INFORMATIONAL REPORT ON FREQUENCY OF CITINGS OF ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PEDIATRIC DENTISTRY

**Background:** The Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry were approved by the Commission on Dental Accreditation in February 2012, with implementation on July 1, 2013. Since the implementation date, 95 site visits have been conducted by visiting committees of the Commission utilizing the July 2013 Standards. At the time of this report, the Standards include 107 “must” statements addressing 230 required areas of compliance. This report presents the number of times areas of non-compliance were cited by visiting committees conducting site visits from July 2013 through October 2019. If special (focused or comprehensive), pre-enrollment or pre-graduation site visits were conducted during this period, citings from those visits are also included.

**Analysis:** The distribution of citings is presented in Appendix 1. The most frequently cited pediatric dentistry-specific area of non-compliance, with 20 citings, is found in Standard 4 related to advocacy. Standard 4-26, related to didactic instruction was cited a total of 9 times. Each area of compliance in Standard 4-26 was cited 3 times and includes didactic instruction in: a) the fundamental domains of child advocacy; b) federally and state funded programs; and c) principles of education. Standard 4-27, related to clinical experiences in advocacy, was cited a total of 11 times. The specific citings relate to clinical experiences in: a) communicating, teaching and collaborating with groups and individuals with 3 citings; b) advocating and advising public health policy legislation and regulations with 4 citings; and c) participating at the local, state and national level in organized dentistry to represent the oral health needs of children with 4 citings.

The second most frequently cited pediatric dentistry-specific standard falls under Standard 4-6 related to clinical experiences in patient management using behavior guidance with a total of 16 citings. These include Standards 4-6b1, completing 20 nitrous oxide analgesia patient encounters as primary operator, with 1 citing; 4-6b2, completing a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used, with 5 citings; 4-6b2a of the 50 patient encounters, each student/resident acting as sole primary operator in a minimum of 25 sedation cases with 3 citings; 4-6b2b, of the remaining sedation cases (those not performed as the primary operator), each student/resident must gain clinical experience, which can be in a variety of activities or settings, including individual or functional group monitoring and human simulation, with 6 citings; and 4-6b2c, sedation cases being completed in accordance with the recommendations and guidelines of the American Academy of Pediatric Dentists (AAPD)/American Academy of Pediatrics (AAP), the American Dental Association’s (ADA) Teaching of Pain Control and Sedation to Dentists and Dental Students, and relevant institutional policies, with 1 citing.

**Summary:** The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

Prepared by: Ms. Peggy Soeldner
ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PEDIATRIC DENTISTRY
Frequency of Citings Based on Required Areas of Compliance

Total Number of Programs Evaluated: 95
July 2013 through October 2019

**STANDARD 1- INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS – 24**

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>The financial resources <em>must</em> be sufficient to support the programs stated goals and objectives.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>The program <em>must</em> develop clearly stated goals and objectives appropriate to advanced dental education, addressing education, patient care, research and service.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Planning for, evaluation of and improvement of educational quality for the program <em>must</em> be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>The program <em>must</em> document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>The financial resources <em>must</em> be sufficient to support the program’s stated goals and objectives.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>The sponsoring institution <em>must</em> 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>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>The authority and final responsibility for curriculum development and approval, student/resident selection, faculty selection and administrative matters <strong>must</strong> rest within the sponsoring institution.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>The institution/program <strong>must</strong> have a formal system of quality assurance for programs that provide patient care.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>The position of the program in the administrative structure <strong>must</strong> be consistent with that of other parallel programs within the institution and the program director <strong>must</strong> have the authority, responsibility, and privileges necessary to manage the program.</td>
</tr>
<tr>
<td>1</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 affiliated institutions.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Documentary evidence of agreements, approved by the sponsoring and relevant affiliated institutions, <strong>must</strong> be available.</td>
</tr>
</tbody>
</table>
| 1                     | 1                      | 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. |
| 1                     | 1-1                    | Affiliation agreements with remote teaching sites **must** clearly specify the status of off-site faculty, the financial commitments with sites, instruction, and liability coverage. |
Non-Compliance Citings | Accreditation Standard | Required Areas of Compliance
---|---|---
1 | 1-2 | A Commission-accredited advanced education program in pediatric dentistry must use, among other outcomes measures, the successful completion by its graduates of the American Board of Pediatric Dentistry certification process.

STANDARD 2- PROGRAM DIRECTOR AND TEACHING STAFF - 23 Required Areas of Compliance

Non-Compliance Citings | Accreditation Standard | Required Areas of Compliance
---|---|---
2 | 2 | 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.)

1 | 2 | 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.

1 | 2 | Documentation of all program activities **must** be ensured by the program director and available for review.

1 | 2-1 | The program director **must** be evaluated annually.

2 | 2-2 | Administrative Responsibilities: The program director **must** have sufficient authority and time to fulfill administrative program assessment and teaching responsibilities in order to achieve the educational goals of the program including:
<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2-2.2</td>
<td>Curriculum development and implementation.</td>
</tr>
<tr>
<td>1</td>
<td>2-2.3</td>
<td>Ongoing evaluation of program goals, objectives and content and outcomes assessment.</td>
</tr>
<tr>
<td>2</td>
<td>2-2.4</td>
<td>Annual evaluations of faculty performance by the program director or department chair; including a discussion of the evaluation with each faculty member.</td>
</tr>
<tr>
<td>1</td>
<td>2.2-8</td>
<td>Maintenance of records related to the educational program, including written instructional objectives, course outlines and student/resident clinical logs (RCLs) for specified procedures.</td>
</tr>
<tr>
<td>1</td>
<td>2.2-9</td>
<td>Responsibility for overall continuity and quality of patient care.</td>
</tr>
<tr>
<td>1</td>
<td>2.2-10</td>
<td>Oversight responsibility for student/resident research.</td>
</tr>
<tr>
<td>1</td>
<td>2-2.11</td>
<td>Responsibility for determining the roles and responsibilities of associate program director(s) and their regular evaluation.</td>
</tr>
<tr>
<td>2</td>
<td>2-3.1</td>
<td>Pediatric dentistry members of the teaching staff, appointed after January 1, 2000, who have not previously served as teaching staff, must be certified by the American Board of Pediatric Dentistry or have completed the educational requirements to pursue certification.</td>
</tr>
<tr>
<td>4</td>
<td>2-3.4</td>
<td>Clinical faculty must be immediately available to provide direct supervision to students/residents for all clinical sessions.</td>
</tr>
</tbody>
</table>
### Frequency of Citings

**Pediatric Dentistry RC CODA Summer 2020**

**Non-Compliance Citings** | **Accreditation Standard** | **Required Areas of Compliance**
--- | --- | ---
1 | 2.3-5 | The faculty includes members who are engaged in scholarly activity.
3 | 2-4 | The program must show evidence of an ongoing faculty development process.

**STANDARD 3- FACILITIES AND RESOURCES – 25 Required Areas of Compliance**

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>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 the Standards.</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Policies <strong>must</strong> be provided to all students/residents, faculty and appropriate support staff and continuously monitored for compliance.</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Additionally, policies on bloodborne and infectious diseases <strong>must</strong> be made available to applicants for admission and patients.</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>All students/residents, faculty and support staff involved in the direct provision of patient care <strong>must</strong> be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>3-1</td>
<td>Students/Residents, faculty and staff engaged in provision of pharmacologic behavior guidance must be certified in PALS or ACLS in accordance with guidelines of the American Academy of Pediatric Dentistry, and institutional and state regulations.</td>
</tr>
<tr>
<td>1</td>
<td>3-3</td>
<td>The program must have access to clinical facilitates that include:</td>
</tr>
<tr>
<td>1</td>
<td>3-3.2</td>
<td>Flexibility to allow for changes in equipment location and for additions or deletions to improve operating efficiency, and promote efficient use of dental instrumentation and allied personnel.</td>
</tr>
<tr>
<td>1</td>
<td>3-3.5</td>
<td>Recovery area facilities.</td>
</tr>
<tr>
<td>1</td>
<td>3-4</td>
<td>Personnel resources must include:</td>
</tr>
<tr>
<td>1</td>
<td>3-4.1</td>
<td>Adequate administrative and clerical personnel.</td>
</tr>
<tr>
<td>4</td>
<td>3-4.2</td>
<td>Adequate allied dental personnel assigned to the program to ensure clinical and laboratory technical support are suitably trained and credentialed.</td>
</tr>
<tr>
<td>1</td>
<td>3-5</td>
<td>Research Facilities: Facilities must be available for students/residents to conduct basic and/or applied (clinical) research</td>
</tr>
<tr>
<td>1</td>
<td>3-6</td>
<td>Information Resources: Appropriate information resources must be available including access to biomedical textbooks, dental journals and other sources pertinent to the area of pediatric dentistry practice and research</td>
</tr>
<tr>
<td>1</td>
<td>3-7</td>
<td>Patient Availability: A sufficient pool of patients requiring a sufficient scope, volume and variety of oral health care needs and a delivery system to provide ample opportunity for training must be available, including healthy individuals as well as patients with special health care needs.</td>
</tr>
</tbody>
</table>
STANDARD 4-  CURRICULUM AND PROGRAM DURATION – 139 Required Areas of Compliance

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>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 discipline’s practice as set forth in specific standards contained in this document.</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>Advanced dental education programs must include instruction or learning experiences in evidence-based practice.</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>The level of discipline-specific instruction in certificate and degree-granting programs must be comparable.</td>
</tr>
<tr>
<td>1</td>
<td>4-1</td>
<td>An advanced education program in pediatric dentistry must prepare a specialist who is competent in providing both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.</td>
</tr>
<tr>
<td>1</td>
<td>4-1</td>
<td>All curricula must be formulated in accordance with current American Academy of Pediatric Dentistry Guidelines.</td>
</tr>
<tr>
<td>1</td>
<td>4-3</td>
<td>The program must also provide experience in closely related areas to ensure that students/residents become competent in comprehensive care.</td>
</tr>
<tr>
<td>2</td>
<td>4-4</td>
<td>Biomedical sciences must be included to support the clinical, didactic and research portions of the curriculum.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>4-4</td>
<td></td>
<td>Instruction must be provided at the understanding level in the following biomedical sciences:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. BIOSTATISTICS and CLINICAL EPIDEMIOLOGY: Including probability theory, descriptive statistics, hypothesis testing, inferential statistics, principles of clinical epidemiology and research design;</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>b. PHARMACOLOGY: Including pharmacokinetics, interaction and oral manifestations of chemotherapeutic regimens, pain and anxiety control, and drug dependency</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>d. EMBRYOLOGY: Including principles of embryology with a focus on the developing head and neck, and craniofacial anomalies;</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>e. GENETICS: Including human chromosomes, Mendelian and polygenic patterns of inheritance, expressivity, basis for genetic disease, pedigree construction, physical examination and laboratory evaluation methods, genetic factors in craniofacial disease and formation and management of genetic diseases;</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>f. ANATOMY: Including a review of general anatomy and head and neck anatomy with an emphasis on the infant, child and adolescent;</td>
</tr>
<tr>
<td></td>
<td>4-5</td>
<td>Didactic Instruction: Didactic instruction in behavior guidance must be at the in-depth level and include:</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>a. Physical, psychological and social development. This includes the basic principles and theories of child development and the age-appropriate behavior responses in the dental setting;</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>b. Child behavior guidance in the dental setting and the objectives of various guidance methods;</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>c. Principles of communication, including listening techniques, including the descriptions of and recommendations for the use of specific techniques, and communication with parents and caregivers;</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>d. Principles of informed consent relative to behavior guidance and treatment options;</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>e. Principles and objectives of sedation and general anesthesia as behavior guidance techniques, including indications and contraindications for their use in accordance with the AAPD guidelines and The Teaching of Pain Control and Sedation to Dentists and Dental Students of the American Dental Association (ADA); and</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>f. Recognition, treatment and management of pharmacologic-related emergencies</td>
</tr>
<tr>
<td>4-6</td>
<td></td>
<td>Clinical Experiences: Clinical experiences in behavior guidance <strong>must</strong> enable students/residents to achieve competency in patient management using behavior guidance:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Experiences <strong>must</strong> include infants, children and adolescents including patients with special health care needs, using:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Non-pharmacological techniques;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Sedation; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Inhalation analgesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Students/Residents <strong>must</strong> perform adequate patient encounter to achieve competency:</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>1. Students/Residents <strong>must</strong> complete 20 nitrous oxide analgesia patient encounters as primary operator; and</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>2. Students/Residents <strong>must</strong> complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>a. Of the 50 patient encounters, each student/resident <strong>must</strong> act as sole primary operator in a minimum of 25 sedation cases.</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>b. Of the remaining sedation cases (those not performed as the primary operator), each student/resident <strong>must</strong> gain clinical experience, which can be in a variety of activities or settings, including individual or functional group monitoring and human simulation.</td>
</tr>
<tr>
<td>1 4-6</td>
<td></td>
<td>c. All sedation cases <strong>must</strong> be completed in accordance with the recommendations and guidelines of AAPD/AAP, the ADA’s Teaching of Pain Control and Sedation to Dentists and Dental Students, and relevant institutional policies.</td>
</tr>
<tr>
<td>4-8</td>
<td>Clinical Experiences: Clinical experiences <strong>must</strong> enable students/residents to achieve competency in:</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>a. Diagnosis of dental, skeletal, and functional abnormalities in the primary, mixed, and young permanent dentition stages of the developing occlusion; and</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>b. Treatment of those conditions that can be corrected or significantly improved by evidence-based early interventions which might require guidance of eruption, space supervision, and interceptive orthodontic treatments.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td></td>
<td>4-10</td>
<td>Clinical Experiences: Clinical experiences in oral facial injury and emergency care <strong>must</strong> enable students/residents to achieve competency in:</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>a. Diagnosis and management of traumatic injuries of the oral and perioral structures including primary and permanent dentition and in infants, children and adolescents; and</td>
</tr>
<tr>
<td></td>
<td>4-15</td>
<td>Didactic Instruction: Didactic instruction <strong>must</strong> be at the in-depth level and include:</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>a. Restorative and prosthetic techniques and dental materials for the primary, mixed and permanent dentitions;</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>b. Management of comprehensive restorative care for pediatric patients;</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>c. Treatment planning for infants, children, adolescents and those with special health care needs; and</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>d. Characteristics of the dental home.</td>
</tr>
<tr>
<td></td>
<td>4-17</td>
<td>Didactic Instruction: Didactic instruction <strong>must</strong> be at the understanding level and include:</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>a. The design implementation and management of a contemporary practice of pediatric dentistry, emphasizing business skills for proper and efficient practice;</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>b. Jurisprudence and risk management specific to the practice of Pediatric Dentistry;</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>c. Use of computers in didactic, clinical and research endeavors, as well as in practice management;</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>1</td>
<td>d. Principles of ethical and biomedical ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management; and</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>e. Working cooperatively with consultants and clinicians in other dental specialties and health fields.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Didactic instruction must be at the in-depth level for the following:</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>f. The prevention and management of medical emergencies in the dental setting.</td>
<td></td>
</tr>
<tr>
<td>4-18</td>
<td>Didactic Instruction: Didactic instruction must</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>a. Formulation of treatment plans for patients with special health care needs.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>b. Medical conditions and the alternatives in the delivery of dental care that those conditions might require.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Management of the oral health of patients with special health care needs, i.e.:</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1. Medically compromised;</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2. Physically compromised or disabled; and diagnosed to have developmental disabilities, psychiatric disorders or psychological disorders.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3. Transition to adult practices</td>
<td></td>
</tr>
<tr>
<td>4-19</td>
<td>Clinical Experiences: Clinical experiences <strong>must</strong> enable advanced students/residents to achieve competency in:</td>
<td></td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>a. Examination, treatment and management of infants, children, adolescents and adults with special health care needs.</td>
</tr>
<tr>
<td>1</td>
<td>4-21</td>
<td>Clinical Experiences: Clinical experiences must enable students/residents to acquire knowledge and skills to function as health care providers within the hospital setting.</td>
</tr>
<tr>
<td></td>
<td>4-21</td>
<td>The program must provide the following clinical experiences:</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>a. Dental treatment in the Operating Room Setting:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Each student/resident participates in the treatment of pediatric patients under general anesthesia in the operating room.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Each student/resident participates in a minimum of twenty (20) operating room cases and these are documented in the RCL (Resident Clinical Log). In ten (10) of the operating room cases above, each student/resident provides the pre-operative workup and assessment, conducting medical risk assessment, admitting procedures, informed consent, and intra-operative management including completion of the dental procedures, post-operative care, discharge and follow up and completion of the medical records.</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>c. Anesthesiology Rotation:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. The rotation must provide and document experiences in: (1) pre-operative evaluation, (2) risk assessment, (3) assessing the effects of pharmacologic agents, (4) venipuncture techniques, (5) airway management, (6) general anesthetic induction and intubation, (7) administration of anesthetic agents, (8) patient monitoring, (9) prevention and management of anesthetic emergencies, (10) recovery room management, and (11) postoperative appraisal and follow up.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>4-24</td>
<td>Didactic Instruction: Didactic instruction must be at the understanding level and include:</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>a. Normal speech and language development and the recognition of speech and language delays/disorders; the anatomy and physiology of articulation and normal articulation development; causes of defective articulation with emphasis on oral anomalies, craniofacial anomalies, dental or occlusal abnormalities, velopharyngeal insufficiency (VPI), history of cleft lip/palate and normal velopharyngeal function and the effect of VPI on resonance; and</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>b. Fundamentals of pediatric medicine including those related to pediatric patients with special health care needs such as:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Developmental disabilities;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Genetic/metabolic disorders;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Infectious disease;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Sensory impairments; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Chronic disease.</td>
<td></td>
</tr>
<tr>
<td>4-26</td>
<td>Didactic Instruction: Didactic Instruction <strong>must</strong> be at an understanding level and include:</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>a. The fundamental domains of child advocacy including knowledge about the disparities in the delivery of dental care, issues around access to dental care and possible solutions;</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>b. Federally and state funded programs like Medicaid and SCHIP that provide dental care to poor populations; and</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>c. Principles of education.</td>
<td></td>
</tr>
</tbody>
</table>
### Frequency of Citings

**Pediatric Dentistry RC**

**CODA Summer 2020**

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4-27</td>
<td>Clinical Experiences: Clinical experiences <strong>must</strong> provide exposure of the advanced education student/resident to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Communicating, teaching, and collaborating with groups and individuals on children’s health issues;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>b. Advocating and advising public health policy legislation and regulations to protect and promote the oral health of children; and</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>c. Participating at the local, state, and national level in organized dentistry to represent the oral health needs of children, particularly the underserved.</td>
</tr>
<tr>
<td>1</td>
<td>4-28</td>
<td>Advanced education students/residents <strong>must</strong> engage in teaching activities which may include peers, predoctoral students, community based programs and activities, and other health professionals.</td>
</tr>
</tbody>
</table>

**STANDARD 5- ADVANCED EDUCATION STUDENTS** – 14 Required Areas of Compliance

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>A system of ongoing evaluation and advancement <strong>must</strong> ensure that, through the director and faculty, each program:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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;</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>There <strong>must</strong> be specific written due process policies and procedures for adjudication of academic and disciplinary complaints, which parallel those established by the sponsoring institution.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>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.</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>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.</td>
</tr>
</tbody>
</table>

**STANDARD 6- RESEARCH – 5 Required Areas of Compliance**

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6</td>
<td>Advanced dental education students/residents must engage in scholarly activity.</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>Advanced dental education students/residents must:</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>a. Participate in and complete a research project;</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>b. Uses data collection and analysis;</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>c. Uses elements of scientific method; and</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>d. Reports results in a scientific forum.</td>
</tr>
</tbody>
</table>
CONSIDERATION OF PROPOSED REVISIONS TO ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN PEDIATRIC DENTISTRY

Background: The Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry were adopted by the Commission on Dental Accreditation at its February 3, 2012 meeting for implementation July 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 Advanced Dental Education Programs in Pediatric Dentistry was conducted in 2018, with results considered at the Commission’s Summer 2018 meeting.

In Summer 2018, the Pediatric Dentistry Review Committee (PED 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 PED 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 individuals representing the American Academy of Pediatric Dentistry (AAPD) and the American Board of Pediatric Dentistry (ABPD), to further study the findings of the Pediatric Dentistry Validity and Reliability Study and identify Accreditation Standards, if any, which warranted revision, with a report to the PED RC and Commission in Winter 2019.

The workgroup members included Dr. Catherine Flaitz, (PED RC and workgroup chair), Dr. Martin Donaldson (PED RC), Dr. Cynthia Hipp (PED RC), Dr. Janice Townsend (PED RC), Dr. Joel Berg (AAPD), Dr. Amr Moursi (AAPD), Dr. Man Wai Ng (ABPD) and Dr. Richard Udin (ABPD). The workgroup conducted five (5), two-hour meetings on November 13, November 16, November 30, December 3, and December 10, 2018.

At the Winter 2019 meeting, the PED RC considered the progress of the workgroup and noted its focus on Standard 2-Program Director and Teaching Staff and Standard 4-Curriculum and Program Duration. Further, the PED RC agreed that the next step was to compile a comprehensive document that reflects all proposed revisions so that the workgroup could consider the changes in totality, look for redundancy, and ensure all current and proposed required components were addressed. To that end, the PED RC agreed and the Commission concurred that the workgroup should continue its work in spring 2019 with a report and proposed revised Standards document submitted for consideration at the Commission’s Summer 2019 PED RC and Commission meetings.
During spring 2019, the workgroup continued its work in preparing a comprehensive Standards document reflecting proposed revisions. The workgroup conducted four (4) two-hour meetings on April 16, May 6, May 20, and June 18, 2019.

At the Summer 2019 meeting, the PED RC further considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry submitted by the workgroup.

Following discussion, the PED RC recommended the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 1) be circulated to the communities of interest, without further edits by the PED RC, for review and comment for one (1) year with hearings conducted at the 2019 American Dental Association (ADA) Annual Meeting, the 2020 American Dental Education Association (ADEA) Annual Session, and the 2020 Annual Meeting of the American Academy of Pediatric Dentistry (AAPD), noting financial implications to the Commission related to the hearing at the AAPD meeting. However, PED RC believed that a hearing among pediatric dentistry educators and practitioners is important, given the extensive revisions in the proposed Accreditation Standards document. Comments would be reviewed at the Commission’s Summer 2020 meeting. At its August 2, 2019 meeting, the Commission concurred and directed that the proposed revisions (Appendix 1) be circulated to the communities of interest for a period of one (1) year, including hearings during the 2019 American Dental Association (ADA) Annual Meeting, the 2020 American Dental Education Association (ADEA) Annual Session, and the 2020 Annual Meeting of the American Academy of Pediatric Dentistry (AAPD).

As directed by the Commission, the proposed revised Standards (Appendix 1) were circulated for comment through June 1, 2020. No (0) comments were received at the September 6, 2019 hearing at the 2019 American Dental Association Annual Meeting.

Due to the COVID-19 pandemic, the 2020 Annual Meeting of the American Dental Education Association (ADEA) was canceled and the 2020 Annual Meeting of the American Academy of Pediatric Dentistry (AAPD) was conducted virtually. Therefore, the Commission’s hearings on accreditation standards were held virtually on May 18, 2020 and May, 20, 2020, respectively. No (0) comments were received at the May 18, 2020 virtual hearing to replace the ADEA hearing; 21 comments were received at the May 20, 2020 virtual hearing to replace the AAPD hearing (Appendix 2). The Commission office received 11 written comments prior to the June 1, 2020 deadline (Appendix 3).

Summary: At this meeting, the Pediatric Dentistry Education Review Committee and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Appendix 1) and all of the comments received prior to the June 1, 2020 deadline (Appendices 2 and 3). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of
interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

**Recommendation:**
Commission on Dental Accreditation

At its Summer 2019 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2020, for review at the Summer 2020 Commission meeting.

Written comments can be directed to soeldnerp@ada.org or mailed to:

ATTN: Ms. Peggy Soeldner, 19th Floor
Manager, Advanced Dental Education
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Proposed Revised Standards
Additions are Underlined; Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry
Proposed Revisions to Pediatric Dentistry Standards
CODA Summer 2020

Accreditation Standards for
Advanced Dental Education Programs in
Pediatric Dentistry

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


## Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry

### Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 3, 2012</td>
<td>Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry</td>
<td>Adopted</td>
</tr>
<tr>
<td>August 10, 2012</td>
<td>Revised Mission Statement</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>January 31, 2013</td>
<td>Revision to Policy on Accreditation of Off-Campus sites</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>January 31, 2013</td>
<td>Revision to Standard 5, Eligibility and Selection</td>
<td>Adopted</td>
</tr>
<tr>
<td>July 1, 2013</td>
<td>Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry</td>
<td>Implemented</td>
</tr>
<tr>
<td>July 1, 2013</td>
<td>Revision to Standard 5, Eligibility and Selection</td>
<td>Implemented</td>
</tr>
<tr>
<td>August 9, 2013</td>
<td>Revised Policy on Accreditation of Off-Campus Sites</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 9, 2013</td>
<td>Revised Policy on Reporting Program Changes in Accredited Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 6, 2015</td>
<td>Revision to Standard 1, Institutional Commitment/Program Effectiveness</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 6, 2015</td>
<td>Revision to Standard 5, Eligibility and Selection</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revision to Policy on Reporting Program Changes in Accredited Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revised Policy on Enrollment Increases in Advanced Dental Specialty Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions—</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revised Policy on Program Changes</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revised Policy on Enrollment Increases in Advanced Dental Specialty Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 5, 2016</td>
<td>Revised Policy on Program Changes</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 5, 2016</td>
<td>Revised Policy on Enrollment Increases in Advanced Dental Specialty Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
<td>Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Standard 4-6, Sedation</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Accreditation Status Definitions—</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Policy on Program Changes</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revisions Standard 1-Affiliations-New Standards—</td>
<td>Adopted</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revision Standard 2, Program Director and Teaching</td>
<td>Adopted</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Staff, New Standard 2-5</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Item</td>
<td>Action</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>July 1, 2018</td>
<td>Revisions Standard 1 - Affiliations - New Standards 1-1 and 1-3</td>
<td>Implemented</td>
</tr>
<tr>
<td>July 1, 2018</td>
<td>Revision Standard 2, Program Director and Teaching Staff - New Standard 2-5</td>
<td>Implemented</td>
</tr>
<tr>
<td>August 3, 2018</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2019</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Implemented</td>
</tr>
<tr>
<td>TBD</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry</td>
<td>Adopted</td>
</tr>
<tr>
<td>TBD</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry</td>
<td>Implemented</td>
</tr>
</tbody>
</table>
# Table of Contents

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>13</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>17</td>
</tr>
<tr>
<td>18</td>
</tr>
<tr>
<td>19</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>21</td>
</tr>
<tr>
<td>22</td>
</tr>
<tr>
<td>23</td>
</tr>
<tr>
<td>24</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>26</td>
</tr>
<tr>
<td>28</td>
</tr>
</tbody>
</table>
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.

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

Revised: 8/17; 2/16; 5/12; 1/99; Reaffirmed: 8/13; 8/10, 7/05; Adopted: 1/98
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: 8/13; 8/10; Adopted: 2/02
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 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, 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 Pediatric Dentistry 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.

Intent: Intent statements are presented to provide clarification to the advanced dental education programs in pediatric dentistry in the application of and in connection with compliance with the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry. 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 standards.

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 is 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.

Resident Clinical Log (RCL): A secure and valid account of procedures and experiences of a student/resident maintained by the program for use in evaluation, accreditation, quality assurance and other purposes.

Treatment: Refers to direct care provided by the student/resident for that condition or clinical problem.
Management: Refers to provision of appropriate care and/or referral for a condition consistent with contemporary practice and in the best interest of the patient.


Interprofessional Education**: When students/residents and/or professionals from two or more professions learn about, from and with each other to enable effective collaboration to improve health outcomes. *(Adapted from the WHO 2010)*

Social Determinants of Health***: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. *(From the WHO)*


*** Definition from the World Health Organization (WHO). (Retrieved from https://www.who.int/social_determinants/sdh_definition/en/, 2019)*
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 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 pediatric dentistry and that one of the program goals is to comprehensively prepare competent individuals to initially practice pediatric dentistry. 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 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, 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.

1-1 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.

f. Documentation of the liability coverage
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).

1-2 A Commission-accredited advanced education program in pediatric dentistry must use, among other outcomes measures, the successful completion by pursuit by its students/residents and graduates of in the American Board of Pediatric Dentistry certification process.

Intent: This is one of the many measures of outcomes assessment that a program may use in their outcomes assessment process.

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.

Intent: All pediatric dental faculty are educationally qualified pediatric dentists. All non-pediatric dentistry members of the teaching staff are educationally qualified or have special expertise in their area(s) of instruction.

If the program utilizes educational activity sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs 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 Biosketch 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 **must** be evaluated annually.

2-2 Administrative Responsibilities: The program director **must** have sufficient authority and time to fulfill administrative program assessment and teaching responsibilities in order to achieve the educational goals of the program including:

**Intent:** Program directors with remote programs have resources to visit these programs.

2-2.1 Student/resident selection, unless the program is sponsored by federal services utilizing a centralized student/resident selection process.

2-2.2 Curriculum development and implementation.
2-2.3 Ongoing evaluation of program goals, objectives and content and outcomes assessment.

_Intent:_ The program uses a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement that relate directly to the stated program goals and objectives.

2-2.4 Annual evaluations of faculty performance by the program director or department chair; including a discussion of the evaluation with each faculty member.

2-2.5 Evaluation of student/resident performance.

2-2.6 Participation with institutional leadership in planning for and operation of facilities used in the educational program.

2-2.7 Evaluation of student’s/resident’s training and supervision in affiliated institutions.

2-2.8 Maintenance of records related to the educational program, including written instructional objectives, course outlines and student/resident clinical logs (RCLs) documenting the completion of specified procedures and/or patient complexity, including:

a) nitrous oxide analgesia patient encounters as primary operator
b) patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used
c) operating room cases
d) clinical procedures (e.g. emergency, trauma, restorative, preventative, orthodontic, multi-disciplinary, etc.)
e) patient diversity/complexity (e.g. well-patient, medically complex, special needs, hospital based, etc.)

_Intent:_ These records are to be available for on-site review: overall program objectives, objectives of student/resident rotations, specific student/resident schedules by semester or year, completed student/resident evaluation forms for current students/residents and recent alumni, self-assessment process, curricula vitae of faculty responsible for instruction. The RCL provides programs with data required for program improvement and gives students/residents and official record of clinical procedures required by regulatory boards and hospitals. The RCL may be comprised of a patient and procedure log and/or a printout of billing codes, for example, and may be compiled by the program, student/resident, and/or staff.
2-2.9 Responsibility for overall continuity and quality of patient care.

2-2.10 Oversight responsibility for student/resident research.

2-2.11 Responsibility for determining the roles and responsibilities of associate program director(s) and their regular evaluation.

2-3 Activities of Teaching Staff:

2-3.1 Pediatric dentistry members of the teaching staff, including those at sites where educational activity occurs, appointed after January 1, 2000, who have not previously served as teaching staff, must be certified by the American Board of Pediatric Dentistry or have completed the educational requirements to pursue board certification. For clinical disciplines other than pediatric dentistry, the supervising faculty member responsible for the specific discipline must be appropriately credentialed in that discipline within the institution.

*Intent:* The clinical curriculum is taught by educationally qualified pediatric dentists and, when necessary to enhance training, by appropriately credentialed faculty members for the curriculum areas for which they are responsible.

2-3.2 Foreign trained faculty members must be comparably qualified.

2-3.3 Internationally trained pediatric dentists must demonstrate evidence of educational qualifications, appropriate licensure and credentialing as required by the institution.

*Intent:* Individuals who are graduates of Commission on Dental Accreditation accredited programs or those with which the Commission on Dental Accreditation has reciprocity are exempt from this requirement.

2-3.3 The program clinical faculty and attending staff must have specific and regularly scheduled clinic assignments to ensure the continuity of the program.

2-3.4 Clinical faculty must be immediately available to provide direct supervision to students/residents for all clinical sessions.

*Intent:* Clinical faculty are physically on site in the treatment area for clinical sessions with scheduled patients and physically present in the clinic, immediately available within one minute, for all conscious/deep sedation patients. Indirect supervision should only be used after careful consideration of the competence of the student/resident and also based on the delineation of privileges and procedure types.
Clinical faculty are held accountable for responsibilities and attendance. Certain funding sources require specific faculty-to-student/resident ratios which should be observed.

2-3.5 The faculty includes members who are engaged in scholarly activity.

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, gender, and generational 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

2-5 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:* The students/residents receive comparable training and evaluation by all appropriate faculty.

**Examples of evidence to demonstrate compliance may include:**
- Ongoing faculty training
- Documentation of faculty participation in calibration exercises
- Calibration training manuals
- Periodic monitoring for compliance
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/administrative 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 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 Students/Residents, and faculty and staff engaged in the provision of pharmacologic behavior guidance sedation in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used must be certified in PALS or ACLS have training in and maintenance of advanced pediatric airway skills (e.g., pediatric advanced life support (PALS), in accordance with guidelines current recommendations of the American Academy of Pediatric Dentistry REFERENCE MANUAL, and institutional and state regulations.

**Intent:** Guidelines require that providers of sedation have these credentials.

3-2 Private practitioners who provide training must have faculty appointments.

**Intent:** Private offices can be used for training and should meet the same facility standards as institutional facilities.

3-3 The program must have access to clinical facilities that include:

3-3.1 Space designated specifically for the advanced dental education program in pediatric dentistry.

3-3.2 Flexibility to allow for changes in equipment location and for additions or deletions to improve operating efficiency, and promote efficient use of dental instrumentation and allied personnel.

3-3.3 Adequate radiographic diagnostic imaging and laboratory facilities in close proximity to the patient treatment area.

3-3.4 Accessibility for patients with special health care needs.

3-3.5 Recovery area facilities.

**Intent:** A recovery area is defined as a designated space equipped properly for patients recovering from sedation. This space must provide for observation/monitoring by appropriately trained personnel. This could be the operatory where the child was sedated.

3-3.6 Reception and patient education areas.

**Intent:** Patient education may also occur in treatment areas.

3-3.7 A suite equipped for carrying out comprehensive oral health care procedures under general anesthesia and/or sedation.
**Intent:** The operation treatment facility could be an appropriately-equipped ambulatory suite in a non-hospital setting.

3-3.8 Inpatient facilities to permit management of general and oral health problems for patients individuals with special health care needs.

**Intent:** Students/Residents have the opportunity to manage oral health problems of inpatients with serious medical problems. Patients Individuals with special health care needs include those with medical, physical, psychological or social circumstances that require modification in normal dental routines to provide of dental treatment. These individuals include (but are not limited to) people with developmental disabilities, complex medical problems and significant physical limitations.

3-3.9 A sufficient number of operatories to accommodate the number of students/residents enrolled.

3-4 Personnel resources must include:

3-4.1 Adequate administrative and clerical personnel.

3-4.2 Adequate allied dental personnel assigned to the program to ensure clinical and laboratory technical support are suitably trained and credentialed.

**Intent:** Allied dental personnel are expected to be available for operating room cases, conscious/deep sedation patients, surgical procedures and behavior management situations. There are instances when a student/resident assisting another student/resident may be beneficial as long as the experience does not negatively impact the students'/residents’ education. Clinic scheduling and off-service rotations will be considered in assessing adequacy of allied dental personnel.

3-5 Research Facilities: Facilities must be available for students/residents to conduct basic and/or applied (clinical) research.

3-6 Information Resources: Appropriate information resources must be available including access to biomedical textbooks, dental journals, online resources, and other sources pertinent to the area of pediatric dentistry practice and research.

**Intent:** Students/Residents have access to electronic-based information resources in the program.

3-7 Patient Availability: A sufficient An adequate and diverse pool of patients requiring a sufficient scope, volume and variety of oral health care needs and a delivery system to provide ample opportunity for training must be available, including healthy individuals as
well as patients individuals with special health care needs. These health care needs must include, but are not limited to, medical, physical, psychological, or social situations that make it necessary to consider a wide range of assessment and care options.

**Intent:** Documentation of the scope, volume and variety of patients and procedures completed by the students/residents, including those with complex impairment who require substantial functional support and modifications to dental treatment, will be provided via the RCLs as described in Standard 2-2.8. These records are to be available for on-site review.
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 and/or program enrolls part-time students/residents, the institution/program 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 ensure 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.
GOALS OF ADVANCED EDUCATION IN PEDIATRIC DENTISTRY

4-1 An advanced dental education program in pediatric dentistry must prepare a graduate who is competent in providing both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those individuals with special health care needs. The program educates future pediatric dentists to be competent in communicating and collaborating with other members of healthcare and social disciplines, to facilitate the provision of health care.

Intent: Students/Residents are trained to provide services in institutional, private, and/or public health settings. The program should encourage the development of a critical and inquiring attitude that is necessary for the advancement of practice, research, and teaching in pediatric dentistry.

This individual is trained to provide services in institutional, private, or public health settings. The program encourages the development of a critical and inquiring attitude that is necessary for the advancement of practice, research, and teaching in pediatric dentistry. The program educates future pediatric dentists to work in coordination with members of other health care and social disciplines.

All curricula must be formulated in accordance with current American Academy of Pediatric Dentistry Guidelines, the REFERENCE MANUAL, if applicable.

4-2 Students/Residents must participate in interprofessional education and collaborative practice programs and receive training to assume a leadership role as a care team member in oral healthcare initiatives.

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

PROGRAM DURATION

4-3 The duration of an advanced dental education program in pediatric dentistry must be a minimum of 24 months of full-time formal training.
CURRICULUM

4-34-4 The program must provide the opportunity to extend the student’s/resident’s diagnostic ability, basic and advanced clinical knowledge and skills, and critical judgment beyond that provided in predoctoral education. The program must also provide experience in closely related areas to ensure that students/residents become competent in comprehensive care.

Intent: A supporting portion of the curriculum extends the student’s/resident’s educational experience and enhances his/her ability to think critically and independently and to communicate information clearly, effectively and accurately.

BIOMEDICAL SCIENCES

4-44-5 Biomedical sciences must be included to support the clinical, didactic and research portions of the curriculum. The biomedical sciences may be integrated into existing curriculum designed especially for the pediatric dentistry program.

Intent: Instruction in biomedical sciences need not occur only in formal courses. Such instruction may be acquired through clinical activities, off-service rotations and other educational activities.

Instruction must be provided at the understanding level in the following biomedical sciences with an emphasis on the infant, child and adolescent, including individuals with special health care needs:

a. BIOSTATISTICS, HEALTH INFORMATICS and CLINICAL EPIDEMIOLOGY: Including probability theory, descriptive statistics, hypothesis testing, inferential statistics, meta-analysis, systematic review, principles of clinical epidemiology and research design;
b. PHARMACOLOGY: Including pharmacokinetics, pharmacogenetics, potential drug interactions and adverse side effects with emphasis on oral manifestations of chemotherapeutic regimens, pain and anxiety control, and drug dependency and substance use disorders;
c. MICROBIOLOGY: Including virology, immunology, and cariology oral microbiome, infectious disease with emphasis on head and neck manifestations, including dental caries and periodontal disease;
d. EMBRYOLOGY: Including principles of embryology with a focus on the developing head and neck, and craniofacial anomalies;
e. GENETICS: Including human chromosomes, chromosomal anomalies/syndromes, Mendelian, and polygenic and epigenetic patterns of inheritance, expressivity, basis for genetic disease, pedigree construction, physical examination and laboratory evaluation methods,
genetic factors in craniofacial disease and formation and management of

genetic diseases, applying the principles of precision medicine;

f. ANATOMY: Including a review of general anatomy and as well as head and
neck anatomy with an emphasis on the infant, child and adolescent; and

g. ORAL PATHOLOGY: Including a review of the epidemiology,
pathogenesis, clinical characteristics, diagnostic methods, formulation of
differential diagnoses and management of oral and perioral lesions and
anomalies with emphasis on the infant, child, and adolescent.

PATHOPHYSIOLOGY: Including a review of major organ diseases with
emphasis on head and neck manifestations and the modification of the
delivery of oral health care. There will be a general understanding of the
epidemiology, etiopathogenesis, clinical presentation, diagnostic imaging and
laboratory studies, differential diagnosis, treatment and prognosis for these
diseases.

CLINICAL SCIENCES

BEHAVIOR GUIDANCE

4-54-6 Didactic Instruction: Didactic instruction in behavior guidance must be at the in-depth level
and include:

a. Physical, psychological and social development. This includes the basic
principles and theories of child development and the age-appropriate behavior
responses in the dental setting;

b. Child behavior guidance in the dental setting and the objectives of various
guidance methods;

c. Principles of communication, including listening techniques, including the
descriptions of and recommendations for the use of specific techniques, and
communication with parents and caregivers, including the application of
motivational interviewing;

d. Principles of informed consent relative to behavior guidance and treatment
options;

e. Principles and objectives of sedation and general anesthesia as behavior
guidance techniques, including indications and contraindications for their use
in accordance with the AAPD REFERENCE MANUAL guidelines and The
Teaching of Pain Control and Sedation to Dentists and Dental Students of the
American Dental Association (ADA); and

f. Recognition, treatment and management of pharmacologic-related
emergencies, adverse events related to sedation and general anesthesia,
including airway problems.

Intent: The term “treatment” refers to direct care provided by the residents/student for that
condition or clinical problem. The term “management” refers to provision of appropriate
care and/or referral for a condition consistent with contemporary practice and in the best interest of the patient.

Clinical Experiences: Clinical experiences in behavior guidance must enable students/residents to achieve competency in patient management using behavior guidance:

a. Experiences must include infants, children and adolescents including patients individuals with special health care needs, using:
   1. Non-pharmacological techniques;
   2. Sedation; and
   3. Inhalation analgesia.

b. Students/Residents must perform adequate patient encounters to achieve competency:
   1. Students/Residents must complete 20 50 nitrous oxide analgesia patient encounters as primary operator; and
   2. Students/Residents must complete a minimum of 50 patient encounters in which sedative agents other than nitrous oxide (but may include nitrous oxide in combination with other agents) are used. The agents may be administered by any route.

   a. Of the 50 patient encounters, each student/resident must act as sole primary operator in a minimum of 25 sedation cases.

   b. Of the remaining sedation cases (those not performed as the sole primary operator), each student/resident must gain clinical experience, which can be in a variety of activities or settings, including individual or functional group monitoring and human simulation.

   c. All sedation cases must be completed in accordance with the recommendations and guidelines of AAPD the REFERENCE MANUAL /AAP, the ADA’s Teaching of Pain Control and Sedation to Dentists and Dental Students, and relevant applicable institutional policies.

Intent: Programs will provide or make available adequate opportunities to meet the above requirements which are consistent with those experiences required by jurisdictions with policies regulating pediatric sedation in dental practice. The numbers of encounters cited in the Standard represents the minimal number of experiences required for a student/resident. In the sole primary operator role, the student/resident is expected to provide the assessment, drug delivery, treatment, monitoring, discharge and emergency prevention/management in conjunction with other medical personnel as required by institutional policies.
In the remaining sedation cases, where the student/resident is not the primary operator, the supplemental cases provide the student/resident with:

1. direct clinical participation in patient care in an observational, data-gathering, monitoring, and/or recording capacity,
2. simulation experiences with direct clinical application to elements of the AAP/AAPD REFERENCE MANUAL sedation guidelines, or
3. participation in activities related to specific patient care episodes such as quality improvement and safety initiatives, apparent cause analysis, Morbidity & Mortality conferences, and/or clinical rounds that review essential elements of an actual patient sedative sedation visit.

These experiences require documentation and inclusion in the student/resident clinical log RCL. It is not an appropriate learning experience for groups of students/residents to passively observe a single sedative treatment sedation being performed. The intent of this standard is not for multiple operators to provide limited treatment on the same sedated patient in order to fulfill the sedation requirement.

**GROWTH & DEVELOPMENT**

**4-74-8** Didactic Instruction: Didactic instruction in craniofacial growth and development must be at the in-depth level with content to enable the student/resident to understand and manage the diagnosis and appropriate treatment modalities for malocclusion problems affecting orofacial form, function, and esthetic in infants, children, and adolescents, and individuals with special health care needs. This includes:

- Theories of normative dentofacial growth mechanisms;
- Principles of diagnosis and treatment planning to identify normal and abnormal dentofacial growth and development;
- Differential classification of skeletal and dental malocclusion in children and adolescents;
- The indications, contraindications, and fundamental treatment modalities in guidance of eruption and space supervision procedures during the developing dentition that can be utilized to obtain an optimally functional, esthetic, and stable occlusion;
- Basic biomechanical principles and the biology of tooth movement. Growth modification and dental compensation for skeletal problems including limitations; and
- Appropriate consultation with and/or timely referral to other specialists when indicated to achieve optimal outcomes in the developing occlusion.

**4-84-9** Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in:
a. Diagnosis and management of dental, skeletal, and functional abnormalities in the primary, mixed, and young permanent dentition stages of the developing occlusion; and

b. Treatment of those conditions that can be corrected or significantly improved by evidence-based early interventions which might require guidance of eruption, space supervision, and interceptive orthodontic treatments. These transitional malocclusion conditions include, the recognition, diagnosis, appropriate referral and/or focused management of:

1. Space maintenance and arch perimeter control associated with the early loss of primary and young permanent teeth;
2. Transverse arch dimensional problems involving simple posterior crossbites;
3. Anterior crossbite discrepancies associated with localized dentoalveolar crossbite displacement and functional anterior shifts (e.g. pseudo-Class III);
4. Anterior spacing with or without dental protrusion;
5. Deleterious oral habits;
6. Preservation of leeway space for the resolution of moderate levels of crowding;
7. Ectopic eruption, ankylosis and tooth impaction problems; and
8. The effects of supernumerary (e.g. mesiodens) and/or missing teeth.

**ORAL FACIAL INJURY AND EMERGENCY CARE**

**4-94-10 Didactic Instruction:** Didactic instruction in oral facial injury and emergency care in infants, children, adolescents, and individuals with special health care needs must be at the in-depth level and include:

Care of orofacial injuries in infants, children and adolescents as follows:—

a. Evaluation, diagnosis and treatment of dentoalveolar trauma to the primary, mixed and permanent dentitions, such as repositioning, replantation, treatment of fractured teeth, and stabilization of intruded, extruded, luxated, and avulsed teeth;

b. Evaluation, diagnosis, and management/treatment of the pulpal, periodontal and associated soft and hard tissues following traumatic injury;

c. Recognition Evaluation of injuries including fractures of the maxilla and mandible and referral for treatment by the appropriate specialist; and

d. Recognition Assessment, evaluation, management and reporting of child abuse and neglect and non-accidental trauma.

**4-104-11 Clinical Experiences:** Clinical experiences in oral facial injury and emergency care must enable students/residents to achieve competency in:
a. **Diagnosis Evaluation, diagnosis** and management of traumatic injuries of the oral and perioral structures including the soft tissues, and the primary and permanent dentition and in infants, children and adolescents; and

b. Emergency services including assessment and management/treatment of dental pain and infections.; and

c. Interprofessional and collaborative care management for patients with complex orofacial/dentoalveolar injuries.

**ORAL DIAGNOSIS, ORAL PATHOLOGY, ORAL RADIOLOGY AND ORAL MEDICINE**

4-114-12 Didactic Instruction: Didactic instruction in oral diagnosis, oral pathology oral radiology and oral medicine with emphasis on the most common and important anomalies, diseases and lesions that affect the infant, child, adolescent and individuals with special health care needs must be at the in-depth level and include:

a. The epidemiology of oral diseases encountered in infants, children and adolescents including those with special health care needs including prevalence and severity;

b. The oral diseases of hard and soft tissue encountered in infants, children and adolescents including those pediatric patients with special health care needs;

c. The diagnosis of oral and perioral lesions and anomalies in infants, children, and adolescents;

d. Gingival, periodontal and other mucosal disorders in infants, children and adolescents; and

e. Treatment of common oral diseases in infants, children and adolescents.

a. Epidemiology, etiology, clinical and radiographic findings, differential diagnosis, management/treatment, and prognosis of entities affecting the oral and maxillofacial region, including gingival and periodontal diseases;

b. Head and neck manifestations of systemic diseases, behavioral disorders and genetic conditions;

c. Referral requirements to appropriate health care or psychosocial professionals;

d. Radiation theory, hygiene and safety;

e. Radiographic imaging selection and technique for oral diagnosis including modifications for individuals with special health care needs; and

f. Radiographic interpretation of normal anatomy, anomalies and oral and maxillofacial lesions/diseases.

Didactic instruction must be at the understanding level in:

f. Ordering and performing uncomplicated oral biopsies, and adjunctive diagnostic tests including exfoliative cytology salivary gland function, microbial cultures and other commercially available tests common, baseline laboratory studies; and
Referring persistent lesions and/or extensive surgical management cases to appropriate specialists. Ordering advanced head and neck imaging, including CBCT and MRI and recognizing deviations from normal.

4-124-13 Clinical Experiences: Clinical experiences in oral diagnosis, oral pathology, oral radiology and oral medicine must enable students/residents to achieve competency in:

a. Detecting and providing differential diagnoses of common and important oral and maxillofacial lesions, including gingival and periodontal diseases;

b. Pediatric Obtaining and interpreting oral and maxillofacial imaging and appropriate procedures of radiation hygiene; and

c. Using appropriate radiation hygiene and recommended radiographic images; and

d. Managing/Treating Treatment of common oral and maxillofacial lesions and diseases, including gingival and periodontal diseases, in infants, children and adolescents.

COMPREHENSIVE ORAL HEALTH CARE

PREVENTION AND HEALTH PROMOTION

4-134-14 Didactic Instruction: Didactic instruction in prevention must be at the in-depth level and include:

a. Characteristics and role of the dental home;

b. Perinatal oral health and infant oral health;

c. Assessment of the risk of dental caries manifestations, periodontal disease, dental trauma and malocclusion;

d. Anticipatory guidance;

e. Patient/parent/caregiver education on home care;

f. Communication strategies to help patients/parents/caregivers guide behavior change, such as teach back and motivational interviewing;

g. Prevention of dental disease strategies including:

1. Fluorides and non-fluoride caries preventive and remineralizing agents;

2. Diet, nutrition and sugars, and their role in oral health and disease;

3. Pit and fissure sealants;

h. Trauma prevention;

ai. The scientific basis for the etiology, detection, diagnosis, prevention, management and restorative treatment of dental caries manifestations and periodontal and pulpal diseases, traumatic injuries, and developmental anomalies; and

aj. The provision of a risk-based, patient/family-centered comprehensive treatment plan that includes a prevention and health promotion plan.

b. The effects of proper diet nutrition, fluoride therapy and sealants in the prevention of oral disease;

c. Perinatal oral health and infant oral health supervision;
d. Scientific principles, techniques and treatment planning for the prevention of oral
diseases, including diet management, chemotherapeutics, and other approaches;
e. Dental health education programs, materials and personnel to assist in the delivery of
preventive care; and
f. Diagnosis of periodontal diseases of childhood and adolescence, treatment and/or
refer cases of periodontal diseases to the appropriate specialist.

Didactic Instruction: Didactic instruction in prevention must be at the understanding level
and include:
   a. Social determinants of health; and
   b. Relationship between oral health and systemic conditions.

4-144-15 Clinical Experiences: Clinical experiences must be of sufficient scope, volume and variety
to enable students/residents to achieve competency in the provision of application of
prevention in clinical practice.
   a. Risk-based, patient/family-centered prevention and health promotion plans for patients
and families in the context of a dental home;
   b. Infant oral health;
   c. Anticipatory guidance;
   d. Dental caries risk assessment and related risk of caries lesion progression;
   e. Risk-based dental caries management protocols including risk reduction methods and
early management of dental caries lesions Patient/Parent/Caregiver education on oral
hygiene practices, diet and nutrition;
   f. Use of fluorides;
   g. Effective communication strategies to help guide behavior change, such as teach back
and motivational interviewing;
   h. Prevention of dental disease strategies including the use risk-based dental caries
management protocol; and
   i. Use of fluoride and non-fluoride dental caries lesion preventive and remineralizing
agents.

COMPREHENSIVE DENTAL CARE Diagnosis of Caries, Non-Restorative
Management and Restorative Treatment

4-154-16 Didactic Instruction: Didactic instruction must be at the in-depth level and include:
   a.——Restorative and prosthetic techniques and dental materials for the primary, mixed and
permanent dentitions;
   b.——Management of comprehensive restorative care for pediatric patients;
   c.——Treatment planning for infants, children, adolescents and those with special health
care needs; and
   d.——Characteristics of the dental home.
Proposed Revisions to Pediatric Dentistry Standards
CODA Summer 2020

4-164-17 Clinical Experiences: Clinical experiences must enable students/residents to achieve competency in:

a. Diagnosis and treatment planning for infants, children, adolescents and those with special health care needs; and
b. Provision of comprehensive dental care to infants, children, adolescents and those with special health care needs in a manner consistent with the dental home.

4-22 4-18 Didactic Instruction: Didactic instruction must be at the in-depth level and include:

a. Pulp histology and pathology of primary and young permanent teeth, including indications and rationale for various types of indirect and direct pulp therapy; and
b. Management of pulpal and periradicular tissues in the primary and developing permanent dentition.

Intent: Pulp therapy management strategies may include vital pulp therapy for primary teeth, including indirect pulp treatment, direct pulp cap, pulpotomy; non-vital pulp treatment for primary teeth including pulpectomy; vital pulp therapy for young permanent teeth.
including apexogenesis, indirect pulp treatment, direct pulp cap, partial pulpotomy for
carious exposures, partial pulpotomy for traumatic exposures; and non-vital pulp therapy for
young permanent teeth including apexification, pulpal regeneration and decoronation.

4-234-19 Clinical Experiences: Clinical experiences must enable students/residents to achieve
competency in:

a. Diagnosis of pulpal disease in primary and permanent teeth;
b. Treatment of pulpal disease Vital and non-vital pulp therapy in primary teeth;
c. Treatment of pulpal disease Vital pulp therapy in immature permanent teeth; and
d. Management of non-vital pulp therapy in immature permanent teeth; and
e. Treatment/Management of pulpal disease in mature permanent teeth, including
emergency care, stabilization and referral to specialists.

MANAGEMENT OF A CONTEMPORARY DENTAL PRACTICE

4-174-20 Didactic Instruction: Didactic instruction must be at the understanding level and include:

a. The design, implementation and management of a contemporary practice of pediatric
dentistry, emphasizing business skills for proper and efficient practice;
b. Jurisprudence and risk management specific to the practice of Pediatric Dentistry;
c. Use of computers in didactic, clinical and research endeavors, as well as in practice
management and telehealth systems;
d. Principles of ethical and biomedical ethical reasoning, ethical decision making and
professional responsibility professionalism as they pertain to the academic
environment, research, patient care and practice management; and
e. Working cooperatively with consultants and clinicians in other dental specialties and
health fields, including interprofessional education activities.

Didactic instruction must be at the in-depth level for the following:

f. The development and monitoring of systems for prevention and management of
adverse events and medical emergencies in the dental setting;
g. Exposure to the principles of quality management systems and the role of continuous
process improvement in achieving overall quality in the dental practice setting;
h. Exposure to the principles of ethics and professionalism in dental practice is an
integral component of all aspects of this process improvement experience; and
i. Employing principles of quality improvement and safety, including an understanding
of the mechanisms to ensure a safe practice environment.

Intent: (d) 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, and (e) The student/resident learns to prevent, recognize and manage common medical emergencies for infants and children through adolescence and when to refer to other health care professionals and (g) Graduates should experience the elements of process improvement and the manner in which to involve the entire team.

Examples of evidence may include (d and g):

- Participation in courses or seminars involving biomedical ethics and/or informed consent issues;
- Institutional review boards; and
- Literature reviews; and
- Discussion of case scenarios;
- Emergency drills;
- Quality improvement projects;
- Interprofessional education and practice experiences;
- Standardized simulations;
- Standardized case studies; and
- Standardized clinical scenarios.

**PATIENTS INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS**

**4-184-22** Didactic Instruction: Didactic instruction must be at the in-depth level and include:

a. Formulation of treatment plans for patients individuals with special health care needs.

b. Medical conditions and the alternatives in the delivery of dental care that those conditions might require.

c. Management of the oral health of patients individuals with special health care needs, i.e.:

1. Medically compromised;
2. Physically compromised or disabled; and diagnosed to have developmental disabilities, psychiatric disorders or psychological disorders.
3. Transition to adult practices

**Intent:** (a) The student/resident learns how and when to modify dental care options as required by a patient’s medical condition; and (c.3) Patients Individuals with special health care needs include those with medical, physical, psychological or social circumstances that require modification in normal dental routines to provide dental treatment. These individuals include (but are not limited
to) people with developmental disabilities, complex medical problems and significant physical limitations. Management should be understood to include consideration of social, educational, vocational and other aspects of special health care needs.

4-19 4-23 Clinical Experiences: Clinical experiences must enable advanced students/residents to achieve competency in:

a. Examination, treatment and management of infants, children, adolescents and adults with special health care needs.; and
b. Participation in interprofessional experiences and collaborative care, including craniofacial teams.

Intent: Pediatric dentists often remain providers of oral health care for individuals with special health care needs patients into adulthood and should be able to render basic dental services to adults with special health care needs. These individuals include (but are not limited to) individuals with developmental disabilities, craniofacial anomalies, complex medical problems and significant physical limitations. Management should be understood to include consideration of social, educational, vocational and other aspects of special health care needs.

HOSPITAL DENTISTRY

4-204-24 Didactic Instruction: Didactic instruction must be at the understanding level and include:

a. hospital policies and procedures; Hospital experiences intended to expose students/residents to hospital function which may include attendance at conferences, seminars, clinic participation, and, if applicable, clinical inpatient rounds;
b. medical/dental staff organization; and Hospital policies and procedures, including organization of the medical/dental staff and medical staff/dental staff member responsibilities; and
c. medical/dental staff member responsibilities. The scope of practice of other healthcare professionals in relationship to the overall health and wellbeing of infants, children, adolescents and individuals with special health care needs.

4-214-25 Clinical Experiences: Clinical experiences must enable students/residents to acquire knowledge and skills to function as health care providers within the hospital setting.

The program must provide the following clinical experiences:

a. Dental treatment in the Operating Room Setting:
   1. Each student/resident must participates in the treatment of pediatric patients under general anesthesia in the operating room.
   2. Each student/resident must participates in a minimum of twenty-five (20 25) operating room cases; and these are documented in the RCL
(Resident Clinical Log). In ten (10) of the operating room cases above, each student/resident provides the pre-operative workup and assessment, conducting medical risk assessment, admitting procedures, informed consent, and intra-operative management including completion of the dental procedures, post-operative care, discharge and follow up and completion of the medical records.

**Intent:** (a.1) Each student/resident participates in and directly provides dental treatment to pediatric patients under general anesthesia in the operating room. This might Some experiences may occur in an out-patient ambulatory care facility.

b. **Inpatient Care:**
   1. Each student/resident **must** participate in the evaluation and management of pediatric patients admitted to the hospital; and
   2. Each student/resident **must** demonstrate understanding of participating in admitting procedures, completing completion of consultations requests, obtaining and evaluating patient/family history, orofacial examination and diagnosis, ordering radiological and laboratory tests, writing patient management orders, pediatric patient monitoring, discharging and chart completion.

c. **Anesthesiology Rotation:**
   1. Students/residents **must** complete a rotation under the supervision of an anesthesiologist in a facility approved to provide general anesthesia;
   2. This rotation **must** be at least four (4) weeks in length, which does not have to be consecutive, and is the principal activity of the student/resident during this scheduled time;
   3. The anesthesiology rotation in pediatric dentistry **must** provide be structured to provide the advanced dental education the student/resident with knowledge and adequate experience in the management of infants, children and adolescents and adolescents undergoing general anesthesia; and
   4. The rotation **must** provide and document experiences in: (1) pre-operative evaluation, (2) risk assessment, (3) assessing the effects of pharmacologic agents, (4) venipuncture techniques, (5) airway assessment and management, (6) general anesthetic induction and intubation, (7) administration of anesthetic agents, (8) patient monitoring, (9) prevention and management of anesthetic emergencies and adverse events, (10) recovery room post anesthesia recovery management, and (11) postoperative appraisal and follow up.

d. Hospital experiences intended to expose students/residents to hospital function which may include attendance at conferences, seminars, clinic participation, and, if applicable, clinical inpatient rounds.
d. **Additional Hospital Experiences:**

1. Each student/resident **must** participate in afterhours call through the hospital emergency department and provide treatment in collaboration with other disciplines.

2. Each student/resident **must** participate on interdisciplinary/multidisciplinary teams, including participation on a Craniofacial Team.

3. Each student/resident **must** participate in providing interprofessional education to other health care professionals within the hospital setting.

**PULP THERAPY**

4-22 Didactic Instruction: Didactic instruction **must** be at the in-depth level and include:

a. Pulp histology and pathology of primary and young permanent teeth, including indications and rationale for various types of indirect and direct pulp therapy; and

b. Management of pulpal and periradicular tissues in the primary and developing permanent dentition.

4-23 Clinical Experiences: Clinical experiences **must** enable students/residents to achieve competency in:

a. Diagnosis of pulpal disease in primary and permanent teeth;

b. Treatment of pulpal disease in primary teeth;

c. Treatment of pulpal disease in immature permanent teeth; and

d. Management of pulpal disease in mature permanent teeth including emergency care, stabilization and referral to specialists.

**PEDIATRIC MEDICINE**

4-24-26 Didactic Instruction: Didactic instruction **must** be at the understanding level and include:

a. Fundamentals of pediatric medicine, including those related to healthy pediatric patients and those with special health care needs such as:

1. Well child care and anticipatory guidance

2. Developmental milestones; and

3. Acute and chronic disease/disorders.

a-b. Normal speech and language development and the recognition of speech and language delays/disorders, the anatomy and physiology of articulation and normal articulation development; causes of defective articulation with emphasis on oral anomalies, craniofacial anomalies, dental or occlusal abnormalities, velopharyngeal
insufficiency (VPI), history of cleft lip/palate and normal velopharyngeal function and the effect of VPI on resonance; and

b. Fundamentals of pediatric medicine including those related to pediatric patients with special health care needs such as:
   1. Developmental disabilities;
   2. Genetic/metabolic disorders;
   3. Infectious disease;
   4. Sensory impairments; and
   5. Chronic disease.

   c. The anatomy and physiology of articulation and normal articulation development; causes of defective articulation with emphasis on oral anomalies, craniofacial anomalies, dental or occlusal abnormalities, velopharyngeal insufficiency (VPI), history of cleft lip/palate and normal velopharyngeal function and the effect of VPI on resonance.

   4-25 4-27 Clinical Experiences: Clinical experiences must expose students/residents to pediatric medicine:

   a. Advanced education students/residents in pediatric dentistry Students/Residents must participate in a pediatric medicine rotation of at least two (2) weeks duration which is the student’s/resident’s principal activity during this scheduled period.
      1. This rotation may occur in a variety of settings i.e., Emergency Department, subspecialty clinics, multi-disciplinary team clinics and general pediatrics; and

   b. 2. The rotation must include exposure to obtaining and evaluating complete medical histories, parental interviews, system-oriented physical examinations, clinical assessments of healthy and ill patients, selection of laboratory tests and evaluation of data, evaluation of physical, motor and sensory development, genetic implications of childhood diseases, the use of drug therapy in the management of diseases, and parental management through discussions and explanation.

   **Intent:** This rotation may occur in a variety of settings i.e., Emergency Department, subspecialty clinics, multi-disciplinary team clinics, and general pediatrics. When appropriate, and to a limited extent, pediatric medicine clinical experiences may be supplemented by clinical simulation.

   Examples of Evidence to demonstrate compliance may include:
   - Observe management of acute asthma attack;
   - Identify child abuse/neglect and referral to social services;
   - Observe management of seizure;
   - Observe management of acute abdominal pain;
• Observe management of shock;
• Listen to heart and lung sounds;
• Observe rapid sequence intubation for pediatric emergency airway management;
• Recognize possible causes and treatment for unconsciousness;
• Understand triage procedures for medical emergencies;
• Observe a cranial-nerve exam; and
• Discuss the selection of laboratory tests.

ADVOCACY AND EDUCATION

4-264-28 Didactic Instruction: Didactic instruction must be at the understanding level and include:

a. The fundamental domains of child advocacy including knowledge about the disparities in the delivery of dental care, issues pertaining to access to dental care and possible solutions;

b. The social determinants of health and the impact on general and oral health;

c. Federally and state funded programs like Medicaid and SCHIP that provide dental care to poor populations; Services available through healthcare and oral healthcare programs for at-risk populations, such as U.S. governmental programs (e.g., Medicaid and SCHIP); and

d. Principles of education, learning and teaching to diverse audiences.

Intent: Pediatric dentists serve as the primary advocates for the oral health of children in America. The intent of the competency standards is to ensure that the resident is adequately trained to assume this role. Such training includes enhancing knowledge about the oral health disparities and available services that exist and within the state and federal programs directed at meeting those needs. It also includes knowledge about their role as advisors to policy makers and organized dentistry.

4-27 4-29 Clinical Experiences: Clinical experiences must provide exposure of the advance education student/resident to:

a. Communicating, teaching, and collaborating with groups and individuals on children’s oral health issues;

b. Advocating and advising public health policy legislation and regulations to protect and promote the oral health of children; and/or

c. Participating at the local, state and/or national level in organized dentistry and child advocacy groups/organizations to represent the oral health needs of children, particularly the underserved.
Advanced education students/residents must engage in teaching activities which may include peers, predoctoral students, community based programs and activities, and other health professionals, including interprofessional education programs.
STANDARD 5 - ADVANCED 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.

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.

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.
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 student/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.

5-1 Programs must define the scope of supervision and responsibility for students/residents in the various components of their program for various stages of their education.

**Intent:** As students/residents advance in the program, they may and should assume differing levels of responsibility defined by their educational progress and skill acquisition. Programs, by their individual institutional rules and policies may grant independence to students/residents for specific procedures and situations. Programs should be able to demonstrate changes in roles of advanced students/residents.
STANDARD 6 - RESEARCH

Advanced dental education students/residents must engage in scholarly activity.

6-1 Advanced dental education students/residents Students/Residents must:

   a. Participate in and complete a research project;
   b. Uses data collection and analysis;
   c. Uses elements of scientific method; and
   d. Reports results in a scientific forum.

Intent: Students/Residents gain an understanding of the scientific method such that they will be able to critically analyze the scientific literature and, independently, conduct a fundamental research project. An understanding of the scientific method requires knowledge and experiences in literature review, experimental design, statistical analysis, and accurate reporting of findings. Due to the complexity of some projects and need for prolonged follow-up periods, a team approach may be utilized with each student/resident defining his or her own research hypothesis, methods, data analysis, reporting of results and discussion in accordance with Standard 6-1 a through d.

Examples of evidence to demonstrate compliance may include:

- Systematic review
- Quality improvement research
- Survey research
- Basic and translational research
- Educational methodology and assessment research
- Clinical research
Commission on Dental Accreditation  
Hearing on Accreditation Standards  

2020 CODA Hearing on Standards  
(AAPD Meeting Replacement)  

Wednesday, May 20, 11:30am - 12:30pm Central Daylight Time  
Virtual Hearing  

**Commissioners in Attendance:** Dr. Arthur Chen-Shu Jee (chair), Dr. Joel Berg, Dr. Scott DeVito, Dr. Jeffery Hicks (vice chair), and Dr. Susan Kass.

**Staff:** Dr. Sherin Took, director, CODA, Mr. Gregg Marquardt, Ms. Michelle Smith, Ms. Jennifer Snow, and Ms. Peggy Soeldner, managers, CODA.

Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry  
(Appendix 3)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Casamassimo</td>
<td>Chief Policy Officer, American Academy of Pediatric Dentistry (AAPD)</td>
<td>AAPD should have sent to CODA a multi-page listing of comments. Significant recommendations – 1) number of cases which are an increase from prior standards are unnecessary, 2) predominant use of word “appropriate” is not beneficial due to ambiguity. A Committee of the AAPD including two prior pediatric Commissioners and others were solicited in preparation of comments.</td>
</tr>
<tr>
<td>Vineet Dhar</td>
<td>University of Maryland</td>
<td>4-7 cases increased significantly and rationale not clear. Also, post COVID-19 it is unclear on usage of nitrous oxide. Please withdraw this change 4-25 cases increased, suggest withdrawal of change. Growing evidence warrants</td>
</tr>
<tr>
<td>Name</td>
<td>Institution</td>
<td>Comment</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Paul Crespi</td>
<td>Long Island Jewish Medical Center</td>
<td>judicious use of operating rooms. Changes in OR protocols also an issue. Finally, no evidence that increase is supported.</td>
</tr>
<tr>
<td>Darryn Weinstein</td>
<td>University of North Carolina at Chapel Hill</td>
<td>Need to move away from quantitative standards more to qualitative standards related to clinical competency.</td>
</tr>
<tr>
<td>David Avenetti</td>
<td>University of Illinois at Chicago</td>
<td>Echo prior comment of competency based model rather than quantitative systems. Competence is not associated with a specific number of experiences.</td>
</tr>
<tr>
<td>Carolyn Kerins</td>
<td>Texas A&amp;M</td>
<td>p. 18, 2-8. More and more general practices are moving toward a dashboard. More clarity on whether information must be printed in a binder is needed. With regard to resident log, is a printed report required. Definition of full-time trainee for 24 months. With HRSA and some students being part-time, there should be language of equivalent of 24 month FT to allow part time for longer period</td>
</tr>
<tr>
<td>Zach Houser</td>
<td>University of Nebraska</td>
<td>Echo prior sentiments regarding prior procedure changes. However, there may be some hard numbers to present to state boards for licensure. Standard 4-14, this does not address public health topics adequately. Health promotion must be</td>
</tr>
</tbody>
</table>
## Commission on Dental Accreditation  
### Hearing on Accreditation Standards

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rena Kravitz</td>
<td>Maimonides, Brooklyn, NY</td>
<td>2-24 – clarification of treatment area and problems with COVID. 2-28 – maintenance of patient record of diversity, what about HIPAA</td>
</tr>
<tr>
<td>David Avenetti</td>
<td>University of Illinois at Chicago</td>
<td>4-27 – Ped Medicine – prefer to rotate to individual clinics aligned with that learning in program. Recommend language of anesthesia requirement that it not be consecutive but add up to the amount of time over the program.</td>
</tr>
<tr>
<td>Lori Barbeau</td>
<td>Children’s Milwaukee, WI</td>
<td>p. 19, line 37 definition of treatment area needs further clarification p. 36, 4-20 management of contemporary dental practice. Pattern in document is in-depth stated first and then understanding. In that area the statements are reversed with understanding listed before in-depth.</td>
</tr>
<tr>
<td>Zach Houser</td>
<td>University of Nebraska</td>
<td>Agree with some of the concerns with nitrous oxide. Also, the term “nitrous oxide analgesia.” Can this be changed to updated term such as nitrous oxide sedation?</td>
</tr>
<tr>
<td>Farhad Yeroshalmi</td>
<td>Jacobi Medical Center</td>
<td>2-28e, complexity of patient care; difficult to document because of software</td>
</tr>
</tbody>
</table>
## Commission on Dental Accreditation
### Hearing on Accreditation Standards

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lori Barbeau</td>
<td>Children’s Milwaukee</td>
<td>p. 39, line 11 – each must participate in admitting procedures. Can this be changed to “co-admitting” since many programs must co-admit with medical service</td>
</tr>
<tr>
<td>Paul Casamassimo</td>
<td>Chief Policy Officer, American Academy of Pediatric Dentistry</td>
<td>AAPD Board document 3-3.3, p. 22 line 25 uses term “adequate” and this term is not clear enough. Standard 4-20, word “proper” is used and not sure what this means. Standard 3-7, p. 23, line 40 “sufficient” lacks clarity. Standard 4-21, line 16 word “enough” is vague. Standard 4-25, “adequate” is not a useful term. Standard 4-25, “experiences be after hours” there is no reasonable evidence that this make a difference, it’s the experience not time of day that is important. Delete “after hours”.</td>
</tr>
<tr>
<td>Carolyn Kerins</td>
<td>Texas A&amp;M</td>
<td>4-20 Management of contemporary dental practice. For some states teledentistry is not allowed or recognized by state board. How would this be documented and what is to be documented, what would be acceptable?</td>
</tr>
</tbody>
</table>
### Commission on Dental Accreditation
#### Hearing on Accreditation Standards

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim Hammersmith</td>
<td>Ohio State University</td>
<td>Standard 4-25, #2 – operating room cases. Suggest adding the language “In the equivalent of the 10 cases above…”</td>
</tr>
<tr>
<td>Marie-Jose Cervantes Mendez</td>
<td>UT Health San Antonio</td>
<td>Echo comments on number of requirements and those of AAPD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard 3-1 do not agree with deletion of ACLS. Some adjunct may only have this training so it should be included as an additional certification for sedation oversight</td>
</tr>
<tr>
<td>Zach Houser</td>
<td>University of Nebraska</td>
<td>Safety is used four times. In one instance it relates to patients, faculty and staff. We could do more to use term “safety” in sedation. Is this patient or staff safety? Needs clarification. General comment to look at patient and staff safety.</td>
</tr>
<tr>
<td>Cynthia Wong</td>
<td>University of Rochester</td>
<td>Concur with prior comments and do not support increase in number of cases being increased. Urge CODA to extend flexibility for COVID-19</td>
</tr>
<tr>
<td>David Avenetti</td>
<td>University of Illinois of Chicago</td>
<td>Lacked clarity of direct or indirect supervision during telehealth and faculty sign-offs. What would be needed?</td>
</tr>
<tr>
<td>Zach Houser</td>
<td>University of Nebraska</td>
<td>Number of times “public health” is mentioned is focused on settings, yet not much mention on didactic training on public health. Addressing that need as</td>
</tr>
<tr>
<td>Commission on Dental Accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing on Accreditation Standards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

relates to pediatric dentistry is important.
Peggy,

I hope you are doing well. I had one comment and one question regarding the revised Pediatric Dentistry Standards.

Comment: I think there may be a typo on page 34, lines 17-19, item 4-15 e. I believe this is actually two separate items. I think “Patient/Parent/Caregiver education…” is the start of new lettered item.

Question: The wording for Standard 3-1 has been changed and if I read it correctly, PALS is now an example of the training the residents must have but not an actual requirement, as previously written. If my interpretation of this is correct does this mean CODA will now allow something like PEARs (Pediatric Emergency Assessment, Recognition, and Stabilization) in place of PALS?

Thanks very much,

Mike
January 27, 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 January 2020 meeting, Council members considered and supported the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry.

The Council believes that the revisions provide additional clarification and better reflect the changing landscape in pediatric dentistry education and practice.

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

Sincerely,

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

LCN:ap

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
Dear Peggy,

Please see my comments regarding the proposed changes to Pediatric Dentistry standards as written below. Please let me know if you need any more information or if a different format is needed.

Page 16- Line 18--- It is my hope that this “intent” will now mean that we can now use general dentists to teach about adolescent/adult special needs care if this is an area of their expertise.

Page 18- line 22—I think that the amount of specific record keeping, especially in relation to patient diversity/complexity, multidisciplinary care, etc is prohibitive, especially for each resident to maintain and then for the residents to maintain and then for the residency to maintain for a total of 7 years. **I feel that if CODA is requiring such specific logs, there should be a centralized hub where they have residents input their data and then the onus is not on each resident/residency to determine how to store/organize this information, but it can be standardized to CODA’s specifications.**

Page 18-Line 40—Similarly to above point, if the RCL is a printout of billing codes it will not give the detailed information for a well-patient vs medically complex; thus again pointing to the need for a standardized way to store and report this information.

Page 19- Line 37—“In the treatment area”- should be changed to “in the clinic”—as the treatment area to me means in the actual treatment room, which is impossible if overseeing multiple residents at the same time.

Page 24- Line 1—Again, I feel the requirement to include in the RCL that patients have complex impairment and need modifications to dental treatment is too cumbersome to keep track of, especially when working in a hospital setting where close to 50% of our patients meet this criteria.

Page 29 line 16- I do not feel that 50 nitrous cases will be difficult to obtain for our residency. I do wonder whether any thought has been given to asking residents to perform procedures WITHOUT use of nitrous oxide so they can focus on honing their behavior management skills.

Page 39 line 11- For residents to participate in admitting procedures, this should be specified to include what parts—currently our residents participate in contacting Peds Med to admit, but they are not doing the admitting H&P or placing dietary orders etc. I think the wording of “demonstrate understanding of” is more appropriate for a pediatric dentist, as many (most) dentists won’t have privileges to admit their own patients in hospitals; they will be the consulting service instead.
Thank you,
Natalie Stinton, DMD
Program Director Pediatric Dentistry
Geisinger

IMPORTANT WARNING: The information in this message (and the documents attached to it, if any) is confidential and may be legally privileged. It is intended solely for the addressee. Access to this message by anyone else is unauthorized. If you are not the intended recipient, any disclosure, copying, distribution or any action taken, or omitted to be taken, in reliance on it is prohibited and may be unlawful. If you have received this message in error, please delete all electronic copies of this message (and the documents attached to it, if any), destroy any hard copies you may have created and notify me immediately by replying to this email. Thank you. Geisinger Health System utilizes an encryption process to safeguard Protected Health Information and other confidential data contained in external e-mail messages. If email is encrypted, the recipient will receive an e-mail instructing them to sign on to the Geisinger Health System Secure E-mail Message Center to retrieve the encrypted e-mail.
Hi Peggy, Hope your doing well in this Covid crises. Can you please submit my suggestion below for the web hearing on the 20th.

The new proposed language in standard 4-12h in the Advanced Education Peds Dent accreditation document recommends trainees get experience ordering and assessing/recognizing abnormal head and neck images on CBCT and MRI.

1) This simply is not feasible clinically as pediatric patients rarely need an MRI for facial issues that are applicable to dentistry with the exception of a mandibular disk and even that is usually only applicable to teenagers or oral cancer, again rare in peds. Therefore, peds dent trainee exposure to MRI is limited and radiologists will certainly question the MRI order without substantial and appropriate justification

2) CBCT is too specific and should be replaced with simply CT of which CBCT is a form. A CT is routine in the ED or hospital for orofacial issues or surgical concerns

3) Therefore the statement would be best stated: Ordering advanced CT head and neck imaging and recognizing deviations from normal.

Thx J

John H Unkel DDS, MD, MPA, FAAP

Medical and Residency Director

Pediatric Dentistry

St Marys Hospital of Richmond/Bon Secours Pediatric Dental Associates

Office: 804-893-8715 Fax 804-285-1292

The information contained in this email message is legally privileged, confidential and may contain medical information intended for an established health care provider of the named patient or those involved in official institutional quality or peer review. The entire contents of this email communication (including any subsequent email communication attaching, responding to or discussing the subject email communication) is privileged pursuant to Virginia statutes, the federal Health Care Quality Improvement Act of 1986, and other applicable law. It is intended ONLY for this use. If you receive this email in error, please notify us immediately either by response e-mail or by phone, and permanently delete the original e-mail, attachment(s), and any copies.
Dear Ms. Soeldner,

I did have a couple concerns regarding the changes proposed for pediatric dentistry.
For 2-3.4 it states the faculty should be in the “treatment area” which can be misleading. I believe a better wording is “on site.” Having faculty with the resident “in the treatment area,” which can be interpreted as in the room or right next to them, for all treatment including recalls and minor treatment is not necessary.

For section 3-1, we believe removing staff needing training is not wise as they are in with the sedations and should have some type of formal training in sedations.

Thank you for your consideration,

Elizabeth Berry DDS, MPH, MSD
Pediatric Dentist
Bon Secours Virginia Health Systems | Pediatric Dental Associates | St. Mary’s Hospital of Richmond
6900 Forest Avenue, Suite 110 | Richmond, VA | 23230

The information in this communication is intended to be confidential to the Individual(s) and/or Entity to whom it is addressed. It may contain information of a Privileged and/or Confidential nature, which is subject to Federal and/or State privacy regulations.

In the event that you are not the intended recipient or the agent of the intended recipient, do not copy or use the information contained within this communication, or allow it to be read, copied or utilized in any manner, by any other person(s). Should this communication be received in error, please notify the sender immediately either by response e-mail or by phone, and permanently delete the original e-mail, attachment(s), and any copies.
Dear Ms. Soeldner,

I made some additions to my comment. Could you please use this revised version?
Many thanks!

Vineet

COMMENTS

The Pediatric Dentistry Programs pride in the fact that our specialty is driven by quality of education and that we provide evidence-based and patient-centered care. I am concerned that some of the proposed requirements in Standards 2-2.8, 4-7, and 4-25 may compromise these values of our specialty and push the programs to become quantity based, or number driven rather than quality based. More importantly the future pediatric dentists will train to be number driven rather than evidence-based in their treatment approaches.

- Under Standard 2-2.8d, the purpose of adding separate documentation of all clinical procedures is unclear. If the intent is to compare and quantify how many of a certain procedure are considered as acceptable, I am worried that this addition may eventually compromise quality of care. Also, by doing this we are perhaps unintentionally advocating that someone who has done 25 procedures is more competent than those who have done 20 procedures, which we have no evidence to believe is true. If the intent is not to quantify competency, I request CODA to please remove this addition considering the programs already provide a detailed resident-wise clinical log at the time of site visit.

- Under Standard 4-7, the requirement of nitrous cases has been increased from 20 to 50. This is a considerable increase and the rationale behind the increase is unclear. Again, I humbly request CODA to continue to keep the emphasis on quality of training. Also, post-COVID-19 the science is currently unclear on safety around usage on nitrous oxide. It is hard to predict when things will normalize or what the new normal for patient care will be one-year from now, but the near-term usage of nitrous oxide is likely to go down to stay compliant with safe environment protocols. I, therefore, request CODA to indefinitely withdraw this change.
Under Standard 4-25 (Clinical experiences under Hospital Dentistry) the required number of OR cases have been increased from 20 to 25. I, once again, request CODA to indefinitely withdraw this change for the following reasons:

- This added requirement conflicts with the increased emphasis on evidence-based medical management of caries recommended in Standard 4-17, which is a value-based addition.
- The growing evidence on association of early exposure to general anesthesia in children with increased risk of learning disabilities warrants judicious use of this modality for elective care.
- The proposed increase adds limited value but a significant burden on the programs, especially post-COVID-19 pandemic, considering the: 1. uncertainties regarding short-term and long-term changes expected in post-pandemic operating room protocols; 2. lack of clarity on the potential start date for pediatric dental OR cases amidst the current backlog for all elective cases; and 3. current guidance on the high risk associated with aerosol generating procedures due to COVID-19.
- Lastly, there is limited evidence to support that 25 cases per resident will constitute a significantly better measure of clinical competence compared to existing 20 cases per resident.

Since the proposed changes were drafted before the COVID-19 pandemic, it is requested that CODA factors the impact of the pandemic on the residency programs in recommending an increase especially in hospital-based procedures; and therefore, re-evaluate implementation of the proposed changes at this time.

Vineet Dhar BDS, MDS, PhD
Clinical Professor & Chair
Diplomate, American Board of Pediatric Dentistry
Director, Advanced Specialty Education Program, Pediatric Dentistry
Department of Orthodontics and Pediatric Dentistry
From: Soeldner, Peggy <soeldnerp@ada.org>
Sent: Thursday, May 7, 2020 11:08 AM
To: Dhar, Vineet K. <VDhar@umaryland.edu>
Subject: RE: Comments on the Proposed Revisions to Pediatric Dentistry Standards

CAUTION: This message originated from a non-UMB email system. Hover over any links before clicking and use caution opening attachments.

Thank you.

Peggy

Peggy Soeldner, M.S. Ed.  soeldnerp@ada.org
Manager, Advanced Dental Education
Commission on Dental Accreditation (CODA)
Office: 312-440-2788
Fax: 312-587-5104

Commission on Dental Accreditation  211 E. Chicago Ave. Chicago, IL 60611
www.ada.org/coda

This email is intended only for the individual or entity to whom it is addressed and may be a confidential communication privileged by law. Any unauthorized use, dissemination, distribution, disclosure, or copying is strictly prohibited. If you have received this communication in error, please notify us immediately and kindly delete this message from your system. Thank you in advance for your cooperation.

From: Dhar, Vineet K. [mailto:VDhar@umaryland.edu]
Sent: Thursday, May 7, 2020 10:04 AM
To: Soeldner, Peggy <soeldnerp@ada.org>
Subject: Comments on the Proposed Revisions to Pediatric Dentistry Standards
Importance: High

Dear Ms. Soeldner,

Hope this email finds you and your family well in these very challenging times. I am writing to submit my comments on the Proposed Revisions to Pediatric Dentistry Standards. I have also shared my comments at the AAPD program director’s forum so apologize in advance if you see them twice.

Best wishes,

Vineet
COMMENTS:

1. My specific comment is regarding the change in Standard 4-25 (Clinical experiences under Hospital Dentistry) increasing the required number of OR cases from 20 to 25. This added requirement conflicts with the increased emphasis on evidence-based medical management of caries recommended in Standard 4-17. In addition, the evidence on association of early exposure to general anesthesia in children with increased risk of learning disabilities warrants judicious use of this modality for elective care. Therefore, the proposed increase adds limited value but a significant burden on the programs, especially post-COVID-19 pandemic, considering the
   1. uncertainties regarding short-term and long-term changes expected in post-pandemic operating room protocols;
   2. lack of clarity on the potential start date for pediatric dental OR cases amidst the current backlog for all elective cases; and
   3. current guidance on the high risk associated with aerosol generating procedures due to COVID-19.

In addition, there is limited evidence to support that 25 cases per resident will constitute a significantly better measure of clinical competence compared to existing 20 cases per resident.

2. Since the proposed changes were drafted before the COVID-19 pandemic, it is requested that CODA factors the impact of the pandemic on the residency programs in recommending an increase in hospital-based procedures; and therefore, re-evaluate the implementation of these proposed changes.

_Vineet_

Vineet Dhar BDS, MDS, PhD
Clinical Professor & Chair
Diplomate, American Board of Pediatric Dentistry
Director, Advanced Specialty Education Program, Pediatric Dentistry
Department of Orthodontics and Pediatric Dentistry
University of Maryland School of Dentistry
650 W. Baltimore St, Room 2221
Baltimore, MD 21201
410 706 7970/ 410 706 4031 FAX
Email: vdhar@umaryland.edu
Comments on Proposed Revisions of Advanced Training Standards

The proposed changes in the accreditation standards for advanced programs in pediatric dentistry have been reviewed by an ad hoc committee comprising past and current program directors, two past CODA commissioners for pediatric dentistry, and others with experience in board certification and AAPD council leadership relative to advanced education. This committee sought input from various stakeholders and provided commentary to AAPD which was considered during the committee’s work. The following report details areas of concern (standards), rationale for recommendations, and when indicated, suggested wording to rectify concerns.

https://www.ada.org/~/media/CODA/Files/2020%20ADEA%20Meeting%20Material/appendix3_PediatricDentistry.pdf?la=en

<table>
<thead>
<tr>
<th>Standard*</th>
<th>Change, If Any to Standard Proposed in Revision or In Existing Standard</th>
<th>AAPD Comment on Change or Substitution for Proposed Revision</th>
<th>Rationale for AAPD Comment on Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>No changes are recommended for this purpose.</td>
<td>All content areas appear to be above the predoctoral level.</td>
<td>Ad hoc committee reviewed Standard 4 for indications for advanced training. This has import for the periodic review of specialties.</td>
</tr>
<tr>
<td>Advanced</td>
<td>The ad hoc committee has recommended that “appropriate” be replaced with defined and measurable terms that can be used for clarity in both training and program evaluation.</td>
<td>Every use of “appropriate” should be converted to terminology that addresses that particular area more concretely. For example, on sub-page 33, item 13 related to radiology, replacing “appropriate” with “institutionally approved radiation hygiene procedures” or some term or phrase that reflects</td>
<td>The Ad hoc committee discussed the lack of utility in use of “appropriate” in a document to train specialists. In no case was it clear what the meaning of “appropriate” was, nor its opposite. In all cases, clearer wording could be applied to that standard to provide consistency in education and evaluation.</td>
</tr>
</tbody>
</table>

*standard or proposed definition


<table>
<thead>
<tr>
<th>P13, In 1</th>
<th>Existing language:</th>
<th>The word has no specific meaning and its presence offers no clarity or precision to the definition</th>
<th>It is assumed that management of conditions would use care that is based on sound practices and evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(in Other terms)</td>
<td>“appropriate” in definition of management.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P13, In 4,</td>
<td>REFERENCE MANUAL</td>
<td>Include this change</td>
<td>The Reference Manual of the American Academy of Pediatric Dentistry contains evidence-based policies and best practices and is used as the standard for oral health care of children. Entries in the Reference Manual are reviewed every three years and revised as needed based on new EBD.</td>
</tr>
<tr>
<td>(in Other terms)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Standard 1</strong></td>
<td>Proposed change uses “pursuit” rather than ABPD completion as an element of program outcomes.</td>
<td>Leave outcome measure as “successful completion”; alternatively include “attempts” as well as attainment. Those metrics would give programs a reasonable sense of their progress, improvement, and direction.</td>
<td>With our high (~83-4%) achievement, the absolute need for board certification for hospital privileging, and the effort of the ABPD to make certification achievable, the substitution of “pursuit” is a step backward. Conceivably, a program could get a “positive” on this outcome and never have a graduate certified. Programs that do not have a positive track record of ABPD certification have serious problems, but as proposed, this would identify those.</td>
</tr>
<tr>
<td>Standard 2</td>
<td>Proposed change allows compiling by residents.</td>
<td>The oversight of the log (RCL) could be better defined. It would be useful for the standard to posit control and security of RCL in the program leadership. Issues of HIPAA and academic integrity strongly advise program control. In “Intent” paragraph revision, replace “log” with another term... in general it is not good practice to use a word in the term in the definition.</td>
<td>This is a good opportunity for attention to be paid to who controls the RCL and how its integrity, and HIPAA compliance are preserved. Maybe the GME medical surgical training guidelines could help in this regard. Ultimately, the RCL contents will direct future changes in advanced standards and their accuracy and integrity matter in that regard as well as accuracy in resident performance assessment.</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2-2 P18, In 40-42</td>
<td>“Clinical procedures” and “patient diversity/complexity” (2-2.8.d and 2-2.8.e)</td>
<td>Items d and e are too vague and not prescriptive enough to provide programs guidance. Use of “e.g.” and “etc.” in the same statement is not helpful and the use of “diversity” is not clear in terms of its meaning relative to sociodemographics or diseases. The Ad hoc committee recommends clarification of what clinical procedures should be included and more precision in</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>As programs are evaluated on the breadth and extent of their clinical offerings, it helps to have some precision in the minimal procedures required. It might be enough to refer to Standard 4 here to identify the range and breadth of procedures in the RCL, rather than use a non-inclusive list as examples. Diversity is used to describe sociodemographics and it is not clear of its intent here and should be clarified to permit programs to develop opportunities to meet the standard.</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>2-3 P 19, Ins 14, 18, 23</td>
<td>2-3 P 19, Ins 39</td>
<td>2-5 P 20, Ins 34</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Addition of the word “appropriate” is unclear.</strong></td>
<td>The current intent statement revision keeps “within one minute...”</td>
<td>“appropriate”</td>
<td>One minute means little. It assumes that programs and site visitors will time faculty availability. Institutions, federal and state regulations, and sedation and other guidelines give measurable guidance as to faculty availability and involvement in clinical care so a timed metric is unnecessary.</td>
</tr>
<tr>
<td><strong>The current intent statement revision keeps “within one minute...”</strong></td>
<td>Replace “one minute” with something in the intent statement like, “…available for immediate, timely and safe supervision consistent with institutional rules and policies...” or simply strike “within one minute” and leave “immediately available” as written.</td>
<td>Remove appropriate</td>
<td>Once again, this word choice offers no direction or guidance for programs and challenges site visitors to identify what would make a faculty member “inappropriate.”</td>
</tr>
<tr>
<td><strong>“appropriate”</strong></td>
<td><strong>“appropriate”</strong></td>
<td><strong>“appropriate”</strong></td>
<td><strong>“appropriate”</strong></td>
</tr>
<tr>
<td><strong>Remove “appropriate”</strong></td>
<td><strong>Remove “appropriate”</strong></td>
<td><strong>Remove “appropriate”</strong></td>
<td>The ad hoc committee’s consensus was that all staff would be provided policies of some sort, so again, the word choice offers little guidance to programs or site visitors.</td>
</tr>
<tr>
<td><strong>Deletion of ACLS.</strong></td>
<td><strong>ACLS should stay. Insert after PALS</strong></td>
<td><strong>ACLS should stay. Insert after PALS</strong></td>
<td>The Ad hoc committee could come up with several scenarios when ACLS-trained faculty...</td>
</tr>
<tr>
<td>3-3.3</td>
<td>“Adequate diagnostic imaging...”</td>
<td>Remove “adequate”. Possibly replace with, “Diagnostic imaging that supports the clinical care of patients.”</td>
<td>The Ad hoc committee identified “adequate” as another term which has no grounding and thus provides programs and site visitors with little guidance.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>P 22, In 25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-3.7</td>
<td>“appropriately”</td>
<td>“Appropriately” should be deleted and possibly replaced with a phrase denoting certification or credentialing by an ambulatory surgical entity.</td>
<td>The Ad hoc committee expressed concern that the risk of untoward events in pediatric sedation and office-based suites requires a more precise directive in the standards.</td>
</tr>
<tr>
<td>P22, In 43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-6</td>
<td>“Appropriate”</td>
<td>Remove “Appropriate” as it is unnecessary</td>
<td>The Ad hoc committee was unclear as to what appropriate information (versus inappropriate information) would be and the intent statement below suggests that access rather than some vague quality measure is the meaning of the standard.</td>
</tr>
<tr>
<td>P 23, In 32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-7</td>
<td>“An adequate and diverse” pool of patients?</td>
<td>Remove “sufficient and diverse” as unnecessary as the remainder of the statement describes the patient pool.</td>
<td>Depending on the type of program - Hospital based vs University- based – it will have a significant variance in patient population - If the intent is to standardize the experiences, counting patients would not necessarily achieve that goal. Programs already report those numbers in their annual report.</td>
</tr>
<tr>
<td>P 23, In 39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>Column 1</td>
<td>Column 2</td>
<td>Column 3</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>3-7</td>
<td>P 23, ln 40</td>
<td>“sufficient”</td>
<td>Remove “sufficient” from the statement</td>
</tr>
<tr>
<td>3-7</td>
<td>P 23, ln 44</td>
<td>“make it necessary to consider...”</td>
<td>Delete “make it necessary” as the phrase is vague and the meaning is clearer without it.</td>
</tr>
<tr>
<td>4-1</td>
<td>P 26, ln 11</td>
<td>“should encourage”</td>
<td>Change “should” to “must”.</td>
</tr>
<tr>
<td>4-1</td>
<td>P 26, ln 6</td>
<td>Consider a sentence about diagnostics and critical appraisal of problem solving related to individual and community health care needs. For example: The program trains pediatric dentists capable of problem solving and analyzing the quality of their decisions and the impact on the person and community.</td>
<td>The Ad hoc committee noted the lack of community health in the proposed standards and recommends modification of the goal statement to reflect the longstanding advocacy and population health emphasis of pediatric dentistry.</td>
</tr>
<tr>
<td>4-1</td>
<td>P 26, ln 10-13</td>
<td>Intent introduces thinking not referred to in the standard.</td>
<td>Add sentence listed immediately above.</td>
</tr>
<tr>
<td>4-2</td>
<td>P 26, ln 26</td>
<td>“…health care initiatives.”</td>
<td>Delete “in oral healthcare initiatives”</td>
</tr>
<tr>
<td>Page</td>
<td>Line</td>
<td>Text</td>
<td>Action</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>4-2</td>
<td>P 26, ln 24</td>
<td>New standard on IPE</td>
<td>Add clarification on experiences and evaluation.</td>
</tr>
<tr>
<td>4-5</td>
<td>P 27, ln 25</td>
<td>“...Health Informatics”</td>
<td>Add a definition for health informatics as well as example(s)</td>
</tr>
<tr>
<td>4-5</td>
<td>P 27, ln 43</td>
<td>“...applying the principles of precision medicine.”</td>
<td>Delete phrase</td>
</tr>
<tr>
<td>4-5</td>
<td>P 28, ln 9:</td>
<td>“general understanding”</td>
<td>Drop “general” from the statement.</td>
</tr>
<tr>
<td>4-6</td>
<td>P 28, ln 28-29</td>
<td>Reference to motivational interviewing</td>
<td>Delete “application of”</td>
</tr>
<tr>
<td>Page</td>
<td>Section</td>
<td>Original Text</td>
<td>Revised Text</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>4-6</td>
<td>P 28, ln 42</td>
<td>“appropriate”</td>
<td>Delete “appropriate” from the intent statement.</td>
</tr>
<tr>
<td>4-7</td>
<td>P 29, ln 14-15</td>
<td>Increasing the number of N2O cases to 50?</td>
<td>Unless there is an evidence based reason to change it, leave required number at 20 cases.</td>
</tr>
<tr>
<td>4-7</td>
<td>P 29, ln 14 and 17</td>
<td>Use of “complete”</td>
<td>Change language to be “sole provider”</td>
</tr>
<tr>
<td>Page</td>
<td>Line</td>
<td>Text</td>
<td>Revised Text</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>------</td>
<td>--------------</td>
</tr>
<tr>
<td>4-7</td>
<td>P29, ln 30</td>
<td>All sedation cases must be completed in accordance with ...</td>
<td>Consider adding something that references state policies and dental boards (after “institutional policies”)</td>
</tr>
<tr>
<td>4-7</td>
<td>P 30, ln 6</td>
<td>“participation in activities”</td>
<td>Add the word “ongoing” prior to activities or something that specifies frequency and regularity.</td>
</tr>
<tr>
<td>4-10</td>
<td>P 31, ln 28</td>
<td>a. Evaluation, diagnosis, and treatment of the pulpal, periodontal...</td>
<td>Add “management” in tandem with treatment to be consistent with other parts of the document.</td>
</tr>
<tr>
<td>4-11</td>
<td>P 32, ln 3</td>
<td>Interprofessional and collaborative....</td>
<td>Add intent statement with possible experience described.</td>
</tr>
<tr>
<td>4-12</td>
<td>P 32, ln 7</td>
<td>Oral radiology...</td>
<td>Use term “Oral Imaging”</td>
</tr>
<tr>
<td>4-12</td>
<td>P32, ln 10</td>
<td>Use of “most common”</td>
<td>Replace most common with something like... Of the most frequently encountered lesions...</td>
</tr>
</tbody>
</table>
| 4-12 | P32, ln 29 | “... appropriate healthcare or | Eliminate “appropriate” and “psychosocial”. | Once again, the meaning is unclear. What is an “appropriate” professional and wouldn’t a
<table>
<thead>
<tr>
<th>Page</th>
<th>Line</th>
<th>Original Text</th>
<th>Proposed Revision</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-12</td>
<td>P 32, ln 31</td>
<td>“technique” for oral diagnosis</td>
<td>Delete “selection and technique”</td>
<td>These words are unnecessary in this item.</td>
</tr>
<tr>
<td>4-12</td>
<td>P32, ln 38-40, 41</td>
<td>“..performing salivary gland function...”</td>
<td>Change wording to “performing uncomplicated oral biopsies and ordering adjunctive tests”.</td>
<td>This sentence implies that the student must perform testing that is so rare that it may be unattainable in the typical program and lead to unnecessary testing. The previous wording was acceptable as indicative of what a pediatric dentist does.</td>
</tr>
<tr>
<td>4-12</td>
<td>P 32, ln 43</td>
<td>“…Ordering…”</td>
<td>Consider adding “interpretation or how to request interpretation…” for all 3D CBCT as well as “reporting on..”</td>
<td>The sub-standard is incomplete in terms of training about these testing options and should be more comprehensive, especially at the understanding level.</td>
</tr>
<tr>
<td>4-13</td>
<td>P33, ln 9</td>
<td>“appropriate and...recommended”</td>
<td>Delete “appropriate” and insert some term to indicate the source of recommendation, like the Reference Manual or minimally “EBD-based”</td>
<td>The use of appropriate is again unclear and the opportunity is here to utilize existing professionally derived EBD-based recommendations, such as from the AAOMFR or the FDA or ADA, as well as AAPD.</td>
</tr>
<tr>
<td>4-15</td>
<td>P34 ln 20 and 24</td>
<td>f and i are essentially the same</td>
<td>Delete “f” and renumber.</td>
<td>The Ad hoc committee could find no compelling reason to keep both items and item “f” was simplistic and of little value.</td>
</tr>
<tr>
<td>4-15</td>
<td>P34, ln 21</td>
<td>&quot;Clinical experiences related to effective communication strategies to help guide behavior&quot;</td>
<td>Remove from those experiences that a graduate must demonstrate competency.</td>
<td>Although there is more research coming out related to motivational interviewing for the child and adolescent, it most certainly isn’t mainstream. There is little to no published,</td>
</tr>
<tr>
<td>P34, In 41</td>
<td>change such as teach back and motivational interviewing”</td>
<td>effective evidence-based data related to teach back. The Ad hoc committee had consensus that these techniques should be confined to didactic exposure at this time. Many smaller programs would be unable to provide instruction by trained professionals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P36, In 2</td>
<td>“…Diagnosis…”</td>
<td>Add “insult”. The standard should include non-disease pulpal related issues, such as insult.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P36, In 15</td>
<td>“…proper…”</td>
<td>Delete “proper” or choose another word for whatever is intended. What does “proper” mean? Consider discussion of business systems, workflow, and quality improvement along with business principles and processes pertinent to dental clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P36, In 17</td>
<td>“…computer…”</td>
<td>Revise to indicate a broader teaching of electronic practice means and approaches. Computers are only one aspect of digital dental practice and the opportunity is here to broaden that aspect of pediatric dental practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P36, In 19</td>
<td>“…ethical…”</td>
<td>Delete at least one use of “ethical”.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| P36, In 40  | Item (g) of intent statement | Rewrite the intent statement. Delete “entire team” Item (g) of the intent statement is esoteric. It ought to be rethought. The standard might use accepted AAMC/GME terminology if that hasn’t been used, so residents (not
| 4-20  | Add a statement on infection control and general safety considerations to be contemporary with AAPD safety initiative | The Ad hoc committee was not sure what “the entire team” meant. |
| 4-21  | Consider adding subsection that includes record keeping and evidence of these experiences and outcomes related to learning. | These items can be added to the list. |
| 4-21  | “enough” | This can easily be restated to eliminate “enough”. |
| 4-22  | “...individuals..” | Change to the most contemporary term, which is persons |
| 4-25  | “participates” | The standards should reflect person-first terminology. |
| 4-25  | “...some...” | Delete the word “some” |
| 4-25  | “...adequate...” | Just leave it out. |

Graduates are exposed to relevant experiences. The document mentions safety but only generally and it needs to be in a required and evaluable format.
<table>
<thead>
<tr>
<th>Page, Line</th>
<th>Comment</th>
<th>Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-25, P 39, In 39</td>
<td>use of “afterhours”</td>
<td>Drop the “afterhours” part of this statement as it has little value.</td>
</tr>
<tr>
<td>4-25, P 40, In 1</td>
<td>...provide interprofessional education...”</td>
<td>Delete this requirement. Just say, must participate in interprofessional education.</td>
</tr>
<tr>
<td>4-26, P c. line 4</td>
<td>“...of articulation...”</td>
<td>This sub-standard needs to address all of speech and language issues and not just articulation so should be revised to be comprehensive.</td>
</tr>
<tr>
<td>4-27, P41, In 18</td>
<td>“complete”</td>
<td>Drop “complete” or define it.</td>
</tr>
<tr>
<td>4-27, P 41, In 32-42</td>
<td>Examples of evidence for Pediatric Medicine rotation listed do not really match the clinical experiences listed on 4-27.a and b.</td>
<td>Recommendation to delete list. Is it realistic to plan a program around observation of a severe asthma attack, seizure or shock? The rotation should provide an opportunity to learn process; observing episodic care is not something to build a program around.</td>
</tr>
<tr>
<td>4-29, P42, In 24</td>
<td>“Clinical”</td>
<td>Change to: “advocacy” experiences</td>
</tr>
</tbody>
</table>

as possible. The term “adequate” provides no guidance in program design or evaluation. The Ad hoc committee was unsure about the rationale for this statement since emergency departments do not operate on a diurnal schedule. The most opportune time may be during the day in some locations. Many programs have limited relationships with hospitals and have no potential for such opportunities. This requirement would place an undue burden on programs to create these experiences outside their regular activities with no demonstrated benefit. Understanding the hearing structure is important too. Speech and language development and production is important and could be better defined here. Consider broadening to the whole speech and language mechanism. Or add a separate element beyond the sound production. The Ad hoc committee questioned why an incomplete medical history would be done. Examples of evidence for Pediatric Medicine rotation listed do not really match the clinical experiences listed on 4-27.a and b. Recommendation to delete list. These are not truly clinical experiences so different terminology applies.
May 31, 2020

ATTN: Ms. Peggy Soeldner, 19th Floor
Manager, Advanced Dental Education
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Commission on Dental Accreditation:

Thank you for the opportunity to provide feedback regarding the proposed Pediatric Dentistry standards. The following recommendations are organized by standard, with general feedback following comment

Standard 1

- In discussion with other program directors, it is unclear whether not meeting program goals and objectives could warrant a “recommendation” from CODA, even if the program is still in compliance with standards. An intention statement clarifying this would be helpful, or the current wording could lead programs to state goals/objectives that are easily achievable.

Standard 2

- Additional details regarding proposed standard 2-2.8 would be helpful. Does the current wording suggest that a report be available for the number, by specific patient, or types of medically complex, special needs, and hospital based patients/procedures? An intention statement is included which suggests a “billing report”, but a billing report does not capture specific patients ages or diagnosis. Additional guidance for how an RCL should be prepared to demonstrate compliance for this would be helpful.
- Clarify the difference and/or overlap between special needs and medically complex. This also relates to newly numbered 4-22.
- Clarify what level of clinical oversight is needed for teledentistry procedures.
Standard 4

- Newly numbered 4-3 states that a program must be full-time for 24 months. I recommend the standard be changed to state the “equivalent of 24 months” to accommodate for related dual-degree programs, such as an MPH or MS which may require 36 months of hybrid learning to complete.
- There is significant variability in the number of sick, vacation, and other days permitted by various programs. Without being too prescriptive, some guidance about an estimated time away from the program for non-educational activity is welcomed. Endodontic standards provide a guideline for how many days of a program activity are required because full-time is vague, so this may be used as a model.
- Newly numbered 4-5: ‘Health informatics’ is very broad and is included as a recommendation in “Biomedical Sciences.” Should this be moved to practice management as it relates to patient records?
- Newly numbered 4-9: clarify if clinical experiences for all of these items should be completed with the pediatric dentist as the primary provider or if exposure through screening and observation of orthodontists/orthodontic residents treating these conditions is acceptable.
- Newly numbered 4-10/4-11: Include wording related to education about harm reduction to minimize risk to dentoalveolar structures (i.e., helmets, mouthguards, seatbelts).
- Newly number 4-14a: Include “care coordination” in this standard.
- Newly numbered 4-20: include a standard related to understanding the structure and function of health care payor systems (private and publicly-funded programs).
- Newly number 4-25: address how cases are counted if two residents share coordination/completion of a single case. Also state that residents should complete the “equivalent” of 25 cases for the steps outlined in this standard since they may be involved with some parts of a case (i.e., obtaining medical consults) but may not complete the entire case.
- Newly numbered 4-27: This standard should model the language used for the anesthesia rotation by stating that the equivalent of 2 weeks does not need to be consecutive since residents may participate in rotations over the course of their time in residency.
- Newly numbered 4-28:
  - Include language about understanding major government health agencies and their role in health care organization and delivery (i.e., CMS, HRSA, NIH)
  - Include language about differentiating programs, agencies, and health care efforts that may be organized at the local/community, state, federal, or international level.
  - Include language about understanding the social ecological model and how interventions can be delivered at each level.
- Include language stating that pediatric dentists should be generally familiar with guidelines for other pediatric organization, such as the American Academy of Pediatrics.
- In general, there is insufficient language pertaining to restorative dentistry and dental materials, yet this is a key component to pediatric dentistry.
- There is no mention of the use of “lasers” in dentistry, which is becoming a more relevant topic.

Standard 3, 5, and 6- No recommendations

A general item for feedback relates to supporting documentation.

- It would be helpful if CODA could provide guidance about whether items must be printed and prepared for each resident, or if they can be downloaded from a “dashboard” or server upon request during a site visit. For example, resident clinical logs reflecting procedures performed, sample presentations, course syllabi and materials, evaluations, orthodontic case records are all housed electronically and would be available upon request to site visitors.
- CODA should provide guidance about if all supporting documentation must be available for all aspects of the program (annually) since the last site visit.
- Exhibits 11a and 11b are vague.

Thank you for the opportunity to provide this feedback. Please let me know if you have any questions or need additional information. I can be reached at avenetti@uic.edu or by telephone at 312-996-2046. The items addressed here reflect my personal feedback and do not reflect the opinions of UIC College of Dentistry or the Department of Pediatric Dentistry.

Thank you,

David M. Avenetti, DDS, MSD, MPH
Post-Graduate Program Director and Clinical Associate Professor
Hi Sherin,

After a review of the CODA Standard proposed changes, here are a few comments and suggestions.

On page 39, line 9-12, in university-based programs, the dentists do not have the privilege to admit patients, so if this is a “must” requirement it does not increase their education and will make it impossible for them to comply. Also, the medical center may not implement the privileges to the residents, which may add to the challenge.

On page 46, line 14-17, it will encourage residents to have less complete research. This does not encourage independent research education, especially if the research work does not start at the beginning. Lines 20 and 21 are not complete research. As educators, we teach the residents the scientific method from beginning to end, but a systematic review does not comply with this. Our recommendation is to not make changes of the lines mentioned (14-17) and remove lines 20-21.

Please let me know if you have any questions.

Best,
Anna

Jung-Wei Chen, DDS, MS, MS, PhD
Program Director and Professor, Advanced Education Program in Pediatric Dentistry
Department of Pediatric Dentistry
LOMA LINDA UNIVERSITY | School of Dentistry
Prince Hall 3301, 11092 Anderson Street, Loma Linda, CA 92350
CONFIDENTIALITY NOTICE: This e-mail communication and any attachments may contain confidential and privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify me immediately by replying to this message and destroy all copies of this communication and any attachments. Thank you.
Attn: Ms. Peggy Soeldner  
Manager, Advanced Dental Education  
Commission on Dental Accreditation  
211 East Chicago Avenue,  
Chicago, IL 60611  

Date: June 1, 2020

Dear Sir/Madam –

I would like to present comments on the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry by the Commission on Dental Accreditation (CODA).

The comments are for the proposed revisions to the following standards:

4-7 b. 1. Students/Residents must complete 50 nitrous oxide analgesia patient encounters as primary operator (Page 29, line 16 and 17)

4-25 a. 2a. Each student/resident must participate in a minimum of twenty-five (25) operating room cases (page 38, line 39 and 40)

**Comments:**

The Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry defined the terms of “Competent” and “Competencies” as the knowledge, skills and values of graduates to be independent and unsupervised in the practice of Pediatric Dentistry. Additionally, it defined the terms of “Formative Assessment” and “Summative Assessment” as a measure of future learning, higher levels of responsibility and professional self-regulation and fitness to practice.

All the above terms and their definition are qualitative measures but not quantitative assessment measures.

The article used as a Reference in the proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry (Epstein, R. M. (2007). Assessment in Medical Education. The New England Journal of Medicine, 387-96. [https://www.nejm.org/doi/pdf/10.1056/NEJMr054784?articleTools=true Accessed May 20, 2020]), emphasizes the use of the above-mentioned terms as an assessment tool in medical education stressing the importance of qualitative assessment measures of postgraduate medical education. The same article also cautions not to assume that educational quantitative data are more reliable, valid, or useful than qualitative data.
The proposed revisions to standards 4-7 b. 1 and 4-25 a. 2a solely focus on an increase in number of patient encounters which contradicts the cautionary warning that the referenced article indicates about the assumption of the superiority of quantitative educational data over qualitative data.

Furthermore, the referenced article does not discuss what is the appropriate quantifiable number of experiences in order to reach the status of “Competent” and/or to adequately measure a “Formative and/or a Summative Assessment”. The proposed increase in cases in standards 4-7 and 4-25 does not guarantee an improvement in the quality of education and training nor will it improve the formative and summative assessment of residents and/or will increase their level of competency. There isn’t any scientific evidence that an increase of thirty (30) nitrous oxide analgesia cases and an increase of five (5) operating room cases to the current CODA-mandated requirement will improve the educational training and/or will promote professional self-regulation and fitness to practice.

Graduate Medical Education (GME) has evolved and focused on qualitative assessment methods for a long period of time. GME has found that qualitative assessment is an efficient and superior way to measure the performance of training residents. GME has created qualitative “Milestones” which have become an important formative component of the accreditation system for medical education in the United States.

“The Milestones describe the learning trajectory within a subcompetency that takes the resident or fellow from a beginner in the specialty or subspecialty, to a highly proficient resident or fellow or early practitioner.” (Page 9) (https://www.acgme.org/Portals/0/MilestonesGuidebook.pdf?ver=2016-05-31-113245-103 Accessed May 28, 2020)

**Attached: Exhibit A**

Figure 1a: general Description of Milestone Levels (https://www.acgme.org/Portals/0/MilestonesGuidebook.pdf?ver=2016-05-31-113245-103 Accessed May 28, 2020)

The proposed increase in number of cases will not add any educational value to the postgraduate education of the residents and will not provide the faculty with any valuable additional data about the competency of their residents. The current number of cases dictated in the existing accreditation standards are sufficient and adequate. This has been demonstrated by the exponential increase in number of Diplomates of the American Board of Pediatric Dentistry (ABPD) through the years. The pursuit and achievement of the diplomate status of the ABPD is the ultimate educational and professional recognition of any pediatric dentist.

The proposed increase in operating room cases can have a negative operational impact in pediatric dentistry programs. Operating room availability in hospitals has been historically low for dental cases, as the great majority of these cases are not approved by insurance or have very low reimbursement rates in comparison to elective medical procedures.
Additionally, the profession of Dentistry as a whole is experiencing very drastic changes due to the CoViD-19 pandemic. The pandemic effect of CoViD-19 has forced dental clinics to reduce the number of patients that they can see on a daily basis, in order to provide care in a safe environment for patients, residents, faculty and administrative staff. These changes are mandated by federal and state governments and the longevity of these changes are unknown. Any additional mandated increase of patient encounters can result in a burden to pediatric dentistry programs and clinics that have had to reduce their volume of patients due to the CoViD-19 pandemic as a safety measure in the provision of care.

It is because of all of the above reasons that as a program director and educator in Pediatric Dentistry, I respectfully disagree with the proposed revisions to Accreditation Standards for Advanced Dental Education Programs in Pediatric Dentistry for an increase in both, nitrous oxide analgesia patient encounters and operating room cases.

Sincerely,

Manali Kanitkar, DMD
Director of Pediatric Dentistry and Residency Program
Wyckoff Heights Medical Center
374 Stockholm Street, Brooklyn, NY 11237
Tel: 718-963-7174 Fax: 718-963-6744

Included: Exhibit A  Figure 1a: general Description of Milestone Levels
contain enough detail or levels of performance on a developmental trajectory to facilitate an accurate determination of the knowledge, skills, or abilities of an individual learner over a short period of time. In addition, the Milestones must not be used as the only set of assessment tools. Instead, the Milestones should inform the use and development of assessment tools aligned with the curricular goals and tasks. As stated previously, the Milestones are not inclusive of all areas of competency, and to limit the assessments to the Milestones would indicate that regular assessment is not occurring in the many other areas of learning.

Figure 1a: General Description of Milestone Levels

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the expectations for a beginning resident?</td>
<td>What are the milestones for a resident who has advanced over entry, but is performing at a lower level than expected at mid-residency?</td>
<td>What are the key developmental milestones mid-residency?</td>
<td>What does a graduating resident look like?</td>
<td>Stretch Goals – Exceeds expectations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What should they be able to do well in the realm of the specialty at this point?</td>
<td>What additional knowledge, skills &amp; attitudes have they obtained?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Are they ready for certification?</td>
<td></td>
</tr>
</tbody>
</table>

Comments: