
1 dental assistant, dental hygienist, dental therapist or dental laboratory technology professional educator
1 dental therapist educator
*a dentist who has completed an advanced dental education program in dental anesthesiology, dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthetics.

Three (3) Advanced Dental Education Review Committees (DPH, OMP, OMR - 5 members each. At least one member must be a dental educator.)
1 discipline-specific Commissioner appointed by the discipline-specific sponsoring organization
1 public member
1 dentist nominated by the discipline-specific sponsoring organization
1 dentist nominated by the discipline-specific certifying board
1 general dentist

Six (6) Advanced Dental Education Review Committees (ENDO, OMS, ORTHO, PERIO, PED, PROS - 6 members each. At least one member must be a dental educator.)
1 discipline-specific Commissioner appointed by the discipline-specific sponsoring organization
1 public member
1 dentist nominated by the discipline-specific sponsoring organization
1 dentist nominated by the discipline-specific certifying board
1 dentist nominated by the discipline-specific certifying board and discipline-specific sponsoring organization
1 general dentist

Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Review Committee (12 members)
1 discipline-specific Commissioner, jointly appointed by American Dental Education Association (ADEA), the Special Care Dentistry Association (SCDA), the American Society of Dentist Anesthesiologists (ASDA), the American Academy of Oral Medicine (AAOM), and the American Academy of Orofacial Pain (AAOP).
1 public member
2 current General Practice Residency (GPR) educators nominated by the SCDA
2 current Advanced Education in General Dentistry (AEGD) educators nominated by ADEA
1 oral medicine educator nominated by the American Academy of Oral Medicine
1 dental anesthesiology educator nominated by the American Society of Dentist Anesthesiologists
1 orofacial pain educator nominated by the American Academy of Orofacial Pain
1 general dentist graduate of a GPR or AEGD
1 non-general* dentist
1 higher education or hospital administrator with past or present experience in administration in a teaching institution
*a dentist who has completed an advanced dental education program in dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthodontics.

Dental Assisting Education Review Committee (10 members)
1 discipline-specific Commissioner appointed by American Dental Assistants Association
1 public member
2 general dentists (practitioner or educator)
5 dental assisting educators
1 dental assisting practitioner who is a graduate of a Commission accredited program

Dental Hygiene Education Review Committee (11 members)
1 discipline-specific Commissioner appointed by American Dental Hygienists’ Association
1 public member
4 dental hygienist educators
2 dental hygienist practitioners
1 dentist practitioner
1 dentist educator
1 higher education administrator

Dental Laboratory Technology Education Review Committee (5 members)
1 discipline-specific Commissioner appointed by National Association of Dental Laboratories
1 public member
1 general dentist
1 dental laboratory technology educator
1 dental laboratory owner nominated by National Association of Dental Laboratories

Revised: 8/18; 2/16; 2/15; 8/14; 2/13, 7/09, 7/08, 1/08; Reaffirmed: 8/17; 8/10; Adopted: 1/06

Nomination Criteria: The following criteria are requirements for nominating members to serve on the Review Committees. Rules related to the appointment term on Review Committees apply.

All Nominees:
• Ability to commit to one (1) four (4) year term;
• Willingness to commit ten (10) to twenty (20) days per year to Review Committee activities, including training, comprehensive review of print and electronically delivered materials and travel to Commission headquarters;
• Ability to evaluate an educational program objectively in terms of such broad areas as curriculum, faculty, facilities, student evaluation and outcomes assessment;
• Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; HIPAA Training, Licensure Attestation, and Professional Conduct Policy and Prohibition Against Harassment);
COMMISSION ON DENTAL ACCREDITATION

- Ability to conduct business through electronic means (email, Commission Web Sites); and
- Active, life or retired member of the American Dental Association, where applicable. Educator Nominees:
  - Commitment to predoctoral, advanced, and/or allied dental education;
  - Active involvement in an accredited predoctoral, advanced, or allied dental education program as a full- or part-time faculty member;
  - Subject matter experts with formal education and credentialed in the applicable discipline; and
  - Prior or current experience as a Commission site visitor.

Educator Nominees:
- Commitment to predoctoral, advanced, and/or allied dental education;
- Active involvement in an accredited predoctoral, advanced, or allied dental education program as a full- or part-time faculty member;
- Subject matter experts with formal education and credentialed in the applicable discipline; and
- Prior or current experience as a Commission site visitor.

Practitioner Nominees:
- Commitment to predoctoral, advanced, and/or allied dental education;
- Majority of current work effort as a practitioner; and
- Formal education and credential in the applicable discipline.

Public/Consumer Nominees:
- A commitment to bring the public/consumer perspective to Review Committee deliberations. The nominee should not have any formal or informal connection to the profession of dentistry; also, the nominee should have an interest in, or knowledge of, health-related and accreditation issues. In order to serve, the nominee must not be a:
  a. Dentist or member of an allied dental discipline;
  b. Member of a predoctoral, advanced, or allied dental education program faculty;
  c. Employee, member of the governing board, owner, or shareholder of, or independent consultant to, a predoctoral, advanced, or allied dental education program that is accredited by the Commission on Dental Accreditation, has applied for initial accreditation or is not-accredited;
  d. Member or employee of any professional/trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission, dental education or dentistry; and
  e. Spouse, parent, child or sibling of an individual identified above (a through d).

Higher Education Administrator:
- A commitment to bring the higher education administrator perspective to the Review Committee deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission; and
  b. Spouse, parent, child or sibling of an individual identified above.

Hospital Administrator:
- A commitment to bring the hospital administrator perspective to Review Committee deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission; and
  b. Spouse, parent, child or sibling of an individual identified above.

Revised: 8/18; 8/17; 8/14; 8/10; Adopted: 07/08
A member of the Commission on Dental Accreditation, including its Standing and Review Committees,* and Appeal Board, may not simultaneously serve as a principal officer of another organization within any of the Commission’s primary communities of interest if that organization has a role in appointing or co-appointing a member of the Commission. The Commission interprets principal officer to mean those in the position of being final decision-makers which usually includes positions such as the president, president-elect, immediate past president, secretary or treasurer of an organization, as well as members of any executive committee that has decision-making authority which does not require confirmation by a board or house. The Commission has defined primary community of interest in this context as any organizations who have a role in appointing Commissioners, and the Regional Clinical Testing Agencies. Additional criteria found in CODA’s Rules for nominations apply during an individual’s entire term on CODA.

When such a conflict is revealed at the time of appointment, the appointing organization will be informed that the conflict exists and requested to take steps to identify a replacement on the specific committee, Appeal Board, or Commission.

When such a conflict arises during the term of a current Commissioner, Review Committee, or Appeal Board member, the Commissioner, or Review Committee, or Appeal Board member will be asked to resolve the conflict by resigning from one of the conflicting appointments. In the event that the member resigns from the Commission or Appeal Board, the appointing organization will appoint another individual to complete the unfinished term, as specified by the Rules of the Commission on Dental Accreditation. In the event that the member resigns from the Review Committee, the Commission will contact the representative organization for nominations to fulfill the unfinished term.

If the term of the vacated Commission, Appeal Board, or Review Committee position has fifty percent (50%) or less of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for appointment to a new, consecutive four-year term. If more than fifty percent (50%) of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

*this applies to appointments made after 2013

Revised: 2/19; 8/18; 8/16; 2/16; 2/13, 7/09, 7/01, 7/95; Reaffirmed: 8/13; 8/10, 7/07
## REVIEW COMMITTEE ON ORAL AND MAXILLOFACIAL RADIOLOGY EDUCATION (Staff: Kirsten Nadler)

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>STRUCTURE CATEGORY</th>
<th>TERM EXPires</th>
</tr>
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<tbody>
<tr>
<td>*Mallya, Sanjay</td>
<td>(Commissioner AAOMR)</td>
<td>2023</td>
</tr>
<tr>
<td>Reddy, Sindhura Anamali</td>
<td>AAOMR nominee</td>
<td>2024</td>
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<tr>
<td>Bacanurschi, Boris</td>
<td>General dentist</td>
<td>2023</td>
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<tr>
<td>Kelber, Gene</td>
<td>Public</td>
<td>2022</td>
</tr>
<tr>
<td>VACANT**</td>
<td>ABOMR nominee</td>
<td>2021**</td>
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** completing vacated term, renewable

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* Committee Chair