REPORT ON ADVANCED EDUCATION IN GENERAL DENTISTRY, GENERAL PRACTICE RESIDENCY, DENTAL ANESTHESIOLOGY, ORAL MEDICINE AND OROFACIAL PAIN ANNUAL SURVEY CURRICULUM SECTION

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

The Curriculum Section of the Commission’s Annual Survey is conducted for advanced dental education programs in advanced education in general dentistry and general practice residency, dental anesthesiology, oral medicine, and orofacial pain in alternate years. The most recent Curriculum Section was conducted in August/September 2018. The draft Curriculum Section of the Annual Survey for advanced dental education programs in advanced education in general dentistry and general practice residency, dental anesthesiology, oral medicine, and orofacial pain can be found in Appendices 1, 2, 3, and 4.

**Summary:** The Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain (AGDOO RC) is requested to review the draft Curriculum Section of the Annual Surveys for advanced education programs in general dentistry and general practice residency, dental anesthesiology, oral medicine, and orofacial pain (Appendices 1, 2, 3, and 4).

**Recommendation:**

Prepared by: Ms. Peggy Soeldner
### Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did FIRST-YEAR students/residents spend in each of the following areas during the 2017-18 residency year?

Column must add up to 100%. Do not enter percent signs.

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations)</td>
<td></td>
</tr>
<tr>
<td>b. Dental inpatient care (management of dental inpatients)</td>
<td></td>
</tr>
<tr>
<td>c. Management of dental inpatients or same-day surgery patients in the hospital operating room suite</td>
<td></td>
</tr>
<tr>
<td>d. Rotations/Assignments to other services (non-dental)</td>
<td></td>
</tr>
<tr>
<td>e. Didactics: courses/lectures/conferences/seminars</td>
<td></td>
</tr>
<tr>
<td>f. Responding to consults</td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

21 (continued). What percentage of time did SECOND-YEAR students/residents spend in each of the following areas during the 2017-18 residency year?

Column must add up to 100%. Do not enter percent signs.

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>h. Ambulatory dental care (treatment provided in the dental clinic, includes dental rotations)</td>
<td></td>
</tr>
<tr>
<td>i. Dental inpatient care (management of dental inpatients)</td>
<td></td>
</tr>
<tr>
<td>j. Management of dental inpatients or same-day surgery patients in the hospital operating room suite</td>
<td></td>
</tr>
<tr>
<td>k. Rotations/Assignments to other services (non-dental)</td>
<td></td>
</tr>
<tr>
<td>l. Didactics: courses/lectures/conferences/seminars</td>
<td></td>
</tr>
<tr>
<td>m. Responding to consults</td>
<td></td>
</tr>
<tr>
<td>n. Other, please specify</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
22. Please indicate the total number of clock hours residents spent in formal courses, lectures and seminars receiving instruction in the following subject areas during the 2017-18 residency year.

If none, enter zero.
<table>
<thead>
<tr>
<th>Clock hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Applied pharmacology</td>
</tr>
<tr>
<td>b. Endodontics</td>
</tr>
<tr>
<td>c. Hospital organization and function</td>
</tr>
<tr>
<td>d. Medical risk assessment</td>
</tr>
<tr>
<td>e. Restorative/Operative dentistry</td>
</tr>
<tr>
<td>f. Oral diagnosis/treatment planning</td>
</tr>
<tr>
<td>g. Oral and maxillofacial pathology</td>
</tr>
<tr>
<td>h. Oral and maxillofacial radiology/imaging</td>
</tr>
<tr>
<td>i. Oral and maxillofacial surgery</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>j. Orthodontics and dentofacial orthopedics</td>
</tr>
<tr>
<td>k. Pain and anxiety control</td>
</tr>
<tr>
<td>l. Pediatric dentistry</td>
</tr>
<tr>
<td>m. Patients with special needs</td>
</tr>
<tr>
<td>n. Periodontics</td>
</tr>
<tr>
<td>o. Physical evaluation</td>
</tr>
<tr>
<td>p. Practice management</td>
</tr>
<tr>
<td>q. Preventive dentistry</td>
</tr>
<tr>
<td>r. Restoration of edentulous space</td>
</tr>
<tr>
<td>s. Other, please specify</td>
</tr>
</tbody>
</table>
23. Indicate all rotations/assignments to non-dental services in either the sponsoring or affiliated institution(s) required of the residents. Give the length in weeks and hours per week for each assignment.

<table>
<thead>
<tr>
<th>Length of rotation/assignment</th>
<th>Average hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Anesthesia</td>
<td></td>
</tr>
<tr>
<td>b. Medicine</td>
<td></td>
</tr>
<tr>
<td>c. Emergency Department</td>
<td></td>
</tr>
<tr>
<td>d. Other, please specify</td>
<td></td>
</tr>
</tbody>
</table>

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

________________________________________________________________
________________________________________________________________
________________________________________________________________
Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

24. Provide the following dental clinic statistics related to outpatient visits for the 2017-18 residency year. Include statistics for both sponsoring and affiliated institution(s).

<table>
<thead>
<tr>
<th>Number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Total number of outpatient visits to the dental clinic (include screening/consultative visits)</td>
</tr>
<tr>
<td>b. Total number of outpatient visits managed by the residents</td>
</tr>
</tbody>
</table>

25. How many patients with special needs did the residents treat during the 2017-18 residency year?

These are defined as patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations.
26. How many patients did residents provide comprehensive care to, from treatment plan to completion (as opposed to episodic or emergency care), during the 2017-18 residency year?

________________________________________________________________

27. Provide the following emergency care statistics for the 2017-18 residency year identifying the activity level(s) at both the sponsoring and affiliated institution(s).

<table>
<thead>
<tr>
<th>Sponsoring institution</th>
<th>Affiliated institution(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The number of dental emergencies treated in the dental clinic by residents</td>
<td></td>
</tr>
<tr>
<td>b. The number of dental emergencies treated in the hospital emergency department by all residents</td>
<td></td>
</tr>
</tbody>
</table>

28. How was emergency care experience provided to the residents during the 2017-18 residency year?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Block assignment to the Emergency Department</td>
<td>〇</td>
</tr>
<tr>
<td>b. On-going/on-call, with resident on premises</td>
<td>〇</td>
</tr>
<tr>
<td>c. On-going/on-call with resident off premises</td>
<td>〇</td>
</tr>
</tbody>
</table>
29. In which of the following conscious sedation techniques did residents receive instruction and clinical experience during the 2017-18 residency year?

<table>
<thead>
<tr>
<th>Instruction provided?</th>
<th>Clinical experience provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>a. Oral</td>
<td>☐</td>
</tr>
<tr>
<td>b. Inhalation</td>
<td>☐</td>
</tr>
<tr>
<td>c. Intramuscular</td>
<td>☐</td>
</tr>
<tr>
<td>d. Intravenous</td>
<td>☐</td>
</tr>
<tr>
<td>e. Intranasal</td>
<td>☐</td>
</tr>
<tr>
<td>f. Other, please specify</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Page Break

Page 8 of 25
Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

NOTE: The procedures listed in Questions 30-33 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students'/residents’ total experience or to imply that all listed procedures are required for accreditation.

30. Indicate the total number of each of the following procedures in Preventive Dentistry completed by residents during the 2017-18 residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>a. Prophylaxis (D1110, D1120)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>b. Topical fluoride treatments (D1203 - D1206)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>c. Sealants (D1351)</td>
</tr>
</tbody>
</table>
31. Indicate the total number of each of the following procedures in Restorative/Operative Dentistry completed by residents during the 2017-18 residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Amalgam Restorations (D2140, D2150, D2160, D2161)</td>
</tr>
<tr>
<td>b. Anterior composites (D2330, D2331, D2332 and D2335)</td>
</tr>
<tr>
<td>c. Posterior composites (D2391, D2392, D2393, &amp; D2394)</td>
</tr>
<tr>
<td>d. Single unit crowns (D2710, D2712, D2720-D2722, D2740, D2750-D2752, D2780-D2783, D2790-D2792, D2794)</td>
</tr>
<tr>
<td>e. Crown cores (cast or prefabricated) (D2952-D2954, D2957)</td>
</tr>
<tr>
<td>f. Crown core build-up, including pins (preparatory work before crown) (D2950)</td>
</tr>
<tr>
<td>g. Inlay/Onlay (D2510-D2664)</td>
</tr>
</tbody>
</table>
32. Indicate the total number of each of the following procedures in Endodontics completed by residents during the 2017-18 residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Single canals (anterior) (D3310, D3346)</td>
</tr>
<tr>
<td>b. Double canals (bicuspids) (D3320, D3347)</td>
</tr>
<tr>
<td>c. Molars (D3330, D3348)</td>
</tr>
<tr>
<td>d. Apicoectomies (D3410, D3421, D3425, D3426)</td>
</tr>
</tbody>
</table>
33. Indicate the total number of each of the following procedures in Periodontics completed by residents during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Scaling, root planing and curettage (D4341, D4342, D4355, D4910)</td>
</tr>
<tr>
<td>b. Gingivectomies (D4210-D4211, D4212)</td>
</tr>
<tr>
<td>c. Soft tissue grafts/gingival flap procedures (D4240, D4241, D4270, D4273, D4275, D4276)</td>
</tr>
<tr>
<td>d. Crown lengthening/Bone grafts/osseous surgery/guided tissue regeneration (D4249, D4260, D4261, D4266, D4267)</td>
</tr>
<tr>
<td>e. Apically repositioned flap (D4245)</td>
</tr>
<tr>
<td>f. Bone graft replacement graft – first site in quadrant (D4263)</td>
</tr>
<tr>
<td>g. Bone replacement graft – each additional site in quadrant (D4264)</td>
</tr>
</tbody>
</table>
h. Biologic materials to aid in soft tissue and osseous tissue regeneration (D4265)

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Page Break

Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.
NOTE: The procedures listed in Questions 34-37 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students’/residents’ total experience or to imply that all listed procedures are required for accreditation.

34. Indicate the total number of each of the following procedures in Removable Prosthodontics completed by residents during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Units/complete dentures (D5110-D5120)</td>
</tr>
<tr>
<td>b. Units/immediate dentures (D5130-D5140)</td>
</tr>
<tr>
<td>c. Units/overdentures (D5863-D5866)</td>
</tr>
<tr>
<td>d. Interim complete dentures (D5810, D5811)</td>
</tr>
<tr>
<td>e. Adjustment to dentures and partials (D5410-D5422)</td>
</tr>
<tr>
<td>f. Complete denture repairs (D5510, D5520)</td>
</tr>
<tr>
<td>g. Repairs to partials (D5610-D5671)</td>
</tr>
<tr>
<td>h. Acrylic partial dentures (D5211-D5212, D5221, D5222, D5225, D5226, D5820-D5821)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>i.</td>
</tr>
<tr>
<td>j.</td>
</tr>
</tbody>
</table>
35. Indicate the total number of each of the following procedures in Implant Services completed by residents during the 2017-18 residency year.

<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Surgical placement of implant body (D6010)</td>
</tr>
<tr>
<td>b. Prefabricated abutment (including placement) (D6056)</td>
</tr>
<tr>
<td>c. Custom abutment (including placement) (D6057)</td>
</tr>
<tr>
<td>d. Implant retained Removable Prosthodontics (D6110-D6113)</td>
</tr>
<tr>
<td>e. Implant retained Fixed Prosthodontics (D6058 –D6077, D6094, D6114-D6117, D6194)</td>
</tr>
</tbody>
</table>
36. Indicate the total number of each of the following procedures in Fixed Prosthodontics completed by residents during the 2017-18 residency year.

<table>
<thead>
<tr>
<th>Units/fixed bridgework (D6205-D6794)</th>
<th>Number of procedures</th>
</tr>
</thead>
</table>

37. Indicate the total number of each of the following procedures in Oral and Maxillofacial Surgery completed by residents during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Uncomplicated extractions (D7111, D7140, D7210, D7250)</td>
</tr>
<tr>
<td>b. Extractions of impacted teeth (D7220, D7230, D7240, D7241)</td>
</tr>
<tr>
<td>c. Oral Tissue biopsy (D7285, D7286)</td>
</tr>
<tr>
<td>d. Brush biopsy (D7288)</td>
</tr>
<tr>
<td>e. Surgical removal of lateral exostosis (maxilla or mandible) (D7471)</td>
</tr>
<tr>
<td>f. Surgical reduction of osseous tuberosity (D7485)</td>
</tr>
<tr>
<td>g. Surgical reduction of fibrous tuberosity (D7972)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>h.</td>
</tr>
<tr>
<td>i.</td>
</tr>
<tr>
<td>j.</td>
</tr>
<tr>
<td>k.</td>
</tr>
<tr>
<td>l.</td>
</tr>
<tr>
<td>m.</td>
</tr>
<tr>
<td>n.</td>
</tr>
<tr>
<td>o.</td>
</tr>
<tr>
<td>p.</td>
</tr>
</tbody>
</table>
q. Excision of hyperplastic tissue – per arch (D7970)

r. Excision of pericoronal gingiva (D7971)

Use this space to enter comments or clarifications for your answers on this page.
Part II - General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

NOTE: The procedures listed in Question 38 have been selected as indicators of the amount, variety, and complexity of clinical experience provided to residents. They are not intended to summarize students/residents’ total experience or to imply that all listed procedures are required for accreditation.

38. Indicate the total number of each of the following procedures in Pediatric Dentistry and Orthodontics completed by residents during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>Number of procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Resin-based Composite posterior (D2391-D2394)</td>
</tr>
<tr>
<td>b. Resin-based Composite anterior (D2330-D2335)</td>
</tr>
<tr>
<td>c. Amalgam restoration (primary or permanent) (D2140-D2161)</td>
</tr>
<tr>
<td>d. Limited ortho treatment of adult dentition (Upright tilted teeth) (D8040)</td>
</tr>
<tr>
<td>e. Limited treatment of primary dentition (Moyer’s or equivalent space analysis) (D8010)</td>
</tr>
<tr>
<td>f. Space maintenance (D1510, D1515, D1520, D1525, D1550, D1555)</td>
</tr>
<tr>
<td>g. Comprehensive ortho treatment (space closures) (D8070, D8080, D8090)</td>
</tr>
<tr>
<td>39. How many times during the 2017-18 residency year were formal documented evaluations of resident performance conducted?</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>40. Please select the response below that best describes the intended outcomes of residents' education.</td>
</tr>
<tr>
<td>○ Goals and objectives</td>
</tr>
<tr>
<td>○ Competencies and proficiencies</td>
</tr>
</tbody>
</table>
Use this space to enter comments or clarifications for your answers on this page.

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

End of Block: AEGD/GPR Curriculum (Q21-40)
Part II - Dental Anesthesiology Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did residents spend in each of the following areas during the 2017-18 residency year?
Column must add up to 100%. Do not enter percent signs.
<table>
<thead>
<tr>
<th></th>
<th>First Year</th>
<th>Second Year</th>
<th>Third Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Anesthesia</td>
<td>Anesthesia for ambulatory dental procedures provided in a dental clinic or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>in a facility outside the hospital operating rooms including office-based</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>venues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Anesthesia</td>
<td>Anesthesia for dental inpatient or same-day surgery within the hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>operating rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Rotation/</td>
<td>Assignment to other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>assignments to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Didactics:</td>
<td>Didactics: conferences/seminars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Teaching</td>
<td>Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Investigative</td>
<td>Investigative work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>
22. Please indicate the number of clock hours residents spent in lectures, seminars or formal courses when on the medical/dental service during the 2017-18 residency year.

<table>
<thead>
<tr>
<th>First Year Clock Hours</th>
<th>Second Year Clock Hours</th>
<th>Third Year Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Applied biomedical sciences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Physical diagnosis and evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Behavioral medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Techniques of anxiety and pain control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Complications and emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Pain management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Critical evaluation of literature</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
23. Please indicate the number of weeks residents spent on the following clinical rotations/assignments during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>First Year: Number of weeks</th>
<th>Second Year: Number of weeks</th>
<th>Third Year: Number of weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Emergency medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. General/Internal medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Intensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Pain clinic/service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Other, please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
i. Other, please specify

______________________________________________________________

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

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Page Break
Part II - Dental Anesthesiology Curriculum Section (continued)

*Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.*

24. Please provide the number of cases/procedures the 2018 graduates completed/performed throughout the entire three-year residency program.
<table>
<thead>
<tr>
<th></th>
<th>Highest number</th>
<th>Lowest number</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Deep sedation/general anesthesia cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Intubated general anesthetics cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Nasal intubations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Advanced airway management techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Cases of children age 7 and under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Patients with special needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Ambulatory patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Patients over age 65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
25. How many months, over their entire three-year residency, do the residents devote exclusively to clinical training in anesthesiology?

________________________________________________________________________

26. How many months, over their entire three-year residency, are the residents assigned to a hospital anesthesia service that provides trauma and/or emergency surgical care?

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Part II - Oral Medicine Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did residents spend in each of the following areas during the 2017-18 residency year?
Column must add up to 100%. Do not enter percent signs.

<table>
<thead>
<tr>
<th></th>
<th>First Year</th>
<th>Second Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Didactics: conferences/seminars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Clinical activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Rotation/assignments to other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Research and/or scholarly activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Other, please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
22. Please indicate the number of clock hours residents spent in formal courses, lectures, and seminars receiving instruction in the following subject areas during the 2017-18 residency year.

If none, enter zero.
<table>
<thead>
<tr>
<th>First Year Clock Hours</th>
<th>Second Year Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Physical evaluation and medical risk assessment</td>
<td></td>
</tr>
<tr>
<td>b. Detecting and diagnosing patients with complex medical problems that affect various organ systems and/or the orofacial region</td>
<td></td>
</tr>
<tr>
<td>c. Selecting appropriate diagnostic procedures</td>
<td></td>
</tr>
<tr>
<td>d. Suitable preventive and/or management strategies to resolve oral manifestations of medical conditions or orofacial problems</td>
<td></td>
</tr>
<tr>
<td>e. Critical evaluation of the scientific literature</td>
<td></td>
</tr>
<tr>
<td>f. Anatomy, physiology, microbiology, immunology, biochemistry, neuroscience and pathology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>g.</td>
<td>Pathogenesis and epidemiology of orofacial diseases and disorders</td>
</tr>
<tr>
<td>h.</td>
<td>Concepts of molecular biology and molecular basis of genetics</td>
</tr>
<tr>
<td>i.</td>
<td>Aspects of internal medicine and pathology</td>
</tr>
<tr>
<td>j.</td>
<td>Concepts of pharmacology mechanisms, actions, interactions and effects of prescription and over-the-counter drugs</td>
</tr>
<tr>
<td>k.</td>
<td>Ameliorating the adverse effects of prescription/over-the-counter products and medical/dental therapy</td>
</tr>
<tr>
<td>l.</td>
<td>Principles of nutrition</td>
</tr>
<tr>
<td>m.</td>
<td>Principles of research</td>
</tr>
</tbody>
</table>
23. Please indicate the number of clock hours the residents spent in didactic instruction and clinical training during the 2017-18 residency year related to establishing a differential diagnosis.
and formulating a working diagnosis prognosis and management plan pertaining to each of the following.

<table>
<thead>
<tr>
<th></th>
<th>First Year: Didactic</th>
<th>First Year: Clinical</th>
<th>Second Year: Didactic</th>
<th>Second Year: Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Oral mucosal disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Medically complex patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Salivary gland disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Acute and chronic orofacial pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Orofacial neurosensory disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
24. Please indicate the clinical rotations/assignment, length in weeks and number of hours per week where the residents gained clinical medical experiences during the 2017-18 residency year.
<table>
<thead>
<tr>
<th></th>
<th>First Year: Length in weeks</th>
<th>First Year: Hours per week</th>
<th>Second Year: Length in weeks</th>
<th>Second Year: Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Internal medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Cardiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Hematology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Oncology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Infectious diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Dermatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Nephrology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Hepatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Endocrinology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Otolaryngology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Oral and maxillofacial radiology/Advanced imaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Other, please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Other, please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Other, please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. If applicable, please indicate the number of hours students/residents participated in teaching activities during the 2017-18 residency year.

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________
End of Block: OralMed Curriculum (Q21-25)
Part II - Orofacial Pain Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.
21. What percentage of time did residents spend in each of the following areas during the 2017-18 residency year?
Column must add up to 100%. Do not enter percent signs.
<table>
<thead>
<tr>
<th></th>
<th>First Year</th>
<th>Second Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Didactics:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>conferences/seminars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Clinical Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orofacial pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Clinical Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Rotations/assignment to other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
22. Please indicate the number of clock hours residents spent in formal courses, lectures, and seminars receiving instruction in the following subject areas during the 2017-18 residency year. If none, enter zero.
<table>
<thead>
<tr>
<th>First Year Clock Hours</th>
<th>Second Year Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Gross and functional anatomy and physiology including the musculoskeletal and articular systems of the orofacial, cranio/orofacial, and cervical structures</td>
<td></td>
</tr>
<tr>
<td>b. Growth, development, and aging of the masticatory system</td>
<td></td>
</tr>
<tr>
<td>c. Head and neck pathology and pathophysiology with an emphasis on pain</td>
<td></td>
</tr>
<tr>
<td>d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures</td>
<td></td>
</tr>
<tr>
<td>e. Sleep physiology and dysfunction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>f.</td>
<td>Oromotor disorders including dystonias, dyskinesias, and bruxism</td>
</tr>
<tr>
<td>g.</td>
<td>Epidemiology of orofacial pain disorders</td>
</tr>
<tr>
<td>h.</td>
<td>Pharmacology and pharmacotherapeutics</td>
</tr>
<tr>
<td>i.</td>
<td>Principles of biostatistics, research design and methodology, scientific writing, and critique of literature</td>
</tr>
<tr>
<td>j.</td>
<td>The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems</td>
</tr>
<tr>
<td>k.</td>
<td>Mechanisms associated with pain referral to and from the orofacial region</td>
</tr>
<tr>
<td></td>
<td>Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>m.</td>
<td>Pain classification systems</td>
</tr>
<tr>
<td>n.</td>
<td>Psychoneuroimmunology and its relation to chronic pain syndromes</td>
</tr>
<tr>
<td>o.</td>
<td>Primary and secondary headache mechanisms</td>
</tr>
<tr>
<td>p.</td>
<td>Pain of odontogenic origin and pain that mimics odontogenic pain</td>
</tr>
<tr>
<td>q.</td>
<td>The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction</td>
</tr>
</tbody>
</table>
r. Cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors

s. The recognition of pain behavior and secondary gain behavior

t. Psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain disorders

u. Conducting and applying the results of psychometric tests

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

________________________________________________________________
________________________________________________________________
________________________________________________________________
Part II - Orofacial Pain Curriculum Section (continued)

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

23. Please indicate the number of clock hours the residents spent in didactic instruction and clinical training addressing the following areas during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>First Year: Didactic</th>
<th>First Year: Clinical</th>
<th>Second Year: Didactic</th>
<th>Second Year: Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Obtain informed consent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Intraoral appliance therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Physical medicine modalities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
e. Sleep-related breathing disorder intraoral appliances
24. Please indicate the clinical rotations/assignment, length in weeks and number of hours per week where the residents gained clinical experiences in other healthcare services during the 2017-18 residency year.
<table>
<thead>
<tr>
<th>First Year: Length in weeks</th>
<th>First Year: Hours per week</th>
<th>Second Year: Length in weeks</th>
<th>Second Year: Hours per week</th>
<th>Total Program: % of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Oral and maxillofacial surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Oral and maxillofacial surgery for intracapsular TMJ disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Outpatient anesthesia pain service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Rheumatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Neurology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Oncology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>g. Otolaryngology</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>h. Rehabilitation medicine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>i. Headache clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>j. Radiology</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>k. Oral Medicine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>l. Sleep Disorder clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>m. Other, please specify</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>n. Other, please specify</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
25. If applicable, please indicate the number of hours residents participated in teaching orofacial pain during the 2017-18 residency year.

________________________________________________________________

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

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

End of Block: OrofacPain Curriculum (Q21-25)
CONSIDERATION OF THE USE OF THE TERM “SHOULD” WITHIN THE ACCREDITATION STANDARDS

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

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

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

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

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

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

AGDOO RC
CODA Winter 2020

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

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

At this meeting, the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine, and Orofacial Pain Education (AGDOO RC) is requested to review the use of the term “Should” within the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain (Appendices 1, 2, 3, 4, and 5). The Review Committee has been directed to revise the term “Should,” and consider additional revisions to the Accreditation Standards that may be warranted as a result of the revised definition of the term “Should,” which CODA approved in Summer 2019. If the Review Committee will conduct a review of its Accreditation Standards through a validity and reliability study, the Committee may consider incorporating the revisions related to the term “Should” within its overall review of the Standards.

Summary: The AGDOO RC is requested to review the Accreditation Standards found in Appendices 1, 2, 3, 4, and 5 related to the Commission’s directive to redefine the term “Should.” If the discipline-specific standards are currently being assessed for validity and reliability or may undergo review in the near future; the Review Committee may consider the timing of its review and revision of the term “Should” to correlate with other revision activities.

Review Committee Recommendation:

Prepared by: Ms. Peggy Soeldner
Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry
Consideration of the Use of the Term “Should” Within the Accreditation Standards

AGDOO RC
CODA Winter 2020

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

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678

(312) 440-4653
www.ada.org/en/coda

Copyright©2019
Commission on Dental Accreditation
All rights reserved. Reproduction is strictly prohibited without prior written permission.

AEGD Standards
-2-
Accreditation Standards for
Advanced Dental Education Programs in
Advanced Education in General Dentistry

Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 3, 2018</td>
<td>Accreditation Standards for Advanced Education Programs in General Dentistry</td>
<td>Adopted and 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>August 2, 2019</td>
<td>Revised Definition of “Patients with special needs”</td>
<td>Adopted and Implemented</td>
</tr>
</tbody>
</table>
# Table of Contents

<table>
<thead>
<tr>
<th>Mission Statement of the Commission on Dental Accreditation</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation Status Definitions</td>
<td>5</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Goals</td>
<td>7</td>
</tr>
<tr>
<td>Accreditation of One- And Two-Year Programs</td>
<td>8</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>9</td>
</tr>
</tbody>
</table>

Standards:

1- Institutional and Program Effectiveness | 11 |
2- Educational Program | 14 |
3- Faculty And Staff | 20 |
4- Educational Support Services | 24 |
5- Patient Care Services | 27 |
Mission Statement of the Commission on Dental Accreditation

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

Commission on Dental Accreditation
Adopted: August 5, 2016
Accreditation Status Definitions

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

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

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

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

Programs That Are Not Fully Operational
A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.
Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).
Introduction

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Advanced Education in General Dentistry for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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

Although the standards are comprehensive and applicable to all institutions that offer advanced education in general dentistry programs, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession, and the prospective resident to assure that programs accredited as Advanced Education Programs in General Dentistry provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in Advanced Education in General Dentistry are educational programs designed to provide training beyond the level of pre-doctoral education in oral health care, using applied basic and behavioral sciences. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates’ knowledge and skills to enable them to provide comprehensive oral health care to a wide range of population groups.

The goals of these programs should include preparation of the graduate to:
1. Act as a primary care provider for individuals and groups of patients. This includes: providing emergency and multidisciplinary comprehensive oral health care; providing patient focused care that is coordinated by the general practitioner; and directing health promotion and disease prevention activities.
2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively and efficiently in multiple health care environments within interdisciplinary health care teams.
5. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making, and technology-based information retrieval systems.
6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
7. Understand the oral health needs of communities and engage in community service.

Accreditation of One-Year and Two-Year AEGD Programs

The Commission on Dental Accreditation will accredit the following types of Advanced Dental Education Programs in Advanced Education in General Dentistry (AEGD) programs: one-year programs, one-year programs with an optional second year of training where residents enroll for the second year of training during the first year, and two-year programs where residents enroll for two years at the beginning of the program. For programs offering an optional second year of training, accreditation of the program will be continued whether or not a resident is enrolled each year for the second year of training as long as there is enrollment of residents in the program’s first year.
The addition of an optional second year of training to an existing one-year program will be considered as a major change to that program rather than as the development of a separate new program. Programs wishing to add an optional second year of training should contact Commission staff to acquire the appropriate forms for reporting a major change.
Definition of Terms

Key terms used in this document (i.e., Must, should, could and may) were selected carefully and indicate the relative weight that the commission attaches to each statement. The definition of these words as used in the standards follows:

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

**Competent**: The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

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

**Goals and Objectives**:

**Program**: Educational goals that describe what the resident will be able to do upon completion of the program. These should describe the resident’s abilities rather than the educational experiences they participate in.

**Resident Training**: Educational goals describing the levels of knowledge, skills and values attained when a particular activity is accomplished.

**HIPAA**: Health Insurance Portability and Accountability Act

**Intent**: Intent statements are presented to provide clarification to the advanced education programs in general dentistry in the application of and in connection with compliance with the Accreditation Standards for Advanced Education Programs in General 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.

**Interdisciplinary**: Including dentistry and other health care professions.

**Manage**: Coordinate the delivery of care using a patient-focused approach within the scope of their training. Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.
May or could: Indicates freedom or liberty to follow a suggested alternative.

Multidisciplinary: Including all disciplines within the profession of dentistry.

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

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

Should: Indicates a suggested way to meet the standard; highly desirable, but not mandatory.

Sponsor: The institution that has the overall administrative control and responsibility for the conduct of the program.

Resident: The individual enrolled in a Commission on Dental Accreditation-accredited advanced education in general dentistry program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 Each sponsoring or co-sponsoring United States-based educational institution, hospital or health care organization must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission, goals and objectives.

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year
1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

**Intent:** Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

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

1-6 There must be opportunities for program faculty to participate in institution-wide committee activities.

**Examples of evidence to demonstrate compliance may include:**
Bylaws or documents describing committee structure
Copy of institutional committee structure and/or roster of membership by dental faculty

1-7 Dental residents must have the same privileges and responsibilities provided residents in other professional education programs.

**Examples of evidence to demonstrate compliance may include:**
Bylaws or documents describing resident privileges

1-8 The program must have written overall program goals and objectives that emphasize:

- general dentistry,
- resident education,
- patient care, and
- community service.

**Intent:** The “program” refers to the Advanced Education in General Dentistry Residency that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standard 2-1, 2-2, 2-3 and 2-4. Specific learning objectives for residents are intended to be described as goals and objectives or
competencies for resident training and included in the response to Standards 2-1, 2-2, 2-3, and 2-4. An example of overall goals can be found in the Goals section on page 8 of this document.

The program is expected to define community service within the institution’s developed goals and objectives.

Examples of evidence to demonstrate compliance may include:
Written overall program goals and objectives

1-9 The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s overall goals and objectives are being met and make program improvements based on an analysis of that data.

Intent: The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-8 are being met.

The outcomes process developed should include each of the following steps:
1. development of clear, measurable goals and objectives consistent with the program's purpose/mission;
2. implementation of procedures for evaluating the extent to which the goals and objectives are met;
3. collection of data in an ongoing and systematic manner;
4. analysis of the data collected and sharing of the results with appropriate audiences;
5. identification and implementation of corrective actions to strengthen the program; and
6. review of the assessment plan, revision as appropriate, and continuation of the cyclical process.

Examples of evidence to demonstrate compliance may include:
Written overall program goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results.
Ethics and Professionalism

1-10 The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

*Intent:* Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program **must** provide didactic and clinical training to ensure upon completion of training, the resident is able to:

a) Act as a primary oral health care provider to include:
   1) providing emergency and multidisciplinary comprehensive oral health care;
   2) obtaining informed consent;
   3) functioning effectively within interdisciplinary health care teams, including consultation and referral;
   4) providing patient-focused care that is coordinated by the general practitioner; and
   5) directing health promotion and disease prevention activities.

b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.

c) Manage the delivery of patient-focused oral health care.

**Intent:** “Patients with special needs” is defined in the Definition of Terms on page 10 of this document.

Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.

**Examples of evidence to demonstrate compliance may include:**
Written goals and objectives or competencies for resident training organized by the areas described above
Didactic and clinical schedules
Resident evaluations
Documentation of treatment planning sessions
Documentation of chart reviews
Records of resident clinical activity including procedures performed in each area described above
Documentation of case simulations
2-2 The program must have written goals and objectives or competencies for resident training and provide didactic and clinical training to ensure that upon completion of training the resident is able to provide the following at an advanced level of skill and/or case complexity beyond that accomplished in pre-doctoral training:

a) operative dentistry;
b) restoration of the edentulous space;
c) periodontal therapy;
d) endodontic therapy;
e) oral surgery;
f) evaluation and treatment of dental emergencies; and
g) pain and anxiety control utilizing behavioral and/or pharmacological techniques.

**Intent:** Determination of “complexity beyond that accomplished in a pre-doctoral training” may be from various aspects including, but not limited to: depth of topic discussion, variety of topic/procedures, quantity of topics/procedures, underlying medical/health considerations related to delivery of topic/procedures, etc.

**Examples of evidence to demonstrate compliance may include:**
Written goals and objectives or competencies for resident training organized by the areas described above
Didactic and clinical schedules
Records of resident clinical activity including procedures performed in each area described above
Patient records
Resident evaluations

2-3 The program must have a written curriculum plan that includes structured clinical experiences and didactic sessions in dentistry and medicine, designed to achieve the written goals and objectives or competencies for resident training.

**Intent:** The program is expected to organize the didactic and clinical educational experiences into a formal curriculum plan.

For each specific goal or objective or competency described in response to Standard 2-1, 2-2, and 2-4, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area.
The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

Examples of evidence to demonstrate compliance may include:
- Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies
- Didactic and clinical schedules

2-4 The program must provide training to ensure that upon completion of the program, the resident is able to manage the following:

- medical emergencies;
- implants;
- oral mucosal diseases;
- temporomandibular disorders; and
- orofacial pain

Intent: “Manage” is defined in the Definition of Terms on page 9 of this document.

The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident’s ability to manage the above areas.

Examples of evidence to demonstrate compliance may include:
- Written goals and objectives or competencies for resident training and proficiencies organized by the areas described above
- Didactic and clinical schedules
- Records of resident clinical activity including procedures performed in each area described above
- Patient records
- Resident evaluations

2-5 Each assigned rotation or experience must have:

- written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
- resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
- evaluations performed by the designated supervisor.
Intent: This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-6 The program must provide formal instruction in physical evaluation and medical assessment, including:

   a) taking, recording, and interpreting a complete medical history;
   b) understanding the indications of and interpretations of laboratory studies and other techniques used in the diagnosis of oral and systemic diseases;
   c) understanding the relationship between oral health care and systemic diseases; and
   d) interpreting the physical evaluation performed by a physician with an understanding of how it impacts on proposed dental treatment.

Intent: Residents should be able to interact appropriately with other health care providers. It is intended that medical assessment be conducted during formal instruction as well as during inpatient, same-day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and medical assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data is being recorded.

Examples of evidence to demonstrate compliance may include:
Didactic schedules
Course outlines
Resident evaluations

2-7 The program must provide instruction in the principles of practice management.

Intent: Suggested topics include: management of allied dental professionals and other office personnel; quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk
management; alternative health care delivery systems; informational technology; and managed care.

Examples of evidence to demonstrate compliance may include:
Course outlines

2-8  Formal patient care conferences **must** be scheduled at least twelve (12) times a year.

*Intent:* Conferences should be distributed throughout the year so that diagnosis, treatment planning, progress, and outcomes can be followed and discussed. These conferences should be attended by residents and faculty and should not replace the daily faculty and resident interactions regarding patient care.

Examples of evidence to demonstrate compliance may include:
Conference schedules

2-9  Residents **must** be given assignments that require critical review of relevant scientific literature.

*Intent:* Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care. This should include the development of critical evaluation skills and the ability to apply evidence-based principles to clinical decision-making.

Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

**Program Length**

2-10 The program **must** be one or two calendar years in length.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-11 Programs **must** be designed as either a one-year program, a one-year program with an optional second year or a mandatory two-year program.
Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident training
Written curriculum plan
Schedules

2-12 Residents enrolled in the optional second year of training **must** have completed an accredited first year of Advanced Education in General Dentistry or General Practice Residency training at this or another institution.

Examples of evidence to demonstrate compliance may include:
Resident records or certificate

2-13 The program **must** have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident didactic and clinical training
Written curriculum plan

2-14 Where a program for part-time residents exists, it **must** be started and completed within a single institution and designed so that the total curriculum can be completed in no more than two years of study for a one-year program and four years of study for a two-year program.

**Intent:** Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

**Evaluation**

2-15 The program’s resident evaluation system **must** assure that, through the director and faculty, each program:
Consideration of the Use of the Term “Should” Within the Accreditation Standards

AGDOO RC
CODA Winter 2020

AEGD Standards
-23-

a) periodically, but at least three times annually, evaluates and documents the resident’s progress towards achieving the program’s written goals and objectives or competencies for resident training using appropriate written criteria and procedures;

b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions must be taken; and

c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.

**Intent:** While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.

**Examples of evidence to demonstrate compliance may include:**
Written evaluation criteria and process
Resident evaluations
Personal record of evaluation for each resident
Evidence that corrective actions have been taken
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by a director who has authority and responsibility for all aspects of the program.

Intent: The program director’s responsibilities include:

a) program administration;

b) development and implementation of the curriculum plan;

c) ongoing evaluation of program content, faculty teaching, and resident performance;

d) evaluation of resident training and supervision in affiliated institutions and off-service rotations;

e) maintenance of records related to the educational program; and

f) resident selection.

It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:

1) what duties are assigned;

2) to whom they are assigned; and

3) what systems of communication are in place between the program director and individuals who have been assigned responsibilities.

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:

Program director’s job description
Job description of individuals who have been assigned some of the program director’s job responsibilities
Formal plan for assignment of program director’s job responsibilities as described above
Program records

3-2 Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, must have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.
Examples of evidence to demonstrate compliance may include:
Program director’s completed BioSketch

3-3 For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.

Examples of evidence to demonstrate compliance may include:
Completed BioSketch for on-site clinical supervisor/director
Written criteria used to certify a non-specialist faculty member as responsible for a specialty teaching area

3-4 All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dentistry included in the program.

Intent: Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible (e.g., the faculty member responsible for endodontics is not required to be an endodontist. Instead, it could be someone with current knowledge and appropriate level of experience in endodontics). The faculty, collectively, should have competence in all areas of dentistry covered in the program.

The program is expected to develop written criteria and qualifications that would enable a faculty member to be responsible for a particular specialty teaching area if that faculty member is not a specialist in that area. The program is expected to evaluate non-specialist faculty members who will be responsible for a particular specialty teaching area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of specialists as trained consultants for the development of a mission and curriculum, and for teaching.

Examples of evidence to demonstrate compliance may include:
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Written criteria used to certify a non-specialist faculty member as responsible for a specialty teaching area
Records of program documentation that non-specialist faculty members are responsible for a specialty teaching area

3-5 General dentists **must** have a significant role in program development and instruction.

*Intent:* General dentists are expected to be actively involved in developing the curriculum and clinical rotations, as well as in the instruction of the residents.

**Examples of evidence to demonstrate compliance may include:**
Faculty meeting minutes
Faculty roster
Departmental policies
Completed BioSketch of faculty members

3-6 A formally defined evaluation process **must** exist that ensures measurements of the performance of faculty members annually.

*Intent:* The written annual performance evaluations should be shared with the faculty members.

**Examples of evidence to demonstrate compliance may include:**
Faculty files
Performance appraisals

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

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

**Examples of evidence to demonstrate compliance may include:**
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-8 A faculty member must be present in the dental clinic for consultation, supervision and active teaching when residents are treating patients in scheduled clinic sessions.

**Intent:** This statement does not preclude the rare situation where a faculty member cannot be available. This Standard applies not only to clinic sessions, but to any location or situation where residents are treating patients in scheduled sessions.

**Examples of evidence to demonstrate compliance may include:**
Faculty clinic schedules

3-9 At each site where educational activity occurs, adequate support staff must be consistently available to ensure:

a) residents do not regularly perform the tasks of allied dental personnel and clerical staff,
b) resident training and experience in the use of current concepts of oral health care delivery and
c) efficient administration of the program.

**Intent:** This statement is meant to emphasize the importance of a well-balanced dental staff that can help address aspects of the delivery of dentistry and the business of dentistry. The areas that are considered current concepts would be scheduling, insurance, dental assisting, dental hygiene and lab procedures. The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives. Allied support may include dental assistants, dental hygienists, dental laboratory technicians and front desk personnel as needed.
Examples of evidence to demonstrate compliance may include:
Staff schedules

3-10 The program must provide ongoing faculty calibration at all sites where educational activity occurs.

Intent: Faculty calibration should be defined by the program.

Examples of evidence to demonstrate compliance may include:
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution must provide adequate and appropriately maintained facilities and learning resources to support the goals and objectives of the program.

Intent: The facilities should permit the attainment of program goals and objectives. Residents should have access to equipment and well-equipped operatories in the dental clinic that permit utilization of current concepts of practice. Equipment, current medications and protocols for treating medical emergencies, dental intra-oral and extra-oral radiographic facilities, equipment for managing medical emergencies, and library resources that include dental resources should be available. Equipment for handling medical emergencies and current medications for treating medical emergencies should be readily accessible. “Readily accessible” does not necessarily mean directly in the dental clinic. Protocols for handling medical emergencies should be developed and communicated to all staff in patient care areas.

Examples of evidence to demonstrate compliance may include:
Description of facilities

Selection of Residents

4-2 Applicants must have one of the following qualifications to be eligible to enter the advanced education program in general dentistry:

a) Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b) Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c) Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-3 Specific written criteria, policies and procedures must be followed when admitting residents.

Intent: Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and
selecting residents and how applicants are informed of their status throughout the selection process.

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

Written admission criteria, policies and procedures

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

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

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

Written policies and procedures on advanced standing

Results of appropriate qualifying examinations

Course equivalency or other measures to demonstrate equal scope and level of knowledge

4-5 The program’s description of the educational experience to be provided must be available to program applicants and include:

a) A description of the educational experience to be provided,

b) A list of goals and objectives or competencies for resident training, and

c) A description of the nature of assignments to other departments or institutions.

**Intent:** Programs are expected to make their lists of specific goals and objectives or competencies for resident training developed in response to Standards 2-1, 2-2,
2-3, and 2-4 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs to apply to. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

Examples of evidence to demonstrate compliance may include:
Brochure or application documents
Description of system for making information available to applicants who do not visit the program
Due Process

4-6 There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

Intent: Adjudication procedures should include institutional policy that provides due process for all individuals who may be potentially involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due process policy, and current accreditation status of the program.

Examples of evidence to demonstrate compliance may include:
Written policy statements and/or resident contract

Health Services

4-7 Residents, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and dental personnel.

Examples of evidence to demonstrate compliance may include:
Immunization policy and procedure documents
STANDARD 5 – PATIENT CARE SERVICES

5-1 The program must ensure the availability of adequate clinical patient experiences that afford all residents the opportunity to achieve the program’s written goals and objectives or competencies for resident training.

Examples of evidence to demonstrate compliance may include:
- Written goals and objectives or competencies for resident training
- Records of resident clinical activity, including specific details on the variety and type and quantity of cases treated and procedures performed
- Description of the method used to monitor the adequacy of patient experiences available to the residents and corrective actions taken if one or more resident is not receiving adequate patient experiences

5-2 Patient records must be organized in a manner that facilitates ready access to essential data and be sufficiently legible and organized so that all users can readily interpret the contents.

Intent: Essential data is defined by the program and based on the information included in the record review process as well as that which meets the multidisciplinary educational needs of the program.

The program is expected to develop a description of the contents and organization of patient records and a system for reviewing records.

Examples of evidence to demonstrate compliance may include:
- Record review plan
- Documentation of record review
- Patient records

5-3 The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.

Intent: Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.

Examples of evidence to demonstrate compliance may include:
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

5-4 All residents, faculty, and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

*Intent:* **ACLS and PALS are not a substitute for BLS certification.**

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program
Exemption documentation for anyone who is medically or physically unable to perform such services.

5-5 The program **must** document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies **must** provide to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases **must** be made available to applicants for admission and patients.

*Intent:* **The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.**

**Examples of evidence to demonstrate compliance may include:**
Infection and biohazard control policies
Radiation policy

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

**Examples of evidence to demonstrate compliance may include:**
Confidentiality policies
Consideration of the Use of the Term “Should” Within the Accreditation Standards
AGDOO RC
CODA Winter 2020

Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in General Practice Residency
Accreditation Standards For
Advanced Dental Education Programs in
General Practice Residency

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
General Practice Residency

Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 3, 2018</td>
<td>Accreditation Standards for Advanced Education Programs in General Practice Residency</td>
<td>Adopted and 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>August 2, 2019</td>
<td>Revised Definition of “Patients with special needs”</td>
<td>Adopted and Implemented</td>
</tr>
</tbody>
</table>
# Table of Contents

Mission Statement of the Commission on Dental Accreditation ..............................................5

Accreditation Status Definitions ........................................................................................................6

Introduction ........................................................................................................................................7

Goals ...................................................................................................................................................8

Accreditation of One- and Two-Year GPR Programs .................................................................8

Definition of Terms ............................................................................................................................9

Standard

1- Institutional and Program Effectiveness ....................................................................................11

2- Educational Program ................................................................................................................15

3- Faculty and Staff .........................................................................................................................23

4- Educational Support Services ..................................................................................................27

5- Patient Care Services ................................................................................................................30
Mission Statement of the Commission on Dental Accreditation

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

Commission on Dental Accreditation
Adopted: August 5, 2016
Accreditation Status Definitions

Programs That Are Fully Operational

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

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

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

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

Programs That Are Not Fully Operational

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

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

**Introduction**

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in General Practice Residency for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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

Although the standards are comprehensive and applicable to all institutions that offer advanced dental education programs in general dentistry programs, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession, and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in General Practice Residency provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in General Practice Residency are educational programs designed to provide training beyond the level of pre-doctoral education in oral health care, using applied basic and behavioral sciences. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates’ knowledge and skills to enable them to provide comprehensive oral health care to a wide range of population groups.

The goals of these programs should include preparation of the graduate to:
1. Act as a primary care provider for individuals and groups of patients. This includes: providing emergency and multidisciplinary comprehensive oral health care; providing patient focused care that is coordinated by the general practitioner; and directing health promotion and disease prevention activities.
2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively within the hospital and other health care environments.
5. Function effectively within interdisciplinary health care teams.
6. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making, and technology-based information retrieval systems.
7. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
8. Understand the oral health needs of communities and engage in community service.

Accreditation of One-Year and Two-Year GPR Programs

The Commission on Dental Accreditation will accredit the following types of General Practice Residency (GPR) programs: one-year programs, one-year programs with an optional second year of training where residents enroll for the second year of training during the first year, and two-year programs where residents enroll for two years at the beginning of the program. For programs offering an optional second year of training, accreditation of the program will be continued whether or not a resident is enrolled each year for the second year of training as long as there is enrollment of residents in the program’s first year.

The addition of an optional second year of training to an existing one-year program will be considered as a major change to that program rather than as the development of a separate new
program. Programs wishing to add an optional second year of training should contact Commission staff to acquire the appropriate forms for reporting a major change.
Definitions of Terms

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

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

**Competent:** The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

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

**Goals and Objectives:**

- **Program:** Educational goals that describe what the resident will be able to do upon completion of the program. These should describe the resident’s abilities rather than the educational experiences they participate in.

- **Resident Training:** Educational goals describing the levels of knowledge, skills and values attained when a particular activity is accomplished.

**HIPAA:** Health Insurance Portability and Accountability Act

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

**Interdisciplinary:** Including dentistry and other health care professions.

**Manage:** Coordinate the delivery of care using a patient-focused approach within the scope of their training. Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.

**May or could:** Indicates freedom or liberty to follow a suggested alternative.
**Mirrored Patient Records:** Records of actual patients prepared solely for training purposes.

**Multidisciplinary:** Including all disciplines within the profession of dentistry.

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

**Patients with special needs:** Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

**Should:** Indicates a suggested way to meet the standard; highly desirable, but not mandatory.

**Sponsor:** The institution that has the overall administrative control and responsibility for the conduct of the program.

**Resident:** The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission, goals and objectives.

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year

1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.
Intent: Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

Examples of evidence to demonstrate compliance may include:
Written agreements

1-6 The medical staff bylaws, rules, and regulations of the sponsoring, co-sponsoring, or affiliated hospital must ensure that dental staff members are eligible for medical staff membership and privileges including the right to:

a) vote and hold office;  
b) serve on medical staff committees; and  
c) manage patients.

Intent: Dental staff members have the same rights and privileges as other medical staff of the sponsoring, co-sponsoring or affiliated hospital, within the scope of practice.

Examples of evidence to demonstrate compliance may include:
All hospital bylaws related to a, b, and c.
Copy of institutional committee structure and/or roster of membership by dental faculty

1-7 Dental residents must be appointed to the house staff of the sponsoring, co-sponsoring, or affiliated hospital and have the same privileges and responsibilities provided residents in other professional education programs.

Examples of evidence to demonstrate compliance may include:
House staff roster  
Related hospital bylaws

1-8 The program must have written overall program goals and objectives that emphasize:

a) general dentistry,  
b) resident education,  
c) patient care, and  
d) community service and include training residents to provide oral health care in a hospital setting.
**Intent:** The “program” refers to the General Practice Residency that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standards 2-1, 2-2, 2-3 and 2-4. Specific learning objectives for residents are intended to be described as goals and objectives or competencies for resident training and included in the response to Standards 2-1, 2-2, 2-3, and 2-4. An example of overall goals can be found in the Goals section on page 8 of this document.

The program is expected to define community service within the institution’s developed goals and objectives.

**Examples of evidence to demonstrate compliance may include:**
Written overall program goals and objectives

1-9 The program **must** have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s overall goals and objectives are being met and make program improvements based on an analysis of that data.

**Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-8 are being met.

The outcomes process developed should include each of the following steps:
1. development of clear, measurable goals and objectives consistent with the program’s purpose/mission;
2. implementation of procedures for evaluating the extent to which the goals and objectives are met;
3. collection of data in an ongoing and systematic manner;
4. analysis of the data collected and sharing of the results with appropriate audiences;
5. identification and implementation of corrective actions to strengthen the program; and
6. review of the assessment plan, revision as appropriate, and continuation of the cyclical process.

**Examples of evidence to demonstrate compliance may include:**
Written overall program goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results
Ethics and Professionalism

1-10 The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

**Intent:** Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
Consideration of the Use of the Term “Should”
Within the Accreditation Standards
AGDOO RC
CODA Winter 2020

STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program must provide didactic and clinical training to ensure that upon completion of training, the resident is able to:

a) Act as a primary oral health care provider to include:
   1) providing emergency and multidisciplinary comprehensive oral health care;
   2) obtaining informed consent;
   3) functioning effectively within interdisciplinary health care teams, including consultation and referral;
   4) providing patient-focused care that is coordinated by the general practitioner; and
   5) directing health promotion and disease prevention activities.

b) Assess, diagnose, and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.

c) Manage the delivery of patient-focused oral health care.

Intent: “Patients with special needs” is defined in the Definition of Terms on page 10 of this document.

Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.

Examples of evidence to demonstrate compliance may include:
Written goals and objectives or competencies for resident training organized by the areas described above
Didactic and clinical schedules
Resident evaluations
Documentation of treatment planning sessions
Documentation of chart reviews
Records of resident clinical activity including procedures performed in each area described above
Documentation of case simulations

2-2 The program must have written goals and objectives or competencies for resident training and provide didactic and clinical training to ensure that upon completion of training the resident is able to provide the following at an advanced level of skill and/or case complexity beyond that accomplished in pre-doctoral training:
Consideration of the Use of the Term “Should” Within the Accreditation Standards
AGDOO RC
CODA Winter 2020

a) operative dentistry;
b) restoration of the edentulous space;
c) periodontal therapy;
d) endodontic therapy;
e) oral surgery;
f) evaluation and treatment of dental emergencies; and
g) pain and anxiety control utilizing behavioral and/or pharmacological techniques.

**Intent**: Determination of “complexity beyond that accomplished in a pre-doctoral training” may be from various aspects including, but not limited to: depth of topic discussion, variety of topic/procedures, quantity of topics/procedures, underlying medical/health considerations related to delivery of topic/procedures, etc.

**Examples of evidence to demonstrate compliance may include:**
Written goals and objectives or competencies for resident training organized by the areas described above
Didactic and clinical schedules
Records of resident clinical activity including procedures performed in each area described above
Patient records
Resident evaluations

2-3 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions in dentistry and medicine, designed to achieve the written goals and objectives or competencies for resident training.

**Intent**: The program is expected to organize the didactic and clinical educational experience into a formal curriculum plan.

For each specific goal or objective or competency described in response to Standard 2-1, 2-2, and 2-4, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

**Examples of evidence to demonstrate compliance may include:**
Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies
Didactic and clinical schedules
2-4 The program must provide training to ensure that upon completion of the program, the resident is able to manage the following:

a) medical emergencies;
b) implants;
c) oral mucosal diseases;
d) temporomandibular disorder, and
e) orofacial pain.

**Intent:** “Manage” is defined in the Definition of Terms on page 9 of this document.

The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident’s ability to manage the above areas.

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

- Written goals and objectives or competencies for resident training and proficiencies organized by the areas described above
- Didactic and clinical schedules
- Records of resident clinical activity including procedures performed in each area described above
- Patient records
- Resident evaluations

2-5 Residents must be assigned to an anesthesia rotation with supervised practical experience in the following:

a) preoperative evaluation;
b) assessment of the effects of behavioral and pharmacologic techniques;
c) venipuncture technique;
d) patient monitoring;
e) airway management;
f) understanding of the use of pharmacologic agents;
g) recognition and treatment of anesthetic emergencies; and
h) assessment of patient recovery from anesthesia.

**Intent:** Program directors should interact with the anesthesia department to determine the rotation length and methods necessary to meet the requirements of the standard.

*Generally a minimum of 70 hours is considered to provide the appropriate practical experience.*

**Examples of evidence to demonstrate compliance may include:**
Written rotation objectives
Rotation schedules including supervising faculty
Resident evaluations

2-6 Residents **must** be assigned to a rotation in medicine that has supervised practical experiences, to include:

   a) obtaining and interpreting the patient’s chief complaint, medical, and social history, and review of systems;
   b) obtaining and interpreting clinical and other diagnostic data from other health care providers;
   c) using the services of clinical, medical, and pathology laboratories; and
   d) performing a history and physical evaluation and collect other data in order to establish a medical assessment.

**Intent:** Program directors should interact with the relevant department to determine the rotation length and methods necessary to meet the requirements of the standard. Ideally, this rotation should be in a primary care setting. However, other medical settings that provide this experience are acceptable. Generally a minimum of 70 hours is considered to provide the appropriate practical experience.

Examples of evidence to demonstrate compliance may include:
Written rotation objectives
Rotation schedules including supervising faculty
Resident evaluations

2-7 The program **must** provide formal instruction in physical evaluation and medical assessment, including:

   a) taking, recording, and interpreting a complete medical history;
   b) understanding the indications of and interpretations of laboratory studies and other techniques used in the diagnosis of oral and systemic diseases;
   c) understanding the relationship between oral health care and systemic diseases; and
   d) interpreting the physical evaluation performed by a physician with an understanding of how it impacts on proposed dental treatment.

**Intent:** Residents should be able to interact appropriately with other health care providers. It is intended that medical assessment be conducted during formal instruction as well as during in-patient, same day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and
medical assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data is being recorded.

Examples of evidence to demonstrate compliance may include:
Didactic schedules
Course outlines
Resident evaluations

2-8 Each assigned rotation or experience must have:

a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c) evaluations performed by the designated supervisor.

Intent: This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-9 The program must provide instruction in the principles of practice management.

Intent: Suggested topics include: management of allied dental professionals and other office personnel; quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care.

Examples of evidence to demonstrate compliance may include:
Course outlines

2-10 The program must provide residents with an understanding of hospital organization, functioning, and credentialing process.

Intent: Information about the credentialing process, application for privileges, and hospital records protocol is expected to be included in the curriculum.

Examples of evidence to demonstrate compliance may include:
Didactic schedules

2-11 Residents **must** receive training and experience in the management of inpatients or same-day surgery patients, including:

- reviewing medical histories and physical examinations;
- prescribing treatment and medication;
- providing care in the operating room; and
- preparing the patient record, including notation of medical history, review of physical examination, pre- and post-operative orders, and description of surgical procedures.

**Intent:** These experiences should occur in conjunction with patients receiving dental care in the hospital operating room, ambulatory surgery clinic, same-day surgery clinic, or a free-standing surgical center. Where this is not possible, the experiences may occur on other services providing care in the same settings. Clinical experiences are expected to be supervised by an attending faculty member.

**Examples of evidence to demonstrate compliance may include:**
Evidence of resident participation in the activities listed above and evidence of attending faculty supervision (for example, patient records, mirrored patient records, co-signature on chart notes, coverage schedule, or attending notes)

Record review policy
Documentation of record review

2-12 Formal patient care conferences **must** be scheduled at least twelve (12) times a year.

**Intent:** Conferences should be distributed throughout the year so that diagnosis, treatment planning, progress, and outcomes can be followed and discussed. These conferences should be attended by residents and faculty and should not replace the daily faculty and resident interactions regarding patient care.

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

2-13 Residents **must** be given assignments that require critical review of relevant scientific literature.

**Intent:** Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care. This should include the development of critical evaluation skills and the ability to apply evidence-based principles to clinical decision-making.
Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

Program Length

2-14 The program must be one or two calendar years in length.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-15 Programs must be designed as either a one-year program, a one-year program with an optional second year or a mandatory two-year program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident training
Written curriculum plan
Schedules

2-16 Residents enrolled in the optional second year of training must have completed an accredited first year of a General Practice Residency or Advanced Education in General Dentistry training at this or another institution.

Examples of evidence to demonstrate compliance may include:
Resident records or certificate

2-17 The program must have written goals and objectives or competencies for resident didactic and clinical training in the optional second year of training that are at a higher level than those of the first year of the program.

Examples of evidence to demonstrate compliance may include:
Written second year goals and objectives or competencies for resident didactic and clinical training
Written curriculum plan

2-18 Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in no
more than two years of study for a one-year program and four years of study for a two-year program.

**Intent:** *Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.*

**Examples of evidence to demonstrate compliance may include:**
- Description of the part-time program
- Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
- Program schedules

**Evaluation**

2-19 The program’s resident evaluation system **must** assure that, through the director and faculty, each program:

a) periodically, but at least three times annually, evaluates and documents the resident’s progress towards achieving the program’s written goals and objectives or competencies for resident training using appropriate written criteria and procedures;

b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions must be taken; and

c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.

**Intent:** *While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-1, 2-2, 2-3, and 2-4. The final resident evaluation or final measurement of educational outcomes may count as one of the three evaluations.*

**Examples of evidence to demonstrate compliance may include:**
- Written evaluation criteria and process
- Resident evaluations
- Personal record of evaluation for each resident
- Evidence that corrective actions have been taken
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by a director who has authority and responsibility for all aspects of the program.

Intent: The program director’s responsibilities include:

a) program administration;
   b) development and implementation of the curriculum plan;
   c) ongoing evaluation of program content, faculty teaching and resident performance;
   d) evaluation of resident training and supervision in affiliated institutions and off-services rotations;
   e) maintenance of records related to the educational program; and
   f) resident selection.

It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:

1) what duties are assigned,
2) to whom they are assigned, and
3) what systems of communication are in place between the program director and individuals who have been assigned responsibilities.

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:
Program director’s job description
Job description of individuals who have been assigned some of the program director’s job responsibilities
Formal plan for assignment of program director’s job responsibilities as described above
Program records

3-2 Program directors appointed after January 1, 2008, who have not previously served as an Advanced Education in General Dentistry or General Practice Residency program director, must have completed an accredited Advanced Education in General Dentistry or General Practice Residency program.
Examples of evidence to demonstrate compliance may include:
Program director’s completed BioSketch

3-3 For each off-campus site, there must be an on-site clinical supervisor/director who is qualified by education and/or clinical experience in the curriculum areas for which he/she is responsible.

Examples of evidence to demonstrate compliance may include:
Completed BioSketch for on-site clinical supervisor/director
Written criteria used to certify a non-specialist faculty member as responsible for a specialty teaching area

3-4 All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dentistry included in the program.

Intent: Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible (e.g., the faculty member responsible for endodontics is not required to be an endodontist. Instead, it could be someone with current knowledge and appropriate level of experience in endodontics). The faculty, collectively, should have competence in all areas of dentistry covered in the program.

The program is expected to develop written criteria and qualifications that would enable a faculty member to be responsible for a particular specialty teaching area if that faculty member is not a specialist in that area. The program is expected to evaluate non-specialist faculty members who will be responsible for a particular specialty teaching area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of specialists as trained consultants for the development of a mission and curriculum, and for teaching.

Examples of evidence to demonstrate compliance may include:
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Written criteria used to certify a non-specialist faculty member as responsible for a specialty teaching area
Records of program documentation that non-specialist faculty members as responsible for a specialty teaching area
3-5 General dentists must have a significant role in program development and instruction.

**Intent:** General dentists are expected to be actively involved in developing the curriculum and clinical rotations, as well as in the instruction of the residents.

Examples of evidence to demonstrate compliance may include:
- Faculty meeting minutes
- Faculty roster
- Departmental policies
- Completed BioSketch of faculty members

3-6 A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

**Intent:** The written annual performance evaluations should be shared with the faculty members.

Examples of evidence to demonstrate compliance may include:
- Faculty files
- Performance appraisals

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

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

Examples of evidence to demonstrate compliance may include:
- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-8 A faculty member must be present in the dental clinic for consultation, supervision and active teaching when residents are treating patients in scheduled clinic sessions.

Intent: This statement does not preclude the rare situation where a faculty member cannot be available. This Standard applies not only to clinic sessions, but to any location or situation where residents are treating patients in scheduled sessions.

Examples of evidence to demonstrate compliance may include:
Faculty clinic schedules

3-9 At each site where educational activity occurs, adequate support staff must be consistently available to ensure:

a) residents do not regularly perform the tasks of allied dental personnel and clerical staff,
b) resident training and experience in the use of current concepts of oral health care delivery and
c) efficient administration of the program.

Intent: This statement is meant to emphasize the importance of a well-balanced dental staff that can help address aspects of the delivery of dentistry and the business of dentistry. The areas that are considered current concepts would be scheduling, insurance, dental assisting, dental hygiene and lab procedures. The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives. Allied support may include dental assistants, dental hygienists, dental laboratory technicians and front desk personnel as needed.

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-10 The program must provide ongoing faculty calibration at all sites where educational activity occurs.

Intent: Faculty calibration should be defined by the program.
Examples of evidence to demonstrate compliance may include:
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution must provide adequate and appropriately maintained facilities and learning resources to support the goals and objectives of the program.

*Intent:* The facilities should permit the attainment of program goals and objectives. Residents should have access to equipment and well-equipped operatories in the dental clinic that permit utilization of current concepts of practice. Equipment, current medications and protocols for treating medical emergencies, dental intra-oral and extra-oral radiographic facilities, equipment for managing medical emergencies, and library resources that include dental resources should be available. Equipment for handling medical emergencies and current medications for treating medical emergencies should be readily accessible. “Readily accessible” does not necessarily mean directly in the dental clinic. Protocols for handling medical emergencies should be developed and communicated to all staff in patient care areas.

Examples of evidence to demonstrate compliance may include:
Description of facilities

Selection of Residents

4-2 Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in general practice residency:

a) Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b) Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c) Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-3 Specific written criteria, policies and procedures must be followed when admitting residents.

*Intent:* Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.

Examples of evidence to demonstrate compliance may include:
Written admission criteria, policies and procedures
Admission of residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program. Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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

**Examples of evidence to demonstrate compliance may include:**
- Written policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

The program’s description of the educational experience to be provided must be available to program applicants and include:

a) A description of the educational experience to be provided,
b) A list of goals and objectives or competencies for resident training, and
c) A description of the nature of assignments to other departments or institutions.

**Intent:** Programs are expected to make their lists of specific goals and objectives or competencies for resident training developed in response to Standards 2-1, 2-2, 2-3, and 2-4 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs to apply to. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

**Examples of evidence to demonstrate compliance may include:**
- Brochure or application documents
- Description of system for making information available to applicants who do not visit the program
Due Process

4-6 There **must** be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

**Intent:** Adjudication procedures should include institutional policy that provides due process for all individuals who may potentially be involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the resident should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due process policy, and current accreditation status of the program.

Examples of evidence to demonstrate compliance may include:
Written policy statements and/or resident contract

Health Services

4-7 Residents, faculty and appropriate support staff **must** be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

Examples of evidence to demonstrate compliance may include:
Immunization policy and procedure documents
STANDARD 5 – PATIENT CARE SERVICES

5-1 The program must ensure the availability of adequate clinical patient experiences that afford all residents the opportunity to achieve the program’s written goals and objectives or competencies for resident training.

Examples of evidence to demonstrate compliance may include:
- Written goals and objectives or competencies for resident training
- Records of resident clinical activity, including specific details on the variety and type and quantity of cases treated and procedures performed
- Description of the method used to monitor the adequacy of patient experiences available to the residents and corrective actions taken if one or more resident is not receiving adequate patient experiences

5-2 Patient records must be organized in a manner that facilitates ready access to essential data and be sufficiently legible and organized so that all users can readily interpret the contents.

**Intent:** Essential data is defined by the program and based on the information included in the record review process as well as that which meets the multidisciplinary educational needs of the program.

The program is expected to develop a description of the contents and organization of patient records and a system for reviewing records.

Examples of evidence to demonstrate compliance may include:
- Patient records
- Record review plan
- Documentation of record reviews

5-3 The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.

**Intent:** Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.

Examples of evidence to demonstrate compliance may include:
- Description of quality improvement process including the role of residents in that process
- Quality improvement plan and reports
5-4 All residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

**Intent:** ACLS and PALS are not a substitute for BLS certification.  
**Examples of evidence to demonstrate compliance may include:** Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program  
Exemption documentation for anyone who is medically or physically unable to perform such services

5-5 The program must document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies must be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and patients.

**Intent:** The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.  
**Examples of evidence to demonstrate compliance may include:**  
Infection and biohazard control policies  
Radiation policy

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

**Examples of evidence to demonstrate compliance may include:**  
Confidentiality policies
Consideration of the Use of the Term “Should” Within the Accreditation Standards
AGDOO RC
CODA Winter 2020

Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology
Consideration of the Use of the Term “Should” Within the Accreditation Standards

Accreditation Standards For Advanced Dental Education Programs in Dental Anesthesiology

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678

(312) 440-4653
www.ada.org/coda

Copyright©2019
Commission on Dental Accreditation
All rights reserved. Reproduction is strictly prohibited without prior written permission

Dental Anesthesiology Standards -2-
### Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology

#### Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 25, 2007</td>
<td>Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology</td>
<td>Approved, Implemented</td>
</tr>
<tr>
<td>July 26, 2007</td>
<td>Standards to Ensure Program Integrity Examples of Evidence Modified (Standard 1-2)</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>July 26, 2007</td>
<td>Name Change: The Joint Commission on Accreditation of Healthcare Organizations to The Joint Commission</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 1, 2008</td>
<td>Revised Definition of Terms and Usage of Examples of Evidence</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>July 31, 2008</td>
<td>Addition of intent statement to Standard 1-5</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>January 29, 2009</td>
<td>Revised Standards 2-2 and 3-2</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>July 31, 2009</td>
<td>Revised Definition of Terms (Anxiety and Pain Control), Revised Standards 2-6 and 5-3</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 6, 2010</td>
<td>Revised Accreditation Status Definitions section</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2011</td>
<td>Revised Accreditation Status Definitions section</td>
<td>Implemented</td>
</tr>
<tr>
<td>February 4, 2011</td>
<td>Revised Standard 3-2</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>February 4, 2011</td>
<td>Ethics and Professionalism Standard (1-10)</td>
<td>Adopted</td>
</tr>
</tbody>
</table>
Consideration of the Use of the Term “Should” Within the Accreditation Standards

AGDOO RC
CODA Winter 2020

July 1, 2011  Ethics and Professionalism Standard (1-10)  Implemented
August 5, 2011  Addition of intent statement to Standard 5-4  Adopted and Implemented
August 9, 2012  Revised Mission Statement  Adopted and Implemented

Document Revision History (continued)

February 1, 2013  Revised definitions, Standards 2-4, 2-6, 2-7, 2-7, 2-8, 2-9, 2-10, 2-17, 3-2, 5-3, and 6-1, and removal of the words proficient and proficiency  Adopted
February 1, 2013  Addition of Standard 3-7  Adopted
July 1, 2013  Addition of Standard 3-7  Implemented
February 6, 2015  Revised Standard 1-1  Adopted, Implemented
February 6, 2015  Revised Standard 4-4  Adopted, Implemented
February 6, 2015  Addition of intent statement to Standard 4-4  Adopted, Implemented
July 1, 2015  Revised definitions, Standards 2-4, 2-6, 2-7, 2-7, 2-8, 2-9, 2-10, 2-17, 3-2, 5-3, and 6-1, and removal of the words proficient and proficiency  Implemented
August 7, 2015  Revision of term “student/resident” to “resident”; revision of definition of “student/resident.”  Approved, Implemented
February 5, 2016  Revised Accreditation Status Definitions  Approved, Implemented
August 5, 2016  Revised Standard 3-1  Approved
August 5, 2016  Revised Mission Statement  Adopted
January 1, 2017  Revised Mission Statement  Implemented
July 1, 2017  Revised Standard 3-1  Implemented
August 4, 2017  Revised Accreditation Status Definitions  Approved, Implemented
August 4, 2017  Revised Standards 1-5, 1-8, 1-9, 2-1, 2-2, 2-3, 2-6, 2-9, 2-11, 2-12, 2-17, 2-19, 3-3, 4-3, 4-4, 4-5, and 4-6 and new Standards 3-8 and 3-9  Adopted
July 1, 2018  Revised Standards 1-5, 1-8, 1-9, 2-1, 2-2, 2-3, 2-6, 2-9, 2-11, 2-12, 2-17, 2-19, 3-3, 4-3, 4-4, 4-5, and 4-6 and new Standards 3-8 and 3-9  Implemented

Dental Anesthesiology Standards
-4-
<table>
<thead>
<tr>
<th>Date</th>
<th>Revision Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<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>August 2, 2019</td>
<td>Revised Definition of “Patients with special needs”</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 2, 2019</td>
<td>Revised Standard 3-2</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2020</td>
<td>Revised Standard 3-2</td>
<td>Implemented</td>
</tr>
<tr>
<td>Standard</td>
<td>Topic</td>
<td>Page</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1</td>
<td>Institutional and Program Effectiveness</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>Educational Program</td>
<td>16</td>
</tr>
<tr>
<td>3-</td>
<td>Faculty and Staff</td>
<td>25</td>
</tr>
<tr>
<td>4-</td>
<td>Educational Support Services</td>
<td>29</td>
</tr>
<tr>
<td>5-</td>
<td>Facilities and Resources</td>
<td>32</td>
</tr>
<tr>
<td>6-</td>
<td>Research</td>
<td>34</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.

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

**Programs That Are Not Fully Operational**

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.
Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).
Introduction

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Dental Anesthesiology for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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

Although the standards are comprehensive and applicable to all institutions that offer advanced dental education programs in dental anesthesiology, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in Dental Anesthesiology provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in Dental Anesthesiology are educational programs designed to train the dental resident, in the most comprehensive manner, to use pharmacologic and non-pharmacologic methods to manage anxiety and pain of adults, children, and patients with special care needs undergoing dental, maxillofacial and adjunctive procedures, as well as to be qualified in the diagnosis and non-surgical treatment of acute orofacial pain and to participate in the management of patients with chronic orofacial pain.

The goals of these programs should include preparation of the graduate to:
1. Deliver anxiety and pain control services for emergency and comprehensive multidisciplinary oral health care.
2. Plan and provide anesthesia-related care for the full range of dental patients, including patients with special needs.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively within the hospital, dental office, ambulatory surgery center, and other health care environments.
5. Function effectively within interdisciplinary health care teams.
6. Apply scientific principles to learning and anesthesia-related oral health care. This includes using critical thinking, evidence- or outcomes-based clinical decision-making, and technology-based information retrieval systems.
7. Utilize the values of professional ethics, lifelong learning, patient-centered care, adaptability, and acceptance of cultural diversity in professional practice.
Definitions of Terms

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

**Anxiety and Pain Control**: Includes the following: analgesia; local anesthesia; minimal, moderate, and deep sedation; and general anesthesia as defined in the American Dental Association’s “Guidelines for the Use of Sedation and General Anesthesia by Dentists.”

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

**Competent**: The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

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

**In-Depth**: A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.

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

**Interdisciplinary**: Including dentistry and other health care professions.

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

**Multidisciplinary**: Including all disciplines within the profession of dentistry.

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

**Outpatient Anesthesia for Dentistry**: The administration of anesthesia services to patients who are discharged from anesthetic care within the same treatment day (same-day surgery) from a facility where only procedures within the scope of dental practice are carried out.
**Patients with special needs:** Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

**Should:** Indicates a suggested way to meet the standard; highly desirable, but not mandatory.

**Sponsor:** The institution which has the overall administrative control and responsibility for the conduct of the program.

**Resident:** The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 The program must be sponsored or co-sponsored by either a United States-based hospital, or educational institution or health care organization that is affiliated with an accredited hospital. Each sponsoring and co-sponsoring institution must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection, and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission and goals and objectives.

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year

1-5 Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. **Intent:** Sites where educational activity occurs include any dental practice setting (e.g., private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

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

1-6 The institutional staff bylaws, rules, and regulations of sponsoring, co-sponsoring or affiliated health care institutions must ensure that dentists are eligible for staff membership and privileges including the right to:

a) Vote and hold office;  
b) Serve on institutional staff committees; and  
c) Admit, manage, and discharge patients.

**Examples of evidence to demonstrate compliance may include:**
All institutional bylaws related to a, b, and c  
Copy of institutional committee structure and/or roster of membership by dental faculty

1-7 Dental residents must be appointed to the staff of the sponsoring, co-sponsoring or affiliated health care institution and enjoy the same privileges and responsibilities provided residents in other professional education programs.

**Examples of evidence to demonstrate compliance may include:**
Institutional staff roster  
Related institutional bylaws

**Intent:** Residents are to be appointed to at least one of the above noted institutions.

1-8 The program must develop a mission statement and supporting written overall program goals and objectives that emphasize:
a) anesthesia for dentistry, 
b) resident education, and 
c) patient care.

and include training residents to provide dental anesthesia care in office-based and hospital settings.

**Intent:** The “program” refers to the Dental Anesthesiology Residency that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standard 2-1 and 2-2. Specific learning objectives for residents are intended to be described as competency requirements and included in the response to Standards 2-1 and 2-2. An example of overall goals can be found in the Goals section on page 8 of this document.

**Examples of evidence to demonstrate compliance may include:**
Mission statement and supporting written program goals and objectives

1. The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s written goals and objectives are being met.

**Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-8 are being met and make program improvements based on an analysis of those data.

The outcomes process developed should include each of the following steps:
1. development of clear, measurable goals and objectives consistent with the program’s purpose/mission;
2. implementation of procedures for evaluating the extent to which the goals and objectives are met;
3. collection of data in an ongoing and systematic manner;
4. analysis of the data collected and sharing of the results with appropriate audiences;
5. identification and implementation of corrective actions to strengthen the program; and
6. review of the assessment plan, revision as appropriate, and continuation of the cyclical process.

**Examples of evidence to demonstrate compliance may include:**
Mission statement and supporting written goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results

**Ethics and Professionalism**

1-10 The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

*Intent:* Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program **must** list the written competency requirements that describe the intended outcomes of residents’ education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

**Intent:** The program is expected to develop specific competency-statements that describe what the resident will be able to do upon completion of the program. These statements should describe the resident’s abilities rather than educational experiences the residents may participate in. These competency statements are to be circulated to program faculty and staff and made available to applicants of the program.

**Examples of evidence to demonstrate compliance may include:**
Written competency requirements

2-2 Upon completion of training, the resident **must** be:

a) Able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;

b) Able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;

c) Competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients’ physiological and psychological factors;

d) Competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;

e) Competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;

f) Competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
g) Competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;

h) Competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region;

i) Familiar with the diagnosis and treatment of chronic pain related to the head and neck region; and

j) Able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

**Intent:** The program’s specific competency requirements and the didactic and clinical training and experiences in each area described above are expected to be at a level of skill and complexity beyond that accomplished in pre-doctoral training and consistent with preparing the dentist to utilize anxiety and pain control methods safely in the most comprehensive manner as set forth in the specific standards contained in this document.

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

- Written competency requirements
- Didactic coursework, including lecture schedules and assigned reading
- Case review conferences
- Records of resident clinical activity including procedures performed in each area described above
- Resident logs
- Patient records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards
- Resident evaluations

2-3 The program must have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program’s written competency requirements.

**Intent:** The program is expected to organize the didactic and clinical educational experience into a formal written curriculum plan.

For each specific competency statement described, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

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

Dental Anesthesiology Standards
Formal written curriculum plan with educational experiences tied to specific competency requirements
Didactic schedules
Clinical schedules

**Didactic Components**

**2-4** Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum must be provided and include:

a) Applied biomedical sciences foundational to dental anesthesiology,

*Intent:* Instruction should include physiology, pharmacology, anatomy, biochemistry, pathology, physics, pathophysiology, and clinical medicine as it applies to anesthesiology. The instruction should be sufficiently broad to provide for a thorough understanding of the body processes related to anxiety and pain control. Instruction should also provide an understanding of the mechanisms of drug action and interaction, as well as information about the properties of drugs used.

b) Physical diagnosis and evaluation,

*Intent:* This instruction should include taking, recording and interpreting a complete medical history and physical examination, and understanding the indications for and interpretations of diagnostic procedures and laboratory studies.

c) Behavioral medicine,

*Intent:* This instruction should include psychological components of human behavior as related to the management of anxiety and pain.

d) Methods of anxiety and pain control,

*Intent:* This instruction should include a detailed review of all methods of anxiety and pain control and pertinent topics (e.g., anesthesia delivery devices, monitoring equipment, airway management adjuncts, and perioperative management of patients).

e) Complications and emergencies,
Intent: This instruction should include recognition, diagnosis, and management of anesthesia-related perioperative complications and emergencies.

f) Pain management, and

Intent: This instruction should include information on pain mechanisms and on the evaluation and management of acute and chronic orofacial pain.

g) Critical evaluation of literature.

Intent: This instruction should include an understanding of scientific literature pertaining to dental anesthesiology and the development of critical evaluation skills, including an understanding of relevant research and statistical methodology.

Clinical Components

2-5 The program must ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program’s stated goals and competency requirements in dental anesthesiology.

Examples of evidence to demonstrate compliance may include:
Records of resident clinical activity, including specific details of the variety, type, and quantity of cases treated and procedures performed

2-6 The following list represents the minimum clinical experiences that must be obtained by each resident in the program at the completion of training:

a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
   (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty-five (25) advanced airway technique requirements can be blind nasal intubations.
   (2) One hundred and twenty-five (125) children age seven (7) and under, and
   (3) Seventy-five (75) patients with special needs,
b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation; and

c) Exposure to the management of patients with chronic orofacial pain.

**Intent:** The resident should be competent in the various methods of sedation and anesthesia for a variety of diagnostic and therapeutic procedures in the office or ambulatory care setting and the operating room. The resident should gain clinical experience in current monitoring procedures, fluid therapy, acute pain management and operating room safety. Instruction and experience in advanced airway management techniques are important parts of the training program and may include but are not limited to the following devices and techniques: blind nasal intubation, bougie, fiberoptic intubation, intubating laryngeal mask airway (LMA), light wand, and video laryngoscopes.

### General Anesthesia Experience/Anesthesia Service

2-7 At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period **must** be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

**Examples of evidence to demonstrate compliance may include:**
- Anesthesia rotation schedules
- Records of resident clinical activity

2-8 Residents **must** be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

**Intent:** This service should be under the direction of an anesthesiologist with a full time commitment, and each resident should participate in all of the usual duties and responsibilities of anesthesiology residents, including preanesthetic patient evaluation, administration of anesthesia in the operating room on a daily scheduled basis, postanesthetic patient management, and emergency call.

### Outpatient Anesthesia for Dentistry
At the completion of the program, each resident must have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

1. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.
2. Experience as the provider of supervised anesthesia care.

**Intent:** Adequate experience in the unique aspects of dental anesthesia care with and without the use of an anesthesia machine and operating room facilities should be provided. Supervising dentist anesthesiologists shall have completed a CODA-accredited dental anesthesiology residency program or a two-year anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable provided that continuous significant practice of general anesthesia in the previous two years is documented.

**Examples of evidence to demonstrate compliance may include:**
Anesthesia rotation schedules
Records of resident clinical activity
Schedules of dental anesthesia faculty

**Medicine Rotations**

Residents must participate in at least four (4) months of clinical rotations from the following list. If more than one rotation is selected, each must be at least one month in length.

a) Cardiology,
b) Emergency medicine,
c) General/internal medicine,
d) Intensive care,
e) Pain medicine,
f) Pediatrics,
g) Pre-anesthetic assessment clinic (max. one [1] month), and
h) Pulmonary medicine.

**Intent:** The dental anesthesia resident should have a strong foundation in clinical medicine that can be achieved through rotations in the above-mentioned areas. When the
resident entering the program has minimal clinical medicine experience, the program director should attempt to increase the time in these rotations beyond the minimum number of months required. The goal is to give the resident experience in medical evaluation and long-term management of patients. Therefore, only one month of the four months of this requirement may be met in the pre-anesthetic assessment clinic, although longer periods of time may be arranged as desired.

**Examples of evidence to demonstrate compliance may include:**
Description and schedule of rotations

2-11 Each assigned rotation or experience **must** have:

a) Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and
c) Evaluations performed by designated faculty.

**Intent:** This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.

**Examples of evidence to demonstrate compliance may include:**
Written objectives of rotations
Description and schedule of rotations
Resident evaluation reports

2-12 Residents **must** be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

**Intent:** Programs are expected to define the educational goals or competency statements in this area. Residents should be able to interact appropriately with other health care providers.

**Examples of evidence to demonstrate compliance may include:**
Consultation records or patient records
Written competency requirements
Resident evaluations

Dental Anesthesiology Standards
-24-
2-13 The program must provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a) Taking, recording, and interpreting a complete medical history;

b) Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;

c) Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and

d) Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

**Intent:** It is intended that medical risk assessment be conducted during formal instruction as well as during in-patient, same-day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and medical risk assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data are being recorded.

**Examples of evidence to demonstrate compliance may include:**
- Course outlines
- Patient records
- Resident evaluations
- Record review policy
- Documentation of record review

**Other Components**

2-14 The program must provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

**Intent:** Information about the credentialing processes involved in hospitals, free-standing surgical centers, and private offices should be provided.

**Examples of evidence to demonstrate compliance may include:**
- Didactic schedules

2-15 Residents must be given assignments that require critical review of relevant scientific literature.

**Intent:** Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care.

**Examples of evidence to demonstrate compliance may include:**
Evidence of experiences requiring literature review

2-16 The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.

Intent: Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.

Examples of evidence to demonstrate compliance may include:
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

Program Length

2-17 The duration of a dental anesthesiology program must be a minimum of thirty six (36) months of full-time formal training.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-18 Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

Intent: Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-19 The program’s resident evaluation system must assure that, through the director and faculty, each program:
Consideration of the Use of the Term “Should” Within the Accreditation Standards

AGDOO RC
CODA Winter 2020

a) Periodically, but at least twice annually, evaluates and documents the resident’s progress towards achieving the program’s written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;
b) Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and
c) Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

**Intent:** While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific competency and anesthesia case requirements described in response to Standards 2-1, 2-2, and 2-6.

**Examples of evidence to demonstrate compliance may include:**
Written evaluation criteria and process
Resident evaluations
Resident case logs
Personal record of evaluation for each resident
Evidence that corrective actions have been taken
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by a director with at least a forty percent (40%) appointment in the sponsoring or co-sponsoring institution and have authority and responsibility for all aspects of the program.

Intent: The program director’s responsibilities include:
1. program administration;
2. development and implementation of the curriculum plan;
3. ongoing evaluation of program content, faculty teaching and resident performance;
4. evaluation of resident training and supervision in affiliated institutions and off-services rotations;
5. maintenance of records related to the educational program; and
6. Resident selection.

It is expected that program directors will devote sufficient time to accomplish the assigned duties and responsibilities. In programs where the program director assigns some duties to other individuals, it is expected that the program will develop a formal plan for such assignments that includes:
1. what duties are assigned;
2. to whom they are assigned; and
3. what systems of communication are in place between the program director and individuals who have been assigned responsibilities.

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:
Program director’s job description
Job description of individuals who have been assigned some of the program director’s job responsibilities
Formal plan for assignment of program director’s job responsibilities as described above
Program records

3-2 The program director must be board certified in dental anesthesiology. Program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology. The program director must have
completed a CODA-accredited 36-month anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards. A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable.

**Intent:** The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology.

**Examples of Evidence to demonstrate compliance may include:**
- Certificate of completion of anesthesiology residency
- Copy of board certification certificate
- Letter from board attesting to current/active board certification

**3-3** All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of dental anesthesiology included in the program.

**Intent:** Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible. The faculty, collectively, should have competence in all areas of dental anesthesiology covered in the program.

The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of dental anesthesiology if that faculty member is not trained in dental anesthesiology. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of discipline-specific faculty as trained consultants for the development of a mission and curriculum, and for teaching.

**Examples of evidence to demonstrate compliance may include:**
- Full and part-time faculty rosters
- Program and faculty schedules
- Completed BioSketch of faculty members
- Written criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of dental anesthesiology
Program documentation that non-discipline specific faculty members are responsible for teaching an area of dental anesthesiology
Program documentation that faculty members are responsible for a particular teaching area

3-4 The number and time commitment of the faculty must be sufficient to provide didactic and clinical instruction to meet curriculum competency requirements and provide supervision of all treatment provided by residents.

Examples of evidence to demonstrate compliance may include:
Faculty roster
Clinical and didactic schedules

3-5 A formally defined evaluation process must exist that ensures measurement of the performance of faculty members annually.

Intent: The written annual performance evaluations should be shared with the faculty members.

Examples of evidence to demonstrate compliance may include:
Faculty files
Performance appraisals

3-6 A faculty member must be present in the clinical care area for consultation, supervision and active teaching when residents are treating patients.

Examples of evidence to demonstrate compliance may include:
Faculty clinic schedules

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

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

Examples of evidence to demonstrate compliance may include:
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-8 At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, **must** be consistently available to allow for efficient administration of the program.

*Intent:* The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives.

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

3-9 The program **must** provide ongoing faculty calibration at all sites where educational activity occurs.

*Intent:* Faculty calibration should be defined by the program.

**Examples of evidence to demonstrate compliance may include:**
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution must provide adequate learning resources to support the goals and objectives of the program.

**Intent:** Appropriate information resources should be readily available and include access to electronic databases, biomedical textbooks, dental journals, the internet and other learning resources. Lecture and seminar rooms and study areas for residents should be available.

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

**Selection of Residents**

4-2 Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in dental anesthesiology:

a. Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b. Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c. Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

4-3 Specific written criteria, policies, and procedures must be followed when admitting residents.

**Intent:** Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.

**Examples of evidence to demonstrate compliance may include:**
Written criteria, policies, and procedures

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

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

**Examples of evidence to demonstrate compliance may include:**
- Written policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

The program’s description of the educational experience to be provided **must** be available to program applicants and include:

a) A description of the educational experience to be provided
b) A list of competencies of residency training
c) A description of the nature of assignments to other departments or institutions

**Intent:** Programs are expected to make their lists of competency requirements developed in response to Standards 2-1 and 2-2 available to all applicants to the program. This includes applicants who may not personally visit the program and applicants who are deciding which programs for which to apply. Materials available to applicants who visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

**Examples of evidence to demonstrate compliance may include:**
- Program brochure, application documents or website content
- Description of system for making information available to applicants who do not visit the program
Due Process

4-6 There must be specific written due-process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

**Intent:** Adjudication procedures should include institutional policy that provides due process for all individuals who may potentially be involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due-process policy, and current accreditation status of the program.

**Examples of evidence to demonstrate compliance may include:**
Written policy statements and/or resident contract

Health Services

4-7 Resident, faculty, and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

**Examples of evidence to demonstrate compliance may include:**
Immunization policy and procedure documents
STANDARD 5 - FACILITIES AND RESOURCES

5-1 Institutional facilities and resources **must** be adequate to provide the didactic and clinical experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies **must** be readily accessible and functional.

**Intent:** The facilities and resources (e.g., support/secretarial staff, allied personnel, and/or technical staff) should permit the attainment of program competency requirements. To ensure health and safety for patients, residents, faculty, and staff, the physical facilities and equipment should effectively accommodate the educational and patient care programs. Equipment and supplies for delivery of all forms of anesthesia care for dental patients should be readily accessible and functional. There should be a space properly equipped for monitoring patients’ recovery from general anesthesia and sedation.

5-2 In cases where off-campus locations are used in residency clinical education, the facilities, equipment, staffing, and supplies **must** be available in accord with all applicable accrediting bodies and state rules and regulations.

**Examples of evidence to demonstrate compliance may include:** Certifications of current compliance/accreditation by appropriate governmental/accrediting agencies

5-3 All residents and those faculty utilizing general anesthesia or moderate sedation in the direct provision of patient care **must** be continuously recognized/certified in advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

**Examples of evidence to demonstrate compliance may include:** Certification/recognition records demonstrating advanced cardiovascular life support training or summary log of certification/recognition maintained by the program

5-4 All other faculty (not included in Standard 5-3) and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support for health care providers.

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program

5-5 Secretarial and clerical assistance must be sufficient to permit efficient operation of the program.

**Intent:** The intent is to ensure operations of the program are managed in an efficient and expeditious manner without placing undue hardship on the faculty and residents in the program.

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

5-6 The program must document its compliance with the institution’s policy and applicable regulations of local, state, and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies must be provided to all residents, faculty, and appropriate support staff and be continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and to patients.

**Intent:** The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.

**Examples of evidence to demonstrate compliance may include:**
Infection and biohazard control policies
Radiation policy

5-7 The program’s policies must ensure that the confidentially of information pertaining to the health status of each individual patient is strictly maintained.

**Examples of evidence to demonstrate compliance may include:**
Confidentiality policy
HIPAA policy
STANDARD 6 – RESEARCH

6-1 Residents must engage in at least one (1) month of scholarly activity and present their results in a scientific/educational forum.

**Intent:** One (1) month of scholarly activity could be gained in one (1) block or in smaller segments. Scholarly activity may include a hypothesis-driven research project, formal case review or review of literature. Options for advanced academic degrees are highly desirable.
Accreditation Standards For Advanced Dental Education Programs in Oral Medicine

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 Oral Medicine

Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2, 2019</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Oral Medicine</td>
<td>Adopted and Implemented</td>
</tr>
</tbody>
</table>
# Table of Contents

| Mission Statement of the Commission on Dental Accreditation | 5 |
| Accreditation Status Definitions | 6 |
| Introduction | 7 |
| Goals | 8 |
| Definition of Terms | 9 |

**Standards:**

| 1- Institutional and Program Effectiveness | 10 |
| 2- Educational Program | 14 |
| 3- Faculty and Staff | 19 |
| 4- Facilities and Regulatory Compliance | 23 |
| 5- Advanced Education Residents | 25 |
| 6- Research | 28 |
Mission Statement of the Commission on Dental Accreditation

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

Commission on Dental Accreditation
Adopted: August 5, 2016
Accreditation Status Definitions

Programs That Are Fully Operational

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

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

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

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

Programs That Are Not Fully Operational

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Oral Medicine for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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

Although the standards are comprehensive and applicable to all institutions which offer post-doctoral dental programs, the Commission recognizes that methods of achieving standards may vary according to the size, type and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in Oral Medicine provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in Oral Medicine are educational programs designed to provide training beyond the level of pre-doctoral education in oral health care, using applied basic and behavioral sciences. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates’ knowledge and skills to enable them to provide comprehensive oral health care to a wide range of population groups.

The goals of these programs should include preparation of the graduate to:

1. Act as a primary care provider for individuals with chronic, recurrent and medically related disorders of the oral and maxillofacial region, at a level and depth beyond the level of pre-doctoral education.
2. Provide consultative services to physicians and dentists treating patients with chronic, recurrent and medically related disorders of the oral and maxillofacial region.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively and efficiently in multiple health care environments and within interdisciplinary health care teams.
5. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making and technology-based information retrieval systems.
6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
7. Understand the oral health needs of communities and engage in community service.
Key verbs used in this document (i.e., Must, should, could and may) were selected carefully and indicate the relative weight that the commission attaches to each statement. The definition of these words as used in the standards follows:

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

**Should:** Indicates a method to achieve the standards.

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

**Levels of Skills:**

**Competent:** The level of skill displaying special ability or knowledge derived from training and experience.

**Other Terms:**

**Affiliated institution:** an institution that has the responsibility of supporting the advanced dental education programs in the area of oral medicine.

**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 programs in the area of oral medicine.

**Sponsoring institution:** an institution with the primary responsibility for advanced dental education programs in the area of oral medicine.

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

**Intent:** Intent statements are presented to provide clarification to the Advanced Dental Education Programs in Oral Medicine in the application of and in connection with compliance with the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine. 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.

**Resident:** The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 Each sponsoring or co-sponsoring United States-based educational institution, hospital or health care organization must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission, goals and objectives.

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year
Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

**Intent**: Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

**Examples of evidence to demonstrate compliance may include:**
- Written agreements

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution.

The medical staff bylaws, rules and regulations of the sponsoring, co-sponsoring or affiliated hospital must ensure that dental staff members are eligible for medical staff membership and privileges.

**Intent**: Dental staff members have the same rights and privileges as other medical staff of the sponsoring, co-sponsoring or affiliated hospital, within the scope of practice.

**Examples of evidence to demonstrate compliance may include:**
- All hospital bylaws
- Copy of institutional committee structure and/or roster of membership by dental faculty

Residents must have the same privileges and responsibilities provided residents in other professional education programs.

**Examples of evidence to demonstrate compliance may include:**
- Bylaws or documents describing resident privileges

Resources and time must be provided for the proper achievement of educational obligations.

**Intent**: The educational mission should not be compromised by reliance on residents to fulfill institutional service, teaching or research obligations.
1-10 The program must have written overall program goals and objectives which emphasize:

1) oral medicine,
2) resident education,
3) patient care,
4) community service, and
5) research.

**Intent:** The “program” refers to the advanced education program in oral medicine which is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the training program rather than specific learning objectives for areas of training as described in Standards 2-10, 2-12 and 2-14. Specific learning objectives for residents are intended to be described as goals and objectives or competencies for resident training and included in the response to Standards 2-10, 2-12 and 2-14. An example of overall goals can be found in the Goals section on page 8 of this document.

The program is expected to define community service within the institution’s developed goals and objectives.

**Examples of evidence to demonstrate compliance may include:**
Written overall program goals and objectives

1-11 The program must have a formal and ongoing outcomes assessment process which regularly evaluates the degree to which the program’s overall goals and objectives are being met.

**Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-10 are being met and make program improvements based on an analysis of that data.

The outcomes process should include each of the following:

1. development of clear, measurable goals and objectives consistent with the program’s purpose/mission,
2. implementation of procedures for evaluating the extent to which the goals and objectives are met,
3. collection of data in an ongoing and systematic manner,
4. analysis of the data collected and sharing of the results with appropriate audiences,
5. identification and implementation of corrective actions to strengthen the program and
6. review of the assessment plan, revision as appropriate and continuation of the cyclical process.

Examples of evidence to demonstrate compliance may include:
Written overall program goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results
Records of successful completion of the American Board of Oral Medicine examination

Ethics and Professionalism

1-12 The program must ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

Intent: Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program must be designed to provide distinct and separate knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards as set forth in this document.

**Intent:** The goal of the curriculum is to allow the resident to attain knowledge and skills representative of a clinician competent in the theoretical and practical aspects of oral medicine. The curriculum should provide the resident with the necessary knowledge and skills to enter a profession of academics, research or clinical care in the field of oral medicine.

2-2 The program must have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program’s written goals and objectives and competencies.

**Intent:** The program is expected to organize the didactic and clinical educational experiences into a formal written curriculum plan.

Program Duration

2-3 The duration of the program must be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

2-4 At least one continuous year of clinical education must take place in a single educational setting.

2-5 If the program enrolls part-time residents, there must be written guidelines regarding enrollment and program duration.

2-6 Part-time residents must start and complete the program within a single institution, except when the program is discontinued or relocated.

**Intent:** The director of an accredited program may enroll residents on a part-time basis providing that (1) residents are also enrolled on a full-time basis, (2) the educational experiences, including the clinical experiences and responsibilities, are equivalent to those acquired by full-time residents and (3) there are an equivalent number of months spent in the program.
Residents enrolled on a part-time basis must be continuously enrolled and complete the program in a period of time not to exceed twice the duration of the program length for full-time residents.

**Biomedical Sciences**

Education in the biomedical sciences must provide the scientific basis needed to understand and carry out the diagnostic and therapeutic skills required of the clinical, academic and research aspects of oral medicine.

**Intent:** Various methods may be used for providing formal instruction, such as traditional course presentations, seminars, self-instruction module systems and rotations through hospital, clinical and research departments. It is recognized that the approach to be utilized will depend on the availability of teaching resources and the educational policies of the individual school and/or department.

A distinct written curriculum must be provided in internal medicine.

Formal instruction in the biomedical sciences must enable graduates to:

a) detect and diagnose patients with complex medical problems that affect various organ systems and/or the orofacial region according to symptoms and signs (subjective/objective findings) and appropriate diagnostic tests;

b) employ suitable preventive and/or management strategies (e.g. pharmacotherapeutics) to resolve oral manifestations of medical conditions or orofacial problems; and

c) critically evaluate the scientific literature, update their knowledge base and evaluate pertinent scientific, medical and technological issues as they arise.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Didactic Schedules
- Resident Evaluations

Formal instruction must be provided in each of the following:

a) anatomy, physiology, microbiology, immununology, biochemistry, neuroscience and pathology concepts used to assess patients with complex medical problems that affect various organ systems and/or the orofacial region;
b) pathogenesis and epidemiology of orofacial diseases and disorders;

c) concepts of molecular biology and molecular basis of genetics;

d) aspects of internal medicine and pathology necessary to diagnose and treat orofacial diseases;

e) concepts of pharmacology including the mechanisms, interactions and effects of prescription and over-the-counter drugs in the treatment of general medical conditions and orofacial diseases;

f) principles of nutrition, especially as related to oral health and orofacial diseases;

g) principles of research such as biostatistics, research methods, critical evaluation of clinical and basic science research and scientific writing; and

h) behavioral science, to include communication skills with patients, psychological and behavioral assessment methods, modification of behavior and behavioral therapies.

Example of Evidence to demonstrate compliance may include:
Course outlines
Didactic Schedules
Resident Evaluations

Clinical Sciences

2-12 The educational program must provide training to the level of competency for the resident to:

a) perform a comprehensive physical evaluation and medical risk assessment on patients who have medically complex conditions and make recommendations for dental treatment plans and modifications;

b) select and provide appropriate diagnostic procedures including bodily fluid studies, cytology, culture and biopsy for outpatients and inpatients to support or rule out diagnoses of underlying diseases and disorders;

c) establish a differential diagnosis and formulate an appropriate working diagnosis prognosis, and management plan pertaining but not limited to:

1. oral mucosal disorders,
2. medically complex patients,
3. salivary gland disorders,
4. acute and chronic orofacial pain, and
5. orofacial neurosensory disorders.

Oral Medicine Standards

-17-
d) critically evaluate the results and adverse effects of therapy;

e) ameliorate the adverse effects of prescription and over-the-counter products and medical and/or dental therapy;

f) communicate effectively with patients and health care professionals regarding the nature, rationale, advantages, disadvantages, risks and benefits of the recommended treatment;

g) interpret and document the advice of health care professionals and integrate this information into patient treatment; and

h) organize, develop, implement and evaluate disease control and recall programs for patients.

Examples of Evidence to demonstrate compliance may include:
Written competency statements organized by areas described above
Course outlines
Records of resident clinical activity
Patient records
Resident evaluations

2-13 The educational program must provide ongoing departmental seminars and conferences, directed by the teaching staff to augment the clinical education.

**Intent:** These sessions should be scheduled and structured to provide instruction in the broad scope of oral medicine and related sciences and should include retrospective audits, clinicopathological conferences, pharmacotherapeutics, research updates and guest lectures. The majority of teaching sessions should be presented by members of the teaching staff.

2-14 The educational program must provide training to the level of competency for the resident to select and provide appropriate diagnostic imaging procedures and the sequential interpretation of images to support or rule out the diagnosis of head and neck conditions.

2-15 The educational program must ensure that each resident diagnose and treat an adequate number and variety of cases to a level that (a) the conditions are resolved or stabilized and (b) predisposing, initiating and contributory factors in the etiology of the diseases or conditions are controlled.

2-16 The educational program must ensure that each resident prepares and presents departmental clinical conferences.
2-17 Clinical medical experiences **must** be provided via rotation through various relevant medical services and participation in hospital rounds.

**Intent:** *At least two months of the total program length should be in hospital medical service rotations.*

2-18 If residents participate in teaching activities, their participation **must** be limited so as not to interfere with their educational process.

**Intent:** *The teaching activities should not exceed on average ½ day per week.*

2-19 Each assigned rotation or experience **must** have:

a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c) evaluations performed by the designated supervisor.

**Intent:** *This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.*

**Examples of evidence to demonstrate compliance may include:**
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-20 The program **must** provide instruction in the principles of practice management.

**Intent:** *Suggested topics include: management of allied dental professionals and other office personnel; quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care.*

**Examples of evidence to demonstrate compliance may include:**
Course outlines
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by an appointed director who is full-time faculty and who is board certified in oral medicine.

Examples of evidence to demonstrate compliance may include:
Program Director’s completed BioSketch
Copy of board certification certificate
Letter from board attesting to current/active board certification

3-2 The program director must have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program.

Intent: The program director’s responsibilities include:
  a) selecting residents;
  b) developing and implementing the curriculum;
  c) utilizing faculty to offer a diverse educational experience in biomedical, behavioral and clinical sciences;
  d) facilitating the cooperation between oral medicine, general dentistry, related dental specialties, medicine and other health care disciplines;
  e) evaluating and documenting resident training, including training in affiliated institutions;
  f) documenting educational and patient care records as well as records of resident attendance and participation in didactic and clinical programs,
  g) ensuring quality and continuity of patient care;
  h) ensuring research opportunities for the residents;
  i) planning for and operation of facilities used in the program;
  j) training of support staff at an appropriate level; and
  k) preparing and encouraging graduates to seek certification by the American Board of Oral Medicine.

Examples of evidence to demonstrate compliance may include:
Program director’s job description
Job description of individuals who have been assigned some of the program director’s job responsibilities
Program records

3-3 All sites where educational activity occurs must be staffed by an appropriate number of full- and part-time faculty who are qualified by education and/or clinical experience in the
curriculum areas for which they are responsible and have collective competence in all areas of oral medicine included in the program.

**Intent:** Faculty should have current knowledge at a level appropriate to their teaching responsibilities. The faculty, collectively, should have competence in all areas of oral medicine covered in the program. The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of oral medicine if that faculty member is not trained in oral medicine. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of discipline-specific faculty as trained consultants for the development of a mission and curriculum, and for teaching.

**Examples of evidence to demonstrate compliance may include:**
- Full and part-time faculty rosters
- Program and faculty schedules
- Completed BioSketch of faculty members
- Criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of oral medicine
- Records of program documentation that non-discipline specific faculty members as responsible for teaching an area of oral medicine

3-4 A formally defined evaluation process must exist that ensures measurements of the performance of faculty members annually and that facilitates improvement of faculty performance.

**Intent:** The written annual performance evaluations should be shared with the faculty members to monitor and improve faculty performance.

**Examples of evidence to demonstrate compliance may include:**
- Performance appraisal schedules
- Evaluation instruments

3-5 A faculty member must be present for consultation, supervision and/or active teaching when residents are treating patients.

**Examples of evidence to demonstrate compliance may include:**
Faculty clinic schedules
Patient records

3-6 Full-time faculty must have adequate time to develop and foster advances in their own education and capabilities in order to ensure their constant improvement as teachers, clinicians and/or researchers.

Examples of evidence to demonstrate compliance may include:
Faculty schedules
Completed BioSketch for faculty

3-7 At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for resident training and to ensure efficient administration of the program.

Intent: The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives.

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-8 The program director and staff must actively participate in the assessment of the outcomes of the educational program.

3-9 The program must show evidence of an ongoing faculty development process.

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

Examples of evidence to demonstrate compliance may include:
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Resident assessment
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-10 The program **must** provide ongoing faculty calibration at all sites where educational activity occurs.

**Intent:** *Faculty calibration should be defined by the program.*

**Examples of evidence to demonstrate compliance may include:**
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – FACILITIES AND REGULATORY COMPLIANCE

4-1 The sponsoring institution must provide adequate and appropriately maintained facilities and learning resources to support the goals and objectives of the program and include access to:
   a) a hospital environment;
   b) well-organized and modern radiographic/imaging facilities;
   c) personnel who are competent in using advanced imaging modalities;
   d) hospital, medical and clinical laboratory facilities to enhance the clinical program;
   e) facilities that support research;
   f) clinical photographic equipment;
   g) audiovisual capabilities and resources to reproduce images and other patient records;
   h) dental and biomedical libraries;
   i) computers and computer services for educational and research purposes throughout the resident training program, including internet access; and
   j) adequate resident personal work space.

4-2 All residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

Intent: ACLS and PALS are not a substitute for BLS certification.

Examples of evidence to demonstrate compliance may include:
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program
Exemption documentation for anyone who is medically or physically unable to perform such services

4-3 The program must document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies must be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and patients.

Intent: The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.
Examples of evidence to demonstrate compliance may include:
Infection and biohazard control policies
Radiation policy
Evidence of program compliance with policies and regulations

4-4 The program’s policies must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained to comply with local, state and federal regulatory agencies.

Examples of evidence to demonstrate compliance may include:
Confidentiality policies
STANDARD 5 – ADVANCED EDUCATION RESIDENTS

Selection of Residents

5-1 Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in oral medicine:

a) Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b) Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c) Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.

5-2 Specific written criteria, policies and procedures must be followed when admitting residents.

Intent: Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.

Examples of evidence to demonstrate compliance may include:
Written admission criteria, policies and procedures

5-3 Admission of residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program.

5-4 Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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

Examples of evidence to demonstrate compliance may include:
Written policies and procedures on advanced standing
Results of appropriate qualifying examinations
Course equivalency or other measures to demonstrate equal scope and level of knowledge

Evaluation

5-5 The program’s resident evaluation system must assure that, through the director and faculty, each program:

   a) periodically, but at least two times annually, evaluates and documents the resident’s progress toward achieving the program’s written goals and objectives or competencies for resident training using appropriate written criteria and procedures;
   b) provides residents with an assessment of their performance after each evaluation; and
   c) maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Intent: The program should employ evaluation methods that measure a resident’s skills or behavior at a given time. It is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standards 2-10, 2-12 and 2-14. Where deficiencies are noted, corrective actions are taken. The final resident evaluation or final measurement of educational outcomes may count as one of the two annual evaluations.

Examples of evidence to demonstrate compliance may include:
Written evaluation criteria and process
Resident evaluations
Personal record of evaluation for each resident
Evidence that corrective actions have been taken

Due Process
5-6 There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

**Intent:** Adjudication procedures should include institutional policy that provides due process for all individuals who may be potentially involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information which affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the resident should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due process policy, and current accreditation status of the program.

**Examples of evidence to demonstrate compliance may include:**
Written policy statements and/or resident contract

5-7 The program’s description of the educational experience must be available in written form to program applicants and include:

- a) a description of the curriculum and program requirements;
- b) a list of goals, objectives, and competencies for resident training;
- c) a description of the nature of assignments to other departments or institutions and teaching commitments; and
- d) obligations and responsibilities to the institution, the program and program faculty.

**Intent:** The description should include information that allows the resident to understand the educational experience. This should also include information pertaining to: (1 tuition, stipend or other compensation; (2) vacation and sick time; (3) practice privileges and other activities outside the educational program; (4) professional liability coverage; (5) due process policy, and (6) the current accreditation status of the program.

**Examples of evidence to demonstrate compliance may include:**
Brochure or application documents
Description of information available to applicants who do not visit the program

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

**Intent:** Residents, faculty and support staff should have access to health care services.

**Examples of evidence to demonstrate compliance may include:**
Immunization policy and procedure documents
STANDARD 6 – RESEARCH

Residents must engage in research or scholarly activity.

**Intent:** The resident should understand research methodology, biostatistics and epidemiology. Residents should participate in journal club and research seminars that discuss ongoing research, future projects, and results. Residents in certificate programs should participate in scholarly activity and be encouraged to publish the results. Residents in degree programs should complete an original research project and be encouraged to publish the results.
Consideration of the Use of the Term “Should” Within the Accreditation Standards

AGDOO RC
CODA Winter 2020

Commission on Dental Accreditation

Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain
Accreditation Standards For
Advanced Dental Education Programs in
Orofacial Pain

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
Orofacial Pain

Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 5, 2016</td>
<td>Accreditation Standards for Advanced General Dentistry Education Programs in Orofacial Pain</td>
<td>Approved</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>July 1, 2017</td>
<td>Accreditation Standards for Advanced General Dentistry Education Programs in Orofacial Pain</td>
<td>Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Accreditation Status Definitions</td>
<td>Approved, Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Standards 1-5, 1-9, 1-10, 2-2, 2-3, 2-4, 2-12, 2-18, 2-20, 3-3, 3-6, 4-6, 4-7, 4-9 and 5-1 and new Standard 3-9</td>
<td>Adopted</td>
</tr>
<tr>
<td>July 1, 2018</td>
<td>Revised Standards 1-5, 1-9, 1-10, 2-2, 2-3, 2-4, 2-12, 2-18, 2-20, 3-3, 3-6, 4-6, 4-7, 4-9 and 5-1 and new Standard 3-9</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>August 2, 2019</td>
<td>Revised Definition of “Patients with special needs”</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 2, 2019</td>
<td>New Standard 4-10</td>
<td>Adopted and Implemented</td>
</tr>
</tbody>
</table>
# Table of Contents

| Mission Statement of the Commission on Dental Accreditation | 5 |
| Accreditation Status Definitions | 6 |
| Introduction | 7 |
| Goals | 8 |
| Definition of Terms | 9 |

**Standard**

1- Institutional and Program Effectiveness | 11
2- Educational Program | 14
3- Faculty and Staff | 21
4- Educational Support Services | 25
5- Patient Care Services | 28
6- Research | 30
Mission Statement of the Commission on Dental Accreditation

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

Commission on Dental Accreditation
Adopted: August 5, 2016
Accreditation Status Definitions

**Programs That Are Fully Operational**

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

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

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

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

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

**Programs That Are Not Fully Operational**

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

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors evaluate Advanced Dental Education Programs in Orofacial Pain for accreditation purposes. It also serves as a program development guide for institutions that wish to establish new programs or improve existing programs.

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

Although the standards are comprehensive and applicable to all institutions that offer advanced dental education programs, the Commission recognizes that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission has an obligation to the public, the profession, and the prospective resident to assure that programs accredited as Advanced Dental Education Programs in Orofacial Pain provide an identifiable and characteristic core of required training and experience.
Goals

Advanced Dental Education Programs in Orofacial Pain are educational programs designed to provide training beyond the level of predoctoral education in oral health care, using applied basic and behavioral sciences. Education in these programs is based on the concept that oral health is an integral and interactive part of total health. The programs are designed to expand the scope and depth of the graduates’ knowledge and skills to enable them to provide care for individuals with orofacial pain.

The goals of these programs should include preparation of the graduate to:

1. Provide education in orofacial pain at a level beyond predoctoral education relating to the basic mechanisms and the anatomic, physiologic, neurologic, vascular, behavioral, and psychosocial aspects of orofacial pain.
2. Plan and provide interdisciplinary/multidisciplinary health care for a wide variety of patients with orofacial pain.
3. Interact with other healthcare professionals in order to facilitate the patient’s total healthcare.
4. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
5. Function effectively and efficiently in multiple health care environments and within interdisciplinary/multidisciplinary health care teams.
6. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making and technology-based information retrieval systems.
7. Enhance the dissemination of information about diagnosis and treatment/management of orofacial pain to all practitioners of the health profession.
8. Encourage the development of multidisciplinary teams composed of basic scientists and clinicians from appropriate disciplines to study orofacial pain conditions, to evaluate current therapeutic modalities, and to develop new and improve upon existing procedures for diagnosis and treatment/management of such conditions/diseases/syndromes.
9. Enhance the interaction and communication among those investigating pain at their institution and beyond.
10. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
Definition of Terms

Key terms used in this document (i.e., Must, should, could and may. were selected carefully and indicate the relative weight that the commission attaches to each statement. The definition of these words as used in the standards follows:

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

**Competent:** The level of knowledge, skills, and values required by residents to perform independently an aspect of dental practice after completing the program.

**Educationally qualified:** Board eligible in orofacial pain or successful completion of an orofacial pain program of at least two years in length.

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

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

**Interdisciplinary:** Including dentistry and other health care professions.

**Manage:** Coordinate the delivery of care using a patient-focused approach within the scope of their training. Patient-focused care should include concepts related to the patient’s social, cultural, behavioral, economic, medical and physical status.

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

**Multidisciplinary:** Including all disciplines within the profession of dentistry.

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

**Patients with special needs:** Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with
developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and/or other vulnerable populations.

Should: Indicates a suggested way to meet the standard; highly desirable, but not mandatory.

SOAP: Subjective Objective Assessment Plan

Sponsor: The institution that has the overall administrative control and responsibility for the conduct of the program.

Resident: The individual enrolled in a Commission on Dental Accreditation-accredited advanced dental education program.
STANDARD 1 – INSTITUTIONAL AND PROGRAM EFFECTIVENESS

1-1 Each sponsoring or co-sponsoring United States-based educational institution, hospital or health care organization must be accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS).

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

Examples of evidence to demonstrate compliance may include:
Accreditation certificate or current official listing of accredited institutions
Evidence of successful achievement of Service-specific organizational inspection criteria

1-2 The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

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

1-3 The authority and final responsibility for curriculum development and approval, resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

1-4 The financial resources must be sufficient to support the program’s stated purpose/mission, goals and objectives.

Examples of evidence to demonstrate compliance may include:
Program budgetary records
Budget information for previous, current and ensuing fiscal year
Arrangements with all sites not owned by the sponsoring institution where educational activity occurs must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

**Intent:** Sites where educational activity occurs include any dental practice setting (e.g. private offices, mobile dentistry, mobile dental provider, etc.). The items that are covered in agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

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

There must be opportunities for program faculty to participate in institution-wide committee activities.

**Examples of evidence to demonstrate compliance may include:**
Bylaws or documents describing committee structure
Copy of institutional committee structure and/or roster of membership by dental faculty

Orofacial pain residents must have the same privileges and responsibilities provided residents in other professional education programs.

**Examples of evidence to demonstrate compliance may include:**
Bylaws or documents describing resident privileges

The medical staff bylaws, rules, and regulations of the sponsoring, co-sponsoring, or affiliated hospital must ensure that dental staff members are eligible for medical staff membership and privileges.

**Intent:** Dental staff members have the same rights and privileges as other medical staff of the sponsoring, co-sponsoring or affiliated hospital, within the scope of practice.

**Examples of evidence to demonstrate compliance may include:**
All related hospital bylaws
Copy of institutional committee structure and/or roster of membership by dental faculty

The program must have written overall program goals and objectives that emphasize:
a. orofacial pain,
b. resident education,
c. patient care, and
d. research.

**Intent:** The “program” refers to the Advanced Dental Education Program in Orofacial Pain that is responsible for training residents within the context of providing patient care. The overall goals and objectives for resident education are intended to describe general outcomes of the residency training program rather than specific learning objectives for areas of residency training as described in Standard 2-2. Specific learning objectives for residents are intended to be described as goals and objectives or competencies for resident training and included in the response to Standard 2-2. An example of overall goals can be found in the Goals section on page 8 of this document.

**Examples of evidence to demonstrate compliance may include:**
Written overall program goals and objectives

**1-10** The program must have a formal and ongoing outcomes assessment process that regularly evaluates the degree to which the program’s overall goals and objectives are being met and make program improvements based on an analysis of that data.

**Intent:** The intent of the outcomes assessment process is to collect data about the degree to which the overall goals and objectives described in response to Standard 1-9 are being met.

The outcomes process developed should include each of the following steps:
1. development of clear, measurable goals and objectives consistent with the program’s purpose/mission;
2. implementation of procedures for evaluating the extent to which the goals and objectives are met;
3. collection of data in an ongoing and systematic manner;
4. analysis of the data collected and sharing of the results with appropriate audiences;
5. identification and implementation of corrective actions to strengthen the program; and
6. review of the assessment plan, revision as appropriate, and continuation of the cyclical process.

**Examples of evidence to demonstrate compliance may include:**
Written overall program goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results
Successful completion of a certifying examination in Orofacial Pain

**Ethics and Professionalism**

1-11  The program **must** ensure that residents are able to demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

**Intent:** Residents should know how to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.
STANDARD 2 – EDUCATIONAL PROGRAM

2-1 The orofacial pain program **must** be designed to provide advanced knowledge and skills beyond the D.D.S. or D.M.D. training.

**Curriculum Content**

2-2 The program **must** either describe the goals and objectives for each area of resident training or list the competencies that describe the intended outcomes of resident education.

**Intent:** The program is expected to develop specific educational goals that describe what the resident will be able to do upon completion of the program. These educational goals should describe the resident’s abilities rather than educational experiences the residents may participate in. These specific educational goals may be formatted as either goals and objectives or competencies for each area of resident training. These educational goals are to be circulated to program faculty and staff and made available to applicants of the program.

**Examples of evidence to demonstrate compliance may include:**
Written goals and objectives for resident training or competencies

2-3 Written goals and objectives **must** be developed for all instruction included in this curriculum.

**Example of Evidence to demonstrate compliance may include:**
Written goals and objectives
Content outlines

2-4 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program’s written goals and objectives or competencies for resident training.

**Intent:** The program is expected to organize the didactic and clinical educational experiences into a formal curriculum plan. For each specific goal or objective or competency statement described in response to Standard 2-2, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal curriculum plan.

**Examples of evidence to demonstrate compliance may include:**
Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies

Didactic and clinical schedules

**Biomedical Sciences**

**2-5** Formal instruction **must** be provided in each of the following:

a. Gross and functional anatomy and physiology including the musculoskeletal and articular system of the orofacial, head, and cervical structures;
b. Growth, development, and aging of the masticatory system;
c. Head and neck pathology and pathophysiology with an emphasis on pain;
d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures;
e. Sleep physiology and dysfunction;
f. Oromotor disorders including dystonias, dyskinesias, and bruxism;
g. Epidemiology of orofacial pain disorders;
h. Pharmacology and pharmacotherapeutics; and
   i. Principals of biostatistics, research design and methodology, scientific writing, and critique of literature.

**2-6** The program **must** provide a strong foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain including:

a. The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems;
b. Mechanisms associated with pain referral to and from the orofacial region;
c. Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain;
d. Pain classification systems;
e. Psychoneuroimmunology and its relation to chronic pain syndromes;
f. Primary and secondary headache mechanisms;
g. Pain of odontogenic origin and pain that mimics odontogenic pain; and
h. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction.
Behavioral Sciences

2-7 Formal instruction must be provided in behavioral science as it relates to orofacial pain disorders and pain behavior including:

a. cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors;

b. the recognition of pain behavior and secondary gain behavior;

c. psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain, sleep disorders, and sleep medicine; and

d. conducting and applying the results of psychometric tests.

Clinical Sciences

2-8 A majority of the total program time must be devoted to providing orofacial pain patient services, including direct patient care and clinical rotations.

2-9 The program must provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders to ensure that upon completion of the program the resident is able to:

a. Conduct a comprehensive pain history interview;

b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient’s orofacial pain and/or sleep disorder complaints;

c. Perform clinical examinations and tests and interpret the significance of the data;

Intent: Clinical evaluation may include: musculoskeletal examination of the head, jaw, neck and shoulders; range of motion; general evaluation of the cervical spine; TM joint function; jaw imaging; oral, head and neck screening, including facial-skeletal and dental-occlusal structural variations; cranial nerve screening; posture evaluation; physical assessment including vital signs; and diagnostic blocks.

d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral; and
Intent: Additional testing may include additional imaging; referral for psychological or psychiatric evaluation; laboratory studies; diagnostic autonomic nervous system blocks, and systemic anesthetic challenges.

e. Establish a differential diagnosis and a prioritized problem list.

2-10 The program must provide instruction and clinical training in multidisciplinary pain management for the orofacial pain patient to ensure that upon completion of the program the resident is able to:

a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits;

b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care;

c. Obtain informed consent;

d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient’s treatment responsibilities;

e. Have primary responsibility for the management of a broad spectrum of orofacial pain patients in a multidisciplinary orofacial pain clinic setting, or interdisciplinary associated services. Responsibilities should include:

1. intraoral appliance therapy;
2. physical medicine modalities;
3. sleep-related breathing disorder intraoral appliances;
4. non-surgical management of orofacial trauma;
5. behavioral therapies beneficial to orofacial pain; and
6. pharmacotherapeutic treatment of orofacial pain including systemic and topical medications and diagnostic/therapeutic injections.

Intent: This should include judicious selection of medications directed at the presumed pain mechanisms involved, as well as adjustment, monitoring, and reevaluation.

Common medications may include: muscle relaxants; sedative agents for chronic pain and sleep management; opioid use in management of chronic pain; the adjuvant analgesic use of tricyclics and other antidepressants used for chronic pain; anticonvulsants, membrane stabilizers, and sodium channel blockers for neuropathic pain; local and systemic anesthetics in management of neuropathic
pain; anxiolytics; analgesics and anti-inflammatories; prophylactic and abortive medications for primary headache disorders; and therapeutic use of botulinum toxin injections.

Common issues may include: management of medication overuse headache; medication side effects that alter sleep architecture; prescription medication dependency withdrawal; referral and co-management of pain in patients addicted to prescription, non prescription and recreational drugs; familiarity with the role of preemptive anesthesia in neuropathic pain.

2-11 Residents **must** participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period).

*Intent:* Experiences may include observation or participation in the following: oral and maxillofacial surgery to include procedures for intracapsular TMJ disorders; outpatient anesthesia pain service; in-patient pain rotation; rheumatology, neurology, oncology, otolaryngology, rehabilitation medicine; headache, radiology, oral medicine, and sleep disorder clinics.

2-12 Each assigned rotation or experience **must** have:

a. written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b. resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c. evaluations performed by the designated supervisor.

*Intent:* This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.

**Examples of evidence to demonstrate compliance may include:**
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-13 Residents **must** gain experience in teaching orofacial pain.

*Intent:* Residents should be provided opportunities to obtain teaching experiences in orofacial pain (i.e. small group and lecture formats, presenting to dental and medical
peer groups, predoctoral student teaching experiences, and/or continuing education programs.

2-14 Residents **must** actively participate in the collection of history and clinical data, diagnostic assessment, treatment planning, treatment, and presentation of treatment outcome.

2-15 The program **must** provide instruction in the principles of practice management.

**Intent:** Suggested topics include: quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care; medicolegal issues, workers compensation, second opinion reporting; criteria for assessing impairment and disability; legal guidelines governing licensure and dental practice, scope of practice with regards to orofacial pain disorders, and instruction in the regulatory requirements of chronic opioid maintenance.

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

2-16 Formal patient care conferences **must** be held at least ten (10) times per year.

**Intent:** Conferences should include diagnosis, treatment planning, progress, and outcomes. These conferences should be attended by residents and faculty representative of the disciplines involved. These conferences are not to replace the daily faculty/resident interactions regarding patient care.

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

2-17 Residents **must** be given assignments that require critical review of relevant scientific literature.

**Intent:** Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care. This should include the development of critical evaluation skills and the ability to apply evidence-based principles to clinical decision-making.
Relevant scientific literature should include current pain science and applied pain literature in dental and medical science journals with special emphasis on pain mechanisms, orofacial pain, head and neck pain, and headache.

Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

Program Length

2-18 The duration of the program must be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-19 Where a program for part-time residents exists, it must be started and completed within a single institution and designed so that the total curriculum can be completed in no more than twice the duration of the program length.

Intent: Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-20 The program’s resident evaluation system must assure that, through the director and faculty, each program:

a) periodically, but at least two times annually, evaluates and documents the resident’s progress toward achieving the program’s written goals and objectives of resident training or competencies using appropriate written criteria and procedures;
b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions **must** be taken; and

c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.

**Intent:** While the program may employ evaluation methods that measure a resident’s skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-2.

**Examples of evidence to demonstrate compliance may include:**
- Written evaluation criteria and process
- Resident evaluations with identifying information removed
- Personal record of evaluation for each resident
- Evidence that corrective actions have been taken
STANDARD 3 – FACULTY AND STAFF

3-1 The program must be administered by a director who is board certified or educationally qualified in orofacial pain and has a full-time appointment in the sponsoring institution with a primary commitment to the orofacial pain program.

3-2 The program director must have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program.

Intent: The program director’s responsibilities include:

a. program administration;
b. development and implementation of the curriculum plan;
c. ongoing evaluation of program content, faculty teaching, and resident performance;
d. evaluation of resident training and supervision in affiliated institutions and off-service rotations;
e. maintenance of records related to the educational program; and
f. resident selection; and

g. preparing graduates to seek certification by the American Board of Orofacial Pain.

In those programs where applicants are assigned centrally, responsibility for selection of residents may be delegated to a designee.

Examples of evidence to demonstrate compliance may include:
Program director’s job description
Job description of individuals who have been assigned some of the program director’s job responsibilities
Formal plan for assignment of program director’s job responsibilities as described above
Program records

3-3 All sites where educational activity occurs must be staffed by faculty who are qualified by education and/or clinical experience in the curriculum areas for which they are responsible and have collective competence in all areas of orofacial pain included in the program.

Intent: Faculty should have current knowledge at an appropriate level for the curriculum areas for which they are responsible. The faculty, collectively, should have competence in all areas of orofacial pain covered in the program.
The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of orofacial pain if that faculty member is not trained in orofacial pain. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program’s criteria and qualifications.

Whenever possible, programs should avail themselves of discipline-specific faculty as trained consultants for the development of a mission and curriculum, and for teaching.

Examples of evidence to demonstrate compliance may include:
Full and part-time faculty rosters
Program and faculty schedules
Completed BioSketch of faculty members
Criteria used to certify a non-discipline specific faculty member as responsible for teaching an area of orofacial pain
Records of program documentation that non-discipline specific faculty members as responsible for teaching an area of orofacial pain

3-4 A formally defined evaluation process must exist that ensures measurements of the performance of faculty members annually.

Intent: The written annual performance evaluations should be shared with the faculty members. The program should provide a mechanism for residents to confidentially evaluate instructors, courses, program director, and the sponsoring institution.

Examples of evidence to demonstrate compliance may include:
Faculty files
Performance appraisals

3-5 A faculty member must be present in the clinic for consultation, supervision, and active teaching when residents are treating patients in scheduled clinic sessions.

Intent: This standard does not preclude occasional situations where a faculty member cannot be available.

Faculty members should contribute to an ongoing resident and program/curriculum evaluation process. The teaching staff should be actively involved in the development and implementation of the curriculum.
Examples of evidence to demonstrate compliance may include:
Faculty clinic schedules

3-6 At each site where educational activity occurs, adequate support staff, including allied dental personnel and clerical staff, must be consistently available to allow for efficient administration of the program.

*Intent:* *The program should determine the number and participation of allied support and clerical staff to meet the educational and experiential goals and objectives.*

Examples of evidence to demonstrate compliance may include:
Staff schedules

3-7 There must be evidence of scholarly activity among the orofacial pain faculty

*Intent:* *Such evidence may include: participation in clinical and/or basic research; mentoring of orofacial pain resident research; publication in peer-reviewed scientific media; development of innovative teaching materials and courses; and presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.*

3-8 The program must show evidence of an ongoing faculty development process.

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

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

Orofacial Pain Standards
-26-
Cultural Competency
Ability to work with residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

3-9 The program must provide ongoing faculty calibration at all sites where educational activity occurs.

Intent: Faculty calibration should be defined by the program.

Examples of evidence to demonstrate compliance may include:
Methods used to calibrate faculty as defined by the program
Attendance of faculty meetings where calibration is discussed
Mentored experiences for new faculty
Participation in program assessment
Standardization of assessment of resident
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design, development and evaluation
Evidence of the ability to work with residents of varying ages and backgrounds
Evidence that rotation goals and objectives have been shared
STANDARD 4 – EDUCATIONAL SUPPORT SERVICES

4-1 The sponsoring institution must provide adequate and appropriately maintained facilities and learning resources to support the goals and objectives of the program.

Intent: The facilities should permit the attainment of program goals and objectives. Clinical facilities suitable for privacy for patients should be specifically identified for the orofacial pain program. Library resources that include dental resources should be available. Resource facilities should include access to computer, photographic, and audiovisual resources for educational, administrative, and research support. Equipment for handling medical emergencies and current medications for treating medical emergencies should be readily accessible. “Readily accessible” does not necessarily mean directly in the dental clinic. Protocols for handling medical emergencies should be developed and communicated to all staff in patient care areas.

Examples of evidence to demonstrate compliance may include:
Description of facilities

4-2 There must be provision for a conference area separated from the clinic for rounds discussion and case presentations, sufficient to accommodate the multidisciplinary team.

4-3 Dental and medical laboratory, dental and medical imaging, and resources for psychometric interpretation must be accessible for use by the orofacial pain program.

4-4 Lecture, seminar, study space, and administrative office space must be available to conduct the educational program.

Selection of Residents

4-5 Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in orofacial pain:

a. Graduates from a predoctoral dental education program accredited by the Commission on Dental Accreditation;

b. Graduates from a predoctoral dental education program in Canada accredited by the Commission on Dental Accreditation of Canada; and

c. Graduates from an international dental school with equivalent educational background and standing as determined by the institution and program.
Specific written criteria, policies and procedures **must** be followed when admitting residents.

**Intent:** Written non-discriminatory policies are to be followed in selecting residents. These policies should make clear the methods and criteria used in recruiting and selecting residents and how applicants are informed of their status throughout the selection process.

**Examples of evidence to demonstrate compliance may include:**
Written admission criteria, policies and procedures

Admission of residents with advanced standing **must** be based on the same standards of achievement required by residents regularly enrolled in the program. Residents with advanced standing **must** receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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

**Examples of evidence to demonstrate compliance may include:**
Written policies and procedures on advanced standing
Results of appropriate qualifying examinations
Course equivalency or other measures to demonstrate equal scope and level of knowledge

The program’s description of the educational experience to be provided **must** be available to program applicants and include:
  a. a description of the educational experience to be provided;
  b. a list of program goals and objectives; and
  c. a description of the nature of assignments to other departments or institutions.

**Intent:** This includes applicants who may not personally visit the program and applicants who are deciding which programs to apply to. Materials available to applicants who
visit the program in person will not satisfy this requirement. A means of making this information available to individuals who do not visit the program is to be developed.

**Examples of evidence to demonstrate compliance may include:**
Brochure or application documents
Program’s website
Description of system for making information available to applicants who do not visit the program

**Due Process**

4-9 There **must** be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

**Intent:** Adjudication procedures should include institutional policy that provides due process for all individuals who may be potentially involved when actions are contemplated or initiated that could result in dismissal of a resident. Residents should be provided with written information that affirms their obligations and responsibilities to the institution, the program and the faculty. The program information provided to the residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation, vacation and sick leave, practice privileges and other activity outside the educational program, professional liability coverage, due process policy, and current accreditation status of the program.

**Examples of evidence to demonstrate compliance may include:**
Written policy statements and/or resident contract

**Health Services**

4-10 Residents, faculty and appropriate support staff **must** be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

**Examples of evidence to demonstrate compliance may include:**
Immunization policy and procedure documents
STANDARD 5 – PATIENT CARE SERVICES

5-1 The program must ensure the availability of patient experiences that afford all residents the opportunity to achieve the program’s written goals and objectives or competencies for resident training.

**Intent:** Patient experiences should include evaluation and management of head and neck musculoskeletal disorders, neurovascular pain, neuropathic pain, sleep-related disorders, and oromandibular movement disorders.

Examples of evidence to demonstrate compliance may include:
Written goals and objectives or competencies for resident training
Records of resident clinical activity, including specific details on the variety and type and quantity of cases treated and procedures performed

5-2 Patient records must be organized in a manner that facilitates ready access to essential data and be sufficiently legible and organized so that all users can readily interpret the contents.

**Intent:** Essential data is defined by the program and based on the information included in the record review process as well as that which meets the multidisciplinary educational needs of the program. The patient record should include a diagnostic problem list, use of pain assessment and treatment contracts, progress sheets, medication log, and outcome data, plus conform to SOAP notes format.

The program is expected to develop a description of the contents and organization of patient records and a system for reviewing records.

Examples of evidence to demonstrate compliance may include:
Patient records
Record review plan
Documentation of record reviews

5-3 The program must conduct and involve residents in a structured system of continuous quality improvement for patient care.

**Intent:** Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.

Examples of evidence to demonstrate compliance may include:
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

5-4 All residents, faculty, and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

**Intent:** ACLS and PALS are not a substitute for BLS certification.

**Examples of evidence to demonstrate compliance may include:**
Certification/recognition records demonstrating basic life support training or summary log of certification/recognition maintained by the program
Exemption documentation for anyone who is medically or physically unable to perform such services

5-5 The program must document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies must be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and patients.

**Intent:** The policies on blood-borne and infectious diseases should be made available to applicants for admission and patients should a request to review the policy be made.

**Examples of evidence to demonstrate compliance may include:**
Infection and biohazard control policies
Radiation policy

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

**Examples of evidence to demonstrate compliance may include:**
Confidentiality policies
STANDARD 6 - RESEARCH

6-1 Residents **must** engage in research or other scholarly activity and present their results in a scientific/educational forum.

*Intent:* The research experience and its results should be compiled into a document or publication