REPORT ON DENTAL HYGIENE PROGRAMS 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 dental hygiene education in alternate years. The most recent Curriculum Survey was conducted in September/October 2019. The draft Curriculum Section is provided in **Appendix 1** for review by the Review Committee on Dental Hygiene Education.

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

**Recommendation:**

Prepared by: Ms. Michelle Smith
2020-21 Hygiene

Curriculum Information

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

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

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

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

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

Retain a copy of this form for your files. The next time this information is collected (2021-22), focus on any changes in the curriculum and update the information relating to your program.
Didactic instruction:
Lectures, demonstrations or other instruction without psychomotor participation by students.

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

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

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

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

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

NOTE: Laboratory faculty/student ratios must be provided for all areas of instruction for which laboratory clock hours are listed. Round all ratios to the nearest whole number.
If there are no laboratory clock hours in an area, delete "1:=" and enter "NA" in the faculty/student ratio column.
<table>
<thead>
<tr>
<th>Didactic instruction clock hours</th>
<th>Laboratory instruction clock hours</th>
<th>Laboratory faculty: student ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>If there are no laboratory clock hours in an area, delete &quot;1.&quot; and enter &quot;NA&quot; in the faculty/student ratio column.</td>
<td>a. Written communications</td>
<td></td>
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<tr>
<td></td>
<td>b. Oral communications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Psychology</td>
<td></td>
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<tr>
<td></td>
<td>d. Sociology</td>
<td></td>
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<td></td>
<td>e. Anatomy</td>
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<td></td>
<td>f. Physiology</td>
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<tr>
<td>g. Chemistry</td>
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<td>h. Biochemistry</td>
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<tr>
<td>i. Microbiology</td>
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<tr>
<td>j. Immunology</td>
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<tr>
<td>k. General and/or pathophysiology</td>
<td></td>
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<tr>
<td>l. Head, neck and oral anatomy</td>
<td></td>
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<tr>
<td>m. Oral embryology and histology</td>
<td></td>
<td></td>
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<tr>
<td>n. Legal and ethical aspects of dental hygiene</td>
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</tbody>
</table>
Use this space to enter comments or clarifications for your answers on this page.

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End of Block: Curriculum Information (Q53a-n)

Start of Block: Curriculum Information (Q53o-54)

Curriculum Information (continued)

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Term 1</th>
<th>Term 2</th>
<th>Term 3 (if applicable)</th>
<th>Term 4 (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st year: pre-clinical</td>
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<tr>
<td>b. 1st year: clinical</td>
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<tr>
<td>c. 2nd year: clinical</td>
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</tbody>
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Use this space to enter comments or clarifications for your answers on this page.

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55. Please indicate which of the following services students are taught to perform, and if so, indicate if they are taught to clinical competence.

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

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

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End of Block: Curriculum Information (Q55)
CONSIDERATION OF PROPOSED REVISIONS TO THE ACCREDITATION STANDARDS FOR DENTAL HYGIENE EDUCATION PROGRAMS

**Background:** The Accreditation Standards for Dental Hygiene Education Programs were adopted by the Commission on Dental Accreditation at its February 3, 2012 meeting for implementation January 1, 2013.

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

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

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

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

As directed by the Commission, the proposed revised Standards (Appendix 1) were circulated for comment through December 1, 2020. Due to the COVID-19 pandemic, the 2020 Annual Meeting of the American Dental Education Association (ADEA) and the 2020 ADEA Allied Program Directors’ Conference were canceled; the 2020 American Dental Hygienists’ Association (ADHA) Annual Meeting was postponed and conducted virtually. Therefore, the Commission’s hearings on accreditation standards were held virtually on May 18, 2020 and October 20, 2020, respectively, to address all hearings directed by the Commission. Five (5) comments were received at the May 18, 2020 virtual hearing to replace the ADEA March and June hearings (Appendix 2); 28 comments were received at the May 18, 2020 virtual hearing to replace the ADHA hearing (Appendix 3); and five (5) comments were received at the October 20, 2020 virtual hearing to replace the ADA hearing (Appendix 4). The Commission office received 26 written comments prior to the December 1, 2020 deadline (Appendix 5).

**Summary:** At this meeting, the Dental Hygiene Education Review Committee and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs (Appendix 1) and all of the comments received prior to the December 1, 2020 deadline (Appendices 2, 3, 4 and 5, respectively). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Ms. Michelle Smith
At its Winter 2020 meeting, the Commission directed that the proposed revisions to Accreditation Standards for Dental Hygiene Education Programs be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2020. Comments will additionally be accepted at hearings conducted at the 2020 American Dental Hygienists’ Association (ADHA) Annual Session and the 2020 ADEA Allied Program Directors’ Conference. Comments will be considered at the Winter 2021 Commission meeting.

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

ATTN: Ms. Michelle Smith, 19th Floor
Manager, Allied Dental Education
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Proposed Revised Standards
Additions are Underlined; Strikethroughs indicate Deletions

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

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

Effective January 1, 2013-TBD

Last Revised: August 2019

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Accreditation Standards for
Dental Hygiene Education Programs

Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>July 26, 2007</td>
<td>Accreditation Standards for Dental Hygiene Education Programs</td>
<td>Adopted</td>
</tr>
<tr>
<td>July 26, 2007</td>
<td>Standards to Ensure Program Integrity</td>
<td>Approved and Implemented</td>
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<tr>
<td></td>
<td>Examples of Evidence Modified: Standard 1-3</td>
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<tr>
<td>February 1, 2008</td>
<td>Intent Statement Modified: Standard 3-3</td>
<td>Approved 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>January 1, 2009</td>
<td>Accreditation Standards for Dental Hygiene Education Programs</td>
<td>Implemented</td>
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<tr>
<td>July 30, 2009</td>
<td>Revised Standard 2-17</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2010</td>
<td>Revised Standard 2-17</td>
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</tr>
<tr>
<td>February 3, 2012</td>
<td>Revised Standards 2-16, 2-17, 2-19, 2-22, 2-25, 3-3, 3-7, 4-3, 4-5, 4-7</td>
<td>Adopted</td>
</tr>
<tr>
<td>August 8, 2012</td>
<td>Revised Standard 3-7</td>
<td>Adopted and Implemented</td>
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<td></td>
<td>Intent Statement Modified: 3-8</td>
<td></td>
</tr>
<tr>
<td>January 1, 2013</td>
<td>Revised Standards 2-16, 2-17, 2-19, 2-22, 2-25, 3-3, 3-7, 4-3, 4-5, 4-7</td>
<td>Implemented</td>
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<tr>
<td>August 9, 2013</td>
<td>Revised Standards 2-20, 3-7</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 1, 2014</td>
<td>Renumbered Standards 2-9 through 2-12 to be subsection a, b, c and d of 2-8</td>
<td>Adopted and Implemented</td>
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<tr>
<td>February 6, 2015</td>
<td>Revised Standards 2-4, 3-6, 3-7,b</td>
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Mission Statement of the 
Commission on Dental Accreditation

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

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

1. Programs That Are Fully Operational:
   Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.
   Approval (with reporting requirements): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards or policies must be demonstrated within a timeframe not to exceed eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

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

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

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

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

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

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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

The Commission on Dental Accreditation

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

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

Specialized Accreditation

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

**Dental Hygiene Accreditation**

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

In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation utilized the following procedures: conducting surveys of communities of interest, holding open hearings and distributing widely a draft of the proposed revision of the standards for review and comment. Prior to approving the revised standards in July 2007 TBD, the Commission carefully considered comments received from all sources. The revised accreditation standards were implemented in January 2009 TBD.
Statement of General Policy

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

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

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

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

4. Provides consultation in initial and ongoing program development.

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

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

Programs and their sponsoring institutions are encouraged to provide for the educational mobility of students through articulation arrangements and career laddering (e.g., between dental assisting education programs and dental hygiene education programs).
Proposed Revisions to Dental Hygiene Standards
Dental Hygiene RC
CODA Winter 2021

Dental Hygiene Standards
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Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying or proficiency examinations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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

Planning and Assessment

1-1 The program must demonstrate its effectiveness using a formal and ongoing planning and assessment process that is systematically documented by:

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

   a) developing a plan addressing teaching, patient care and service;
   b) an ongoing plan consistent with the goals of the sponsoring institution and the goals of the dental hygiene program;
   c) implementing the plan to measure program outcomes in an ongoing and systematic process;
   d) assessing and analyzing the outcomes, including measures of student achievement;
   e) use of the outcomes assessment results for annual program improvement and reevaluation of program goals.

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

Examples of evidence to demonstrate compliance may include:

- program completion rates related to outcomes
- employment rates related to outcomes
- success of graduates on state licensing examinations
- success of graduates on national boards
- surveys of alumni, students, employers, and clinical sites
1. other benchmarks or measures of learning used to demonstrate effectiveness
2. examples of program effectiveness in meeting its goals
3. examples of how the program has been improved as a result of assessment
4. ongoing documentation of change implementation
5. mission, goals and strategic plan document
6. assessment plan and timeline

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

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

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

Financial Support

1-2-3. The institution must have a strategic plan which identifies stable financial resources sufficient to support the program's stated mission, goals and objectives. A financial statement document must be submitted providing revenue and expense data for the dental hygiene program.

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

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

1-3-1-4 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.

4-4 1-5 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest within the sponsoring institution.

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

Institutional Accreditation

4-51-6 Programs must be sponsored by institutions of higher education that are accredited by an institutional accrediting agency (i.e., a regional or appropriate* national accrediting agency) recognized by the United States Department of Education for offering college-level programs.

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

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

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

1-61-7 All arrangements with co-sponsoring or affiliated institutions must be formalized by means of written agreements which clearly define the roles and responsibilities of each institution involved.

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

Examples of evidence to demonstrate compliance may include:

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

Community Resources

1-71-8 There must be an active liaison mechanism between the program and the dental and allied dental professions in the community. The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters must rest with the educational institution.
Intent:

The purpose of an active liaison mechanism is to provide a mutual exchange of information for improving the program, recruiting qualified students and meeting employment needs of the community. The responsibilities of the advisory body should be defined in writing and the program director, faculty, and appropriate institution personnel should participate in the meetings as non-voting members to receive advice and assistance.

Examples of evidence to demonstrate compliance may include:

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

Instruction

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

A college document must include institutional due process policies and procedures.

**Intent:**

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

Examples of evidence to demonstrate compliance may include:

- written remediation policy and procedures
- records of attrition/retention rates related to academic performance
- institutional due process policies and procedures

**Admissions**

Admission of students must be based on specific written criteria, procedures and policies. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability must be utilized as criteria in selecting students who have the potential for successfully completing the program.

Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental hygienists.

**Intent:**

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

Examples of evidence to demonstrate compliance may include:

- admissions management policies and procedures

Dental Hygiene Standards
• copies of catalogs, program brochures or other written materials
• established ranking procedures or criteria for selection
• minutes from admissions committee
• periodic analysis supporting the validity of established admission criteria and procedures
• results from institutional research used in interpreting admissions data and criteria and/or correlating data with student performance
• graduation rates
• analysis of attrition
• employment rates

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

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

Examples of evidence to demonstrate compliance may include:
• policies and procedures on advanced standing
• results of appropriate qualifying examinations
• course equivalency or other measures to demonstrate equal scope and level of knowledge
2-5 The number of students enrolled in the program must be proportionate to the resources available.

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

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

Curriculum

2-6 The dental hygiene program must define and list the competencies needed for graduation. The dental hygiene program must employ student evaluation methods that measure all defined program competencies. These competencies and evaluation methods must be written and communicated to the enrolled students.

2-6 The dental hygiene program must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The number of hours of clinical practice scheduled must ensure that students attain clinical competence and develop appropriate judgment. Clinical practice experience must be distributed throughout the curriculum and include the following to ensure students attain clinical competence:

a) minimum of 6 hours of preclinical experience per week, with a minimum of 90 hours total;

b) minimum of 8 hours of clinical experience per week for first year dental hygiene students, with a minimum of 120 hours total; and

c) minimum of 12 hours of clinical experience per week for second and/or final year dental hygiene students, with a minimum of 360 hours total.

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

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

Examples of evidence to demonstrate compliance may include:

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

**Patient Care Competencies**

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

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

Examples of evidence to demonstrate compliance may include:

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

Patient Care Competencies

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

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

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

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

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

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

2-13 Graduates must be competent in providing the dental hygiene process of care which includes:
a) comprehensive collection of patient data to identify the physical and oral health status;

b) analysis of assessment findings and use of critical thinking in order to address the patient’s dental hygiene treatment needs;

c) establishment of a dental hygiene care plan that reflects the realistic goals and treatment strategies to facilitate optimal oral health;

d) provision of comprehensive patient-centered treatment and evidence-based care in a manner minimizing risk and optimizing oral health;

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

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

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

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

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

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

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

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

**Intent:**

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

Examples of evidence to demonstrate compliance may include:

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

2-16 Graduates must demonstrate competence in:

a) assessing the oral health needs of community-based programs

b) planning an oral health program to include health promotion and disease prevention activities

c) implementing the planned program, and,

d) evaluating the effectiveness of the implemented program.
1
2
Intent:
3Population based activities will allow students to apply community dental health
4principles to prevent disease and promote health.
5
Examples of evidence to demonstrate compliance may include:
6• student projects demonstrating assessing, planning, implementing and
7evaluating community-based oral health programs
8• examples of community-based oral health programs implemented by students
9during the previous academic year
10• evaluation mechanisms designed to monitor knowledge and performance
11
2-17 Graduates must be competent in providing appropriate life support
12measures for medical emergencies that may be encountered in dental hygiene
13practice.
14
Intent:
15Dental hygienists should be able to provide appropriate support for medical or
dental emergencies basic life support as providers of direct patient care.
16
Examples of evidence to demonstrate compliance may include:
17• evaluation methods/grading criteria such as classroom or clinic examination,
18station examination, and performance on emergency simulations, basic life
19support certification/recognition
20
2-18 Where graduates of a CODA accredited dental hygiene program are
21authorized to perform additional functions defined by the program’s state-
specific dental board or regulatory agency, required for initial dental
22hygiene licensure, as defined by the program’s state specific dental board or
23regulatory agency, and the program has chosen to include those functions in
24the program curriculum, the program must include content at the level,
25depth, and scope required by the state. Further, curriculum content must
26include didactic and laboratory/preclinical/clinical objectives for the
27additional dental hygiene skills and functions. Students must demonstrate
28laboratory/preclinical/clinical competence in performing these skills.
29Students must be informed of the duties for which they are educated within
30the program.
31
Intent:
To ensure functions allowed by the state dental board or regulatory agency for dental hygienists are taught and evaluated at the depth and scope required by the state. The inclusion of additional functions cannot compromise the length and scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.

Ethics and Professionalism

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:
- evaluation mechanisms designed to monitor knowledge and performance;
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Dental Hygiene Standards

- outcomes assessment mechanisms demonstrating application of critical thinking skills;
- activities or projects that demonstrate student experiences with analysis of problems related to comprehensive patient care;
- demonstration of the use of active learning methods that promote critical appraisal of scientific evidence in combination with clinical application and patient factors.

Curriculum Management

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

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

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

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

Dental Hygiene Standards
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STANDARD 3 - ADMINISTRATION, FACULTY AND STAFF

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

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

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

Program Administrator

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

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

Examples of evidence to demonstrate compliance may include:
- program administrator position description and/or contract
- faculty schedules including contact hours and supplemental responsibilities
- policies of the institution which define teaching load for full-time faculty and administrators
- copies of union regulations and/or collective bargaining agreements
3-3 The program administrator must be a dental hygienist or a dentist who is a graduate of a program accredited by the Commission on Dental Accreditation and possesses a masters or higher degree, or is currently enrolled in a masters or higher degree program or a dentist who has background in education and the professional experience necessary to understand and fulfill the program goals. A dentist who was appointed as program administrator prior to [date of implementation] is exempt from the graduation requirement.

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

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

3-4 The program administrator must have the authority and responsibility necessary to fulfill program goals including:

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

Examples of evidence to demonstrate compliance may include:
- program administrator position description
Faculty

3-5. The number and distribution of faculty and staff must be sufficient to meet the dental hygiene program’s stated purpose, goals and objectives.

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

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

3-6-3-5. The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public. In preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every five students. In laboratory sessions for dental materials courses, there must not be less than one faculty for every ten students to ensure the development of clinical competence and maximum protection of the patient, faculty and students.

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

Intent:
The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and clinical practice sessions rather than by the number of full-time equivalent positions for the program. The faculty to student ratios in clinical and radiographic practice should allow for individualized instruction and evaluation of the process as well as the end results.

Faculty are responsible for both ensuring that the clinical and radiographic services delivered by students meet current standards for dental hygiene care and for the instruction and evaluation of students during their performance of those services.
Examples of evidence to demonstrate compliance may include:

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

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

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

All dental hygiene program faculty members must have:

a) current knowledge of the specific subjects they are teaching.

b) documented background in current educational methodology concepts consistent with teaching assignments.

c) Faculty who are dental hygienists or dentists must be graduates of dental hygiene programs accredited by the Commission on Dental Accreditation. A dentist who was appointed as a faculty prior to [date of implementation] is exempt from the graduation requirement.

d) evidence of faculty calibration for clinical evaluation.

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

Examples of evidence to demonstrate compliance may include:

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

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

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

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

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

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

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

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

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

Support Staff

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

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

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

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

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

Facilities

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

Clinical Facilities

The dental hygiene facilities must include the following:

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

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

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

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

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

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

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

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

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

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

The radiography facilities must contain the following:

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

- Institutional, local, state and federal agencies related to radiation safety report(s)
- Institutional local, state and federal quality assurance compliance report(s)
Laboratory Facilities

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

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:

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

4-4 The educational institution must provide physical facilities and equipment which are sufficient to permit achievement of program objectives. If the institution finds it necessary to contract for use of an existing facility for basic clinical education and/or distance education, When the institution uses an additional facility for clinical education that includes program requirements then the following conditions must be met in addition to all existing Standards:

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

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

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

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

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

Office Space

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

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

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

Learning Resources

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

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

Student Services

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

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

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

Infectious Disease/Radiation Management

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

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

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

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

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

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

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

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

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

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

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

Emergency Management and Life Support Certification

5-3 The program must establish, enforce, and instruct students in preclinical/clinical/laboratory protocols and mechanisms to ensure the management of common medical emergencies in the dental setting. These program protocols must be provided to all students, faculty and appropriate staff. Faculty, staff
and students must be prepared to assist with the management of emergencies.

Faculty, staff and students must be prepared to assist with the management of emergencies. All students, clinical faculty and clinical support staff must be continuously recognized/certified in basic life support procedures, including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED).

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

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

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

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

Examples of evidence to demonstrate compliance may include:

• documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided
• quality assurance policy and procedures
• patient bill of rights

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

a) standards of care that are patient-centered, focused on comprehensive care, and written in a format that facilitates assessment with measurable criteria;

b) an ongoing audit review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;

c) mechanisms to determine the cause of treatment deficiencies;

d) patient review policies, procedure, outcomes and corrective measures.

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

- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided evidence of chart audits
- quality assurance policy and procedures
- patient bill of rights
- documentation of policies on scope of care provided, recalls and referrals
- description of the quality assurance process for the patient care program
- samples of outcomes assessment measures that assess patients’ perceptions of quality of care, i.e., patient satisfaction surveys and results
- results of patient records review and documentation of corrective measures

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

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

Examples of evidence to demonstrate compliance may include:

- patient bill of rights
- documentation that patients are informed of their rights
- continuing care (recall) referral policies and procedures

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

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

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

g) treatment that meets the standard of care in the profession.

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

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

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

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

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

Examples of evidence to demonstrate compliance may include:
- evidence of confidentiality training
- student, faculty and staff attestation to ensure patient confidentiality
- evidence of HIPAA training
Commission on Dental Accreditation
Hearing on Accreditation Standards

2020 CODA Hearing on Standards
(ADEA March and June Meeting Replacement)
Monday, May 18, 1:00 – 2:00pm Central Daylight Time
Virtual Hearing

Commissioners in Attendance: Dr. Arthur Chen-Shu Jee (chair), Dr. John Agar, Dr. Linda Casser, Dr. Scott DeVito, Dr. John Hellstein, Dr. Jeffery Hicks (vice chair), Dr. Susan Kass, Dr. Steven Levy, Dr. William Nelson, Dr. Marsha Pyle, and Dr. Bruce Rotter.

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

Accreditation Standards for Dental Hygiene Education Programs (Appendix 4)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Ann Spolarich</td>
<td>Arizona School of Dentistry and Oral Health, representing American Dental Hygienists’ Association</td>
<td>Standard 1-1, p. 17 line 9-24 – elimination of research. All DH need to have ability to assess research to adopt EBD practice. Need to be able to critically evaluate research to practice. Research must be included in all DH programs. The revision does not support ADHA policy, advocates for research. See Written Comment</td>
</tr>
<tr>
<td>Maureen Archer</td>
<td>Director, New York City College of Dental Hygiene, Dental Hygiene Program</td>
<td>Please define Special Needs.</td>
</tr>
<tr>
<td>Amy Coplen</td>
<td>Director, Pacific University, Dental Hygiene Program</td>
<td>Standard 2-10, p. 29, line 29-38 – ensure clinical competence in Standards but A, B, and C now includes a total hour requirement for clinic that has not been in there in the past. There is no flexibility related to sickness, funeral, snow day, etc. Suggest weekly hour requirement and eliminate total hour requirement.</td>
</tr>
</tbody>
</table>
| Maureen Archer| Director, New York City College of Dental Hygiene, Dental Hygiene Program    | Standard 3-3, Program Director – does the new wording mean that the                                                                 
| Ellen Grimes                     | Director, Vermont Technical College, Dental Hygiene Program | Dentist must also possess a master’s degree or higher? Standard 2-10, lines 29-38. Request that the Commission look for different verbiage to make it clear for programs that not only have a 2-year curriculum. Suggest make it a total number of hours for the full curriculum and not the number of hours per week. Sometimes it’s hard to know where the divide is between years. Requiring the total number of hours for clinical education and leaving it to the program to determine would be fairer for all programs. See Written Comment |
Hello Michelle,

Below is my suggestion for standard 2-10 that I presented at the hearing today.

Standard 2-10 page 35 Which provides specific hours that students are required to be in clinic per week. As dental hygiene programs are set up very differently and some are set up in quarters, trimesters and semesters and they have various lengths I recommend that there be a total number of minimal clinical and pre-clinical hours that need to be completed and that the program should determine the best method to deliver that education continuously to students. My understanding is that there is no such requirement in the dental standards so it is my suggestion is that this specificity should not be included in the dental hygiene standards.

Thank you,

Ellen

Ellen B. Grimes, RDH, MA, MPA, Ed.D
Dental Hygiene Program Director
Vermont Technical College
Dear Dr. Took,

My name is Ann Spolarich and I am Professor and Director of Research at the Arizona School of Dentistry & Oral Health, A.T. Still University. I am representing the American Dental Hygienists’ Association with my testimony today. I am providing testimony regarding Appendix 4 - Proposed Revisions to Dental Hygiene Standards, Standard 1-1: Planning and Assessment; Page 17, Lines 9-24 and the proposed change to eliminate “research” from the standard.

I think that there is a perception that all dental hygienists need to know how to conduct research, but that is not so. Arguably, those of us who have become researchers know that additional education, training and experience are required beyond entry-level education to be able to conduct original research. However, all dental hygienists must be familiar with basic research principles as well as be good consumers of the scientific literature to support their roles as practicing professionals. Without plans for integrating research into the dental hygiene curriculum, how will clinicians learn how to adopt an evidence-based philosophy of practice? At a bare minimum, clinicians must learn and understand the terminology of research as well as basic study design so that they can critically evaluate the articles that they are reading to support their decision-making and clinical reasoning. Patients depend upon all of us to make recommendations for product selection and treatment interventions that are based on sound science. Clinicians who work on interprofessional care teams need to read and apply key principles learned from the research conducted by our colleagues in other disciplines so that as we care for our mutual patients, our approaches to care are well-aligned to achieve improved patient outcomes. Public health and community-based dental hygienists need to understand how to select and implement the appropriate indices to evaluate the oral health status of their communities so that they can design appropriate interventions. Educators need to know how to measure the impact of their teaching on their students' learning outcomes and the effectiveness of their curricula. These are just some of the most obvious examples of why research principles must be included in all dental hygiene programs. There is a need to support our educational programs with good resources, including faculty training for teaching research methodology and how to critically appraise the literature.

This proposed revision does not support ADHA policy which states, “The American Dental Hygienists’ Association advocates the role of dental hygienists in research, including their contributions to interdisciplinary studies and practice.”

I thank the Commission on Dental Accreditation for their consideration of my testimony.

Sincerely,
Ann Spolarich, RDH, PhD, FSCDH

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Ann Eshenaur Spolarich, RDH, PhD, FSCDH
Professor and Director of Research
Arizona School of Dentistry & Oral Health
A.T. Still University
Commission on Dental Accreditation
Hearing on Accreditation Standards

2020 CODA Hearing on Standards
(ADHA Meeting Replacement)
Monday, May 18, 4:00 – 5:00pm Central Daylight Time
Virtual Hearing

Commissioners in Attendance: Dr. Arthur Chen-Shu Jee (chair), Dr. Scott DeVito, Dr. John Hellstein, Dr. Jeffery Hicks (vice chair), Dr. Susan Kass, and Ms. Deanna Stentiford.

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

Accreditation Standards for Dental Hygiene Education Programs (Appendix 4)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gwendolyn Boyce</td>
<td>Georgia Highlands College, Rome, GA</td>
<td>Standard 2-10, p. 29. There needs to be minimum clinical numbers per week with a total. Does this allow for an average number of hours or is there to be 6, 8 or 12 hours per week.</td>
</tr>
<tr>
<td>Michelle Hurlbutt</td>
<td>West Coast University</td>
<td>Standard 3-5, p. 40. The removal “must not be less than 1 faculty for 5 students” and adding “must not exceed” could create confusion in the interpretation of this requirement. Recommend not using word “exceed”</td>
</tr>
<tr>
<td>Mary-Catherine Dean</td>
<td>Community College of Denver, Denver, Colorado</td>
<td>Standard 3-6, full-time and baccalaureate faculty must have a baccalaureate or higher. Is that for all aspects of the program? Need to clarify.</td>
</tr>
<tr>
<td>Brenda Armstrong</td>
<td>Dixie State University, St. George, Utah</td>
<td>Standard 1-1a, when thinking of service is this community service or patient service.</td>
</tr>
<tr>
<td>Shavonne Healy</td>
<td>Fones School of Dental Hygiene and practicing hygienist.</td>
<td>Standard 2-8c, p. 28. Hoping in the future to see language regarding implantology, which is lacking.</td>
</tr>
<tr>
<td>Michelle Hurlbutt</td>
<td>West Coast University</td>
<td>Standard 3-2, p. 38. Understand where CODA is going but when says “majority of hours” this is</td>
</tr>
<tr>
<td>Commenter</td>
<td>Institution/Program</td>
<td>Standard No.</td>
</tr>
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</tr>
<tr>
<td>Ellen Grimes</td>
<td>Program Director, Vermont Technical College</td>
<td>Standard 2-10, p. 35.</td>
</tr>
<tr>
<td>Michelle Hurlbutt</td>
<td>West Coast University</td>
<td>Standard 2-18, p. 34.</td>
</tr>
<tr>
<td>Dianne Sefo</td>
<td>NYU College of Dentistry</td>
<td>Standard 2-10, p. 29.</td>
</tr>
<tr>
<td>Joanna Allaire</td>
<td>Lone Star College Kingswood, Texas, Program Director</td>
<td>Standard 5-1, p. 51.</td>
</tr>
<tr>
<td>Mary-Catherine Dean</td>
<td>Community College of Denver, Denver, Colorado</td>
<td>Standard 2-24, Curriculum review – changed from ongoing to annual.</td>
</tr>
<tr>
<td>Name</td>
<td>Institution</td>
<td>Comment</td>
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</tr>
<tr>
<td>Wendy Garcia</td>
<td>Fones School of Dental Hygiene</td>
<td>Standard 2-12, p. 31. Example of Evidence, bullet 1, program definition for each patient population. Does this mean that the program defines the patient populations (e.g., adolescent, geriatric, special needs)? Would think there would be a standard definition used by all dental hygiene programs.</td>
</tr>
<tr>
<td>Michelle Hurlbutt</td>
<td>West Coast University</td>
<td>Support colleagues that question change to Standard 2-10. The Standards are competency based, so by changing 2-10 this is no longer competency based. Should not be added with hours; go back to competency based as the other standards</td>
</tr>
<tr>
<td>Marion Manski</td>
<td>Fones School of Dental Hygiene</td>
<td>Agree with other comments on Standard 2-10. Do not support hours being required.</td>
</tr>
<tr>
<td>Amber Telandar</td>
<td>Laramie County Community College, Cheyenne, Wyoming</td>
<td>Agree with other comments on Standard 2-10. Do not support hours being required.</td>
</tr>
<tr>
<td>Joyce Sumi</td>
<td>USC Dental Hygiene</td>
<td>Program definition for periodontology. Will each program define periodontal disease classifications rather than a standard criteria for all programs?</td>
</tr>
<tr>
<td>Marion Manski</td>
<td>Fones School of Dental Hygiene</td>
<td>Standard 2-18, p. 34. Re-write states and the program has chosen to include those functions… Does the program have the ability to choose what it teaches if in state law?</td>
</tr>
<tr>
<td>Gwendolyn Boyce</td>
<td>Georgia Highlands College, Rome, GA</td>
<td>Standard 2-18. We have delegated duties that are delegated to dental assistants and can be done by dental hygienists, so would like to see this stay for program to decide</td>
</tr>
<tr>
<td>Name</td>
<td>Institution</td>
<td>Comment</td>
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</tr>
<tr>
<td>Lida Bilich</td>
<td>Eastern Washington University, Spokane, WA</td>
<td>Agree with last comment. Some delegable duties would be difficult to teach if we didn’t have a dental school. Packing extraction site, for example.</td>
</tr>
<tr>
<td>Dianne Sefo</td>
<td>NYU College of Dentistry</td>
<td>Refer back to 2-18, p. 34. In NY State local anesthesia is an additional certification so maybe this is why the language was changed. Support proposed language.</td>
</tr>
<tr>
<td>Lisa Kamibayashi</td>
<td>West Los Angeles College, Program Director</td>
<td>Support ambiguity of Standard 2-18.</td>
</tr>
<tr>
<td>Sarah Ostrander</td>
<td>Harrisburg Area Community College, Pennsylvania</td>
<td>Standard 3-2, p. 38. Would like to see more definition on majority and limited teaching hours for program director.</td>
</tr>
<tr>
<td>Adina Pineschi-Petty</td>
<td>Dental Hygiene Board of California</td>
<td>Standard 2-18. The Question is not to ambiguity but if there are specific areas of licensure that are required for initial dental hygiene licensure that is where the issue lies. For example, SLN is required for initial licensure and must be in the curriculum. If required for initial licensure the program should not be allowed to include it or not.</td>
</tr>
<tr>
<td>Amber Telander</td>
<td>Laramie County Community College, Cheyenne, WY</td>
<td>Standard 3-5 page 40, ratio 1 faculty to 5 students. Need further clarification. Prior language of may not be less than was clearer.</td>
</tr>
<tr>
<td>Gwendolyn Boyce</td>
<td>Georgia Highlands College, Rome, GA</td>
<td>Standard 3-3, or dentist was added, but last sentence offers an exemption. What is the intent of the change in Standard 3-3? Not sure why the change was made.</td>
</tr>
<tr>
<td>Marina McGraw</td>
<td>Northern Virginia Community college, Program Director</td>
<td>Standard 3-3, confused about statement for dentist being exempt from requirement. What is the exemption?</td>
</tr>
<tr>
<td>Name</td>
<td>Institution</td>
<td>Remarks</td>
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</tr>
<tr>
<td>Wendy Garcia</td>
<td>Fones School of Dental Hygiene</td>
<td>With concern about Standard 3-3, with dentist being appointed prior to date of implementation, this same concept appears on p. 41 with Standard 3-6</td>
</tr>
<tr>
<td>Adina Pineschi-Petty</td>
<td>Dental Hygiene Board of California</td>
<td>Standard 2-10, concern related to clinical practice to experience. There is no definition for clinical or preclinical experience</td>
</tr>
<tr>
<td>Michelle Hurlbutt</td>
<td>West Coast University</td>
<td>Thank CODA for hearing, it was helpful and glad that CODA is interested in voices of those teaching in dental hygiene. Back to Standard 3-6, in favor of requirement that dentist working in dental hygiene program should be graduate of CODA-accredited dental or dental hygiene program.</td>
</tr>
</tbody>
</table>
Hello Michelle,

Below is my suggestion for standard 2-10 that I presented at the hearing today.

Standard 2-10 page 35  Which provides specific hours that students are required to be in clinic per week. As dental hygiene programs are set up very differently and some are set up in quarters, trimesters and semesters and they have various lengths I recommend that there be a total number of minimal clinical and pre-clinical hours that need to be completed and that the program should determine the best method to deliver that education continuously to students. My understanding is that there is no such requirement in the dental standards so it is my suggestion is that this specificity should not be included in the dental hygiene standards.

Thank you,
Ellen

Ellen B. Grimes, RDH, MA, MPA, Ed.D
Dental Hygiene Program Director
Vermont Technical College
Commission on Dental Accreditation  
Hearing on Accreditation Standards  

**2020 CODA Hearing on Standards**  
*(ADA Annual Meeting Hearing)*  

**Tuesday, October 20, 2020, 6:00pm – 7:00pm Central Daylight Time**  
*Virtual Hearing*  

**Commissioners in Attendance:** Dr. Jeffery Hicks (chair), Dr. Bruce Rotter (vice-chair), Dr. Victor Badner, Dr. Joel Berg, Dr. Linda Casser, Dr. Maxine Feinberg, Dr. Amid Ismail, Dr. Susan Kass, Ms. Martha McCaslin, and Dr. Garry Myers.  

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

Accreditation Standards for Dental Hygiene Education Programs (Appendix 2)  

<table>
<thead>
<tr>
<th>Name</th>
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<th>Comment</th>
</tr>
</thead>
</table>
| Lisa Moravec    | Scotts Bluff, Nebraska  
President, American Dental  
Hygienists’ Association  
(ADHA) and  
University of Nebraska  
Lincoln, NE  
Faculty | ADHA values the work of CODA and supports Accreditation Standards. In role as educator, I have seen how standards are implemented. Applaud CODA’s efforts to ensure standards are relevant.  
p. 17, line 9-24 – recommend reject these changes to standard 1-1. Deeply troubled that research is proposed for removal. The word research is used in many other standards. Standard 1-1 must include research as a critical aspect of other standards. Need to educate students on importance of research in patient care. Programs should prepare the next generation of researchers.  
p. 33 line 3 – this is relevant and timely and dental hygiene programs are preparing students for the new classification system. |
<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Kamibayashi</td>
<td>West Los Angeles College Dental Hygiene Program</td>
<td>p. 29 standard 2-10 – minimum hours per week and totals are very prescriptive and competence can be accomplished without specific hours per week. Okay with total hours but this change should be reconsidered, especially due to COVID-19 time. See Written Comment</td>
</tr>
<tr>
<td>Amber Tlander</td>
<td>Laramie County Community College Cheyenne, WY</td>
<td>p. 41, standard 3-6 – Full and part-time faculty must possess BA degree. This is a challenge for some rural states, like Wyoming and this is not a common degree for hygienists in this area.</td>
</tr>
<tr>
<td>Brian Partido</td>
<td>Seattle Central College Seattle, WA</td>
<td>Standard 1-1-Removal of Research – there is a need for research, which becomes more relevant with interprofessional education. Dental hygiene graduates must be well versed in research. Full support that CODA reject proposed revision – this will be detrimental to profession and public.</td>
</tr>
<tr>
<td>Leslie Koberna</td>
<td>Texas Woman’s University Denton, TX</td>
<td>Support for Standard 2-10, which gives program’s the minimum number of hours for preclinical and clinical instruction. This is important in reviewing programs, very important in program review as CODA site visitor. Standard 3-6, education requirement for clinical faculty at baccalaureate degree for FT and PT. This should be the minimum</td>
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<td>Commission on Dental Accreditation</td>
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<td>Hearing on Accreditation Standards</td>
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Requirement, should be degree higher than program offers, including programs at the associate degree level.
October 20, 2020
Commission on Dental Accreditation (CODA)
211 E. Chicago Ave.
19th Floor Chicago, IL 60611

Re: Comments on Proposed Revision to Dental Hygiene Accreditation Standards

Dear CODA Review Committee:

I would like to make a comment on the proposed revision to the Dental Hygiene Accreditation Standards. For Page 29, Standard 2-10, the current proposal is as follows:

Clinical experience must be distributed throughout the curriculum and include the following to ensure students attain clinical competence:

a) minimum of 6 hours of preclinical experience per week, with a minimum of 90 hours total;
b) minimum of 8 hours of clinical experience per week for first year dental hygiene students, with a minimum of 120 hours total; and
c) minimum of 12 hours of clinical experience per week for second and/or final year dental hygiene students, with a minimum of 360 hours total.

I don’t support inclusion of specific number of hours per week for clinical instruction for the standard for the following reasons.

- Specific number of weekly hours will restrict certain activities that can be incorporated in the dental hygiene program. For example, when students desire to attend professional conference and other professional activities, the weekly hours requirements can be a barrier to the attendance and extra-curricular opportunities.

- Specific number of weekly hours will restrict certain students for cultural and religious freedom. For example, students who follows Orthodox Jewish practice, they must be observing some holidays during the semester and they may not be able to fulfill certain numbers of hours per week in certain weeks. They should have opportunities to make up hours before or after holidays. Setting the weekly hours requirement will prohibit certain students’ cultural and religious activities.

- Specific numbers of weekly hours will not allow flexibility during the state of emergency. For example, natural disaster like fires, floods, and pandemic, can result in closing of the clinics and patient flows in the clinic. Requiring certain number of hours during the week may not be possible during the emergency situation.

I support continuous experience that is distributed throughout the curriculum. I agree with the requirements of certain total hours of clinical instruction for the dental hygiene program.

I hope my comments will be taken into the consideration for the final version of the dental hygiene standard update.

Best Regards,

Lisa Kamibayashi, RDH, MSDH
Director of Dental Hygiene Program
Hello Michelle,

Below is my suggestion for standard 2-10 that I presented at the hearing today.

Standard 2-10 page 35  Which provides specific hours that students are required to be in clinic per week. As dental hygiene programs are set up very differently and some are set up in quarters, trimesters and semesters and they have various lengths I recommend that there be a total number of minimal clinical and pre-clinical hours that need to be completed and that the program should determine the best method to deliver that education continuously to students. My understanding is that there is no such requirement in the dental standards so it is my suggestion is that this specificity should not be included in the dental hygiene standards.

Thank you,

Ellen

Ellen B. Grimes, RDH, MA, MPA, Ed.D
Dental Hygiene Program Director
Vermont Technical College
Greetings All,

This proposed change creates several challenges:

- Students complain that they cannot obtain one-on-one instruction with fewer faculty
- The clinic cannot be used to full capacity without the ability to have more than 5 students per faculty
- New budgets cannot accommodate hiring more part-time faculty to accommodate 6 or more students in clinical settings.

3-63.5 The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public. In preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every five students. In laboratory sessions for dental materials courses, there must not be less than one faculty for every ten students to ensure the development of clinical competence and maximum protection of the patient, faculty and students.

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

Thank you,

Dr. Tracey A. Moore, RDH, MS
Chair, Department of Dental Hygiene
Northern Arizona University

“Human compassion is equal to human cruelty. It is up to each of us to tip the balance.”
-Alice Walker
Hello Michelle,

I wanted to express concerns for revisions in Standards 3-6 (previously 3-7) by adding part-time faculty to require BS. That is definitely a burden for our program at a community college. We employ multiple part-time clinical faculty with an associates degree due to the ratios required. They do not teach in the classroom but have strong clinical skills. We would definitely be limited in applicants for employment since many hygienists do not possess a BS degree in our area. Also, the pay scale would also be higher with a higher degree. I have significant concerns on the financial impact to the institution and also difficulty in filling positions.

In regards to Standard 2-18, I support the language "the program has chosen to include those functions"
There are a lot of functions that the board lists that add significant content to the curriculum if required.

For Standard 2-24, I support the language of "annual formal"

For Standard 3-2, it would be helpful to add a minimum percentage expected (51%) in the intent to clarify "majority of hours."

Thank you for consideration,

Angie Maida
Greetings,

I would like to comment that the proposed Accreditation Standard 2-10 for Dental Hygiene Education Programs is too specific in requiring a minimum number of hours for preclinical and clinical experiences to deem students competent. The number of total hours of pre-clinical and clinical experiences necessary to deem a student’s competence can vary between each student. Faculty members should not be restricted by a specific number of hours to determine a student’s competence.

Kind regards,

Jackie

Jacqueline Singleton, RDH, MEd, PhD
Dental Hygiene Program Director
University of Louisville School of Dentistry
May 27, 2020

Michelle Smith, RDH, MS
Manager, Allied Dental Education
Commission on Dental Accreditation (CODA)
211 E. Chicago Ave.
Chicago, IL 60611

Re: Proposed Revision to Dental Hygiene Standards

Dear Ms. Smith:

I am writing to you with the purpose of submitting my written comments on the “Proposed Revision to Dental Hygiene Standards” specifically the proposed revision for 3-7:

3-7 3-6 The full-time and part-time faculty of a dental hygiene program must possess a baccalaureate or higher degree. All part-time clinical and dental science laboratory faculty appointed prior to [date of implementation] are exempt from the degree requirement.

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

I totally agree with, and support, the change regarding part-time faculty who provide didactic instruction. However, I would like to propose the following wording to be consider in regards to part-time clinical instructors:

3-7 3-6 The full-time and all part-time faculty providing didactic instruction of a dental hygiene program must possess a baccalaureate or higher degree. All part-time preclinical/clinical instructors and dental science laboratory faculty appointed prior to [date of implementation] are exempt from the this degree requirement.

My rational for this change in wording is:

- Preclinical/clinical instructors are primarily hired for their clinical experience. Their real and current clinical experience is valuable in helping students “connect the dots” between their didactic learning experience and the required clinical application.

An Equal Opportunity Employer
To require all part-time preclinical/clinical instructors to possess a baccalaureate degree will severely handicap community college dental hygiene programs in particular for the following two reasons:

1. Recruiting part-time faculty is extremely difficult, because of the inability of our pay scale structure to compete with what dental hygienist can earn in private practice or with large organizational clinics. We constantly lose part-time instructors because they are offered higher pay by private practices in the area and/or by the many Naval dental clinics at Camp Lejeune here in Jacksonville.

2. From my vantage point in life, requiring all part-time preclinical/clinical instructors to possess a baccalaureate degree is degree creep, and in my opinion, for those of us in the very important nationwide community college system of higher education, it will cripple our efforts to find qualified and talented part-time preclinical/clinical instructors.

It is for these reasons I respectfully submit my comments to you for considerations.

Sincerely yours,

Warren F. Gabarée, Jr., D.D.S., M.Ed
Department Head/Instructor, Dental Programs
Coastal Carolina Community College
Commission on Dental Accreditation  
211 E. Chicago Avenue, 19th Floor  
Chicago, IL 60611

5/29/2020

Dear Commission on Dental Accreditation,

This email is to comment on the proposed Accreditation Standards for Dental Hygiene Education Programs. The two standards I would like to provide comments on are 3-3 and proposed 3-6.

3-3 The program administrator must be a dental hygienist or a dentist who is a graduate of a program accredited by the Commission on Dental Accreditation and possesses a masters or higher degree, or is currently enrolled in a masters or higher degree program or a dentist who has background in education and the professional experience necessary to understand and fulfill the program goals. A dentist who was appointed as program administrator prior to [date of implementation] is exempt from the graduation requirement.

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

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

Comment: I understand that this standard intends to have program administrators who have advanced degrees that focus on education (a master’s degree) lead dental hygiene programs. The probability that there are individuals in all areas of the United States that have dental hygiene schools that possess these advanced degrees, may not be accurate. A dental hygienist who is interested in leading a program should have the opportunity to lead a program while working towards an advanced degree. Most hygienists in our area, graduate with an associate’s degree. They do have the opportunity to start working on a bachelor’s while in the program but may choose to finish it later. They practice for several years and then go back to school to pursue their master’s degree. Many are enrolling in online programs that focus on dental hygiene education (like Idaho State University, Eastern Washington, UMKC, etc.) and are receiving strong dental hygiene education backgrounds to lead these programs. Please don’t limit these individuals on pursuing an open position because the degree is not complete. Dental hygiene schools need program directors who are interested in administrative work, especially with the influx of retirements that are/will be
occurring. Administrative work is not for the faint of heart.

I do agree that the dentists who are leading these programs need an advanced degree with educational background. The DDS curriculum does not provide an educational program on how to teach adult learners, provide budgets for a department, understand curriculum and accreditation, understand conflict resolution, etc. It provides a curriculum for the entry-level dentist.

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

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

All dental hygiene program faculty members must have:

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

Comment: While I am in favor of the entry-level degree for dental hygiene to be a bachelor’s degree, my program grants an associate’s degree through Sheridan College. We do have a partnership with the University of Wyoming and students can transfer their pre-requisites and dental hygiene courses to the University and complete 15-18 more upper-division credits to complete a bachelor’s degree. Students have the option to complete the associate’s degree or both the associates and bachelor’s degrees at the time of graduation (or later). There is no difference in pay in our state if you have an associate degree or a bachelor’s degree. Many of our students are interested in coming back and helping us teach the new generation of dental hygiene students.

I agree that the full-time faculty member must possess a bachelor’s degree. At our institution, we need to have one degree higher than the degree we are granting. If the faculty member wants to become tenured, they must possess a master's degree. Those full-time who do not have a master’s degree are placed on a non-tenure track.

I do not agree that the part-time instructors in the clinic/labs (not the lead instructor) must possess a bachelor’s degree. The previous students that I mentioned above who received the associates’ degree who come back and help us teach in the clinic are the ones who have been in the “trenches” and really understand what is going on in private practice. Their clinic experience is very important as they connect with the students and help them adapt their instruments to remove a piece of calculus or help them understand the flow of the appointment and increasing their speed to make a 45-minute appointment possible. We need educators who have dental hygiene experience. Based on their experience, as well as advanced education allows program directors to place educators in the correct learning environment (lab, clinic, lecture). Part-time instructing is also a great way to “groom”
future full-time faculty members. We need to think about how to develop future educators and not limit them based on the degree they currently have. Find the correct fit and then encourage them to complete more advanced education.

Thank you for the opportunity to provide comments on the proposed Accreditation Standards for Dental Hygiene Education Programs.

Sincerely,

Sara L. Beres
Sheridan College Dental Hygiene Director
Dear Manager, Allied Dental Ed Smith,

Please do NOT eliminate the word "research" from standard 1-1. It is essential that the dental hygiene profession contributes to the body of scientific evidence supporting our profession. It is unacceptable to eliminate this term from the educational requirements.

Sincerely,

Elizabeth Carr
Dear Manager, Allied Dental Ed Smith,

My name is Sarah Jackson and I am full time faculty in the dental hygiene department at Eastern Washington University. I am concerned with the changes to Standard 1-1 on page 17, lines 9 through 24 because the proposed text would remove the word research from the standard.

Research is key to advancing the profession and I feel this should not be taken out of the standard.

Sincerely,

Sarah Jackson
Dear Manager, Allied Dental Ed Smith,

My name is Dawn Ann Dean, RDH, MSDH, and I have served the dental hygiene profession for 30+ years as a Clinical Dental Hygienist, researcher, educator, and RDH entrepreneur, in addition to serving the American Dental Hygienists’ Association (ADHA) for 20+ years in volunteer leadership on the local, state, and national level. I am commenting today on Standard 1-1 Planning & Assessment and recommending that CODA reject the proposal to eliminate “research” from the Standard. Research is critical to the advancement of the dental hygiene profession and ADHA’s policy advocates for the role of dental hygienists in research, including contributing to interdisciplinary studies and practice. Research scholarship and literacy are vital to providing evidence-based treatment and oral and overall health care. Dental Hygiene research should be included in all aspects of planning and assessment of every level of dental hygiene education.

Sincerely,

Dawn Dean
Dear Manager, Allied Dental Ed Smith,

My name is Lisa Bilich and I live in Idaho but I am the Department Chair of a Dental Hygiene Program at Eastern Washington University. I have been a dental hygienist for 31 years. I am writing to you about the proposed change eliminating “research” from the standard 1-1 on page 17, Lines 9-24.

I feel research is an important part of being a dental hygienist. Dental Hygiene is an evidence-based profession that is constantly changing. A dental hygienist who is the preventive professional in the dental office needs to be able to apply critical thinking when recommending treatment and/or products. Students need to be guided on how to apply research and how to research best practices. This is an important part of dental hygiene education.

In closing, I am opposed to the removal of the word research in Standard 1-1 on page 17, Lines 9-24.

Kind Regards,
Lisa Bilich RDH, MSEd, Department Chair

Sincerely,

Lisa Bilich
July 9, 2020

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

Dear Doctor Jee:

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

However, the Council was not supportive of the proposed additions to Standard 3-3 and 3-6. Specifically, the current Standard 3-3 states that a dental hygienist or dentist may serve as a program director. If the proposed language is adopted, in the future dentist-directors must be graduates of a dental (DDS/DMD) program accredited by the Commission on Dental Accreditation. This change will disqualify internationally trained dentists in the future from serving in the capacity of program director. The Council had the same concern regarding the proposed change to Standard 3-6.

Accordingly, the Council urges the Commission to modify Standards 3-3 and 3-6 so that licensed dentists who are not graduates of CODA-accredited dental education programs also may serve as dental hygiene program directors or faculty members in the future.

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

Sincerely,

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

LCN:ap

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

My name is Marcia Lorentzen from Weston, Connecticut and I just completed 7 1/2 years as Dean/Director of the Fones School of Dental Hygiene at the University of Bridgeport, January 2012 to May 2019.

I recommend that CODA reject the proposed changes to Standard 1-1 on page 17, lines 9-24 because the proposed change would eliminate the word “research” from the standard.

I have been a faculty member of the Fones School of Dental Hygiene since 1995, and graduated from this program in the 1970’s. I have used my understanding of research principles and knowledge of indices to provide thorough patient assessments and plans for treatment throughout my clinical practice and in my teaching of courses in the entry-level program: Clinic I, II, III, and IV, and Periodontology I and II. An effective dental hygiene education demands that students learn about research and how it is integrated with dental and oral hygiene patient assessments, treatment plans, and customized continued professional and personal care. As primary health-care providers, dental hygiene practitioners need to have skills in looking for and referencing research as this is the evidence-based support for planning treatment, sharing that with the patient/client, and effectively collaborating with other professional to improve health outcomes.

The intent of Standard 1-1, lines 29-34, references that a formal and ongoing process ... “to promote achievement of program goals will maximize the academic success of the enrolled students in an accountable and cost effective manner......” The foundation of the dental hygiene profession requires dedicated teaching in and successful formative and summative assessment of program students in the technically demanding dental hygiene profession. Research is integral to dental hygiene education, as are skills in teaching, patient care, and service. These four elements need to continue to be addressed within the educational program and evaluated for attainment. Support for retaining “research” in Standard 1-1 is found in Standard 2-6, Curriculum, on page 25, and is additionally validated with reference to life-long learner in Standards 2-21 through 2-23, Critical Thinking, on page 36.

Sincerely,

Marcia Lorentzen
Dear Manager, Allied Dental Ed Smith,

My name is Heather Hessheimer from Lincoln, Nebraska and I am an Assistant Professor at the University of Nebraska Medical Center (UNMC) Dental Hygiene Program. Thank you for hearing comments from fellow educators.

My only comment is on the removal of the word, "research" from Standard 1-1 on page 17, lines 9 through 24. While UNMC is very fortunate to be a bachelor's degree program within a dental school, I do realize there are many programs that do not have faculty who can teach and assist students with conducting a research project. However, I believe that research is still an integral role in treating patients using evidence based practice and thus is very important to the assessment and planning of treatment for patients. Programs could demonstrate that they fulfill teaching research by implementing critically appraised topic projects or by teaching research methodology and how to read research articles. Article reviews are a great way for entry level dental hygienists to begin to understand what to look for in literature when patients ask them questions. It will also be imperative as they are introduced to new products/theories.

By removing the word "research", I feel it takes the profession of dental hygiene backwards and lowers our expectations for evidence based practice, which we all know is vital in the treatment of our patients. Thank you for your consideration.

Sincerely,

Heather Hessheimer
Dear Manager, Allied Dental Ed Smith,

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

Sincerely,

Kim Attanasi
Greetings All,

3-63.5 The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public. In preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every five students. In laboratory sessions for dental materials courses, there must not be less than one faculty for every ten students. To ensure the development of clinical competence and maximum protection of the patient, faculty and students.

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

This proposed change creates several challenges by limiting the number of faculty:

- Students constantly complain that they cannot obtain one-on-one instruction with fewer faculty; therefore, more faulty in labs and clinics improves student learning outcomes.
- The clinic cannot be used to full capacity without the ability to have more than 5 students per faculty. For larger student populations, this proposed change limits the number of students assigned to clinical and laboratory settings.
- New budgets cannot accommodate hiring more part-time faculty to accommodate 6 or more students in clinical settings. For larger student populations, this proposed change would require hiring more part-time faculty and/or providing additional clinics and lab offerings.

The recommended language should read:

1. In preclinical and clinical sessions, the ratio should be a minimum of one (1) faculty per five (5) students.
2. In radiography laboratory sessions, the ratio should be a minimum of one (1) faculty per five (5) students.
3. In other dental sciences laboratory sessions, the ratio should be a minimum of one (1) faculty per ten (10) students.
Extended campus facilities may not have faculty hired by the school to provide clinical instruction for students. Many extended campus facilities have employees (dentists, hygienists) who are calibrated by the school, but not necessarily employed faculty by the school.

The recommended language should read:

f. clinical instruction is provided and evaluated by calibrated dental hygiene program designated personnel

Thank you,

Dr. Tracye A. Moore, RDH, MS
Chair, Department of Dental Hygiene
Northern Arizona University

"Human compassion is equal to human cruelty. It is up to each of us to tip the balance."
Dear Manager, Allied Dental Ed Smith,

I am concerned about the proposed changes to Standard 1-1 on page 17, lines 9 through 24 because the proposed text would remove the word research from the standard. Research is an integral aspect of advancing the dental hygiene profession and ADHA’s policy advocates the role of dental hygienists in research, including their contributions to interdisciplinary studies and practice.

Sincerely,

Anaika Forbes
Dear Manager, Allied Dental Ed Smith,

My name is Dianne Sefo from New York, NY and I am the Chair of the Department of Dental Hygiene and Dental Assisting at New York University. I am in opposition for the adoption of Standard 1-1 on page 17, lines 9 through 24 with the removal of the word research. Research is an integral aspect of the dental hygiene profession and should be included in program goals to comprehensively prepare competent individuals in the discipline. I am also in opposition for the adoption of Standard 2-10 on page 29, lines 29 through 38. The total number of preclinical and clinical hours does not ensure competency. Different individuals may attain competency in various skills at various times, which would be determined by successful completion of competency assessments, not by total number of hours completed.

Sincerely,

Dianne Sefo
Michelle,

I wanted to formally express the UMMC School of Dentistry Department of Dental Hygiene’s **opposition** to the elimination of the word ‘research’ from Appendix 2, Subpage 17 line 9 of the Proposed Revisions to Dental Hygiene Standards document.

Rationale: The profession demands a body of research, Universities demand research for progression of faculty, and students who are not taught the importance of research will not pursue research after graduation. Eliminating this essential function from programs is detrimental.

Thank you,

Elizabeth O. Carr, RDH, MDH, DHA, MAADH
Associate Professor of Dental Hygiene
Chair- Dental Hygiene Department
Coordinator- Online Dental Hygiene Advanced Standing Baccalaureate Program
University of Mississippi Medical Center
School of Dentistry Department of Dental Hygiene

Individuals who have received this information in error or are not authorized to receive it must promptly return or dispose of the information and notify the sender. Those individuals are hereby notified that they are strictly prohibited from reviewing, forwarding, printing, copying, distributing or using this information in any way.
Michelle,

I am expressing my opposition to the elimination of a Baccalaureate degree for part time clinical faculty, which is listed in the proposed standards change document for current standard 3-7. **The elimination of educated faculty is unacceptable.** We are NOT in a shortage of BS-degree level faculty members in this country. Decreasing not only the education of faculty members but also ignoring the precedent of virtually every higher educational system (your teacher is one degree higher than the one you are attaining) is totally against what educational norms are.

I voraciously oppose the elimination of the BS degree requirement changes that CODA is proposing, and frankly this is offensive to me personally.

Elizabeth O. Carr, RDH, MDH, DHA, MAADH
Associate Professor of Dental Hygiene
Chair- Dental Hygiene Department
Coordinator- Online Dental Hygiene Advanced Standing Baccalaureate Program
University of Mississippi Medical Center
School of Dentistry Department of Dental Hygiene

Individuals who have received this information in error or are not authorized to receive it must promptly return or dispose of the information and notify the sender. Those individuals are hereby notified that they are strictly prohibited from reviewing, forwarding, printing, copying, distributing or using this information in any way.
Dear Manager, Allied Dental Ed Smith,

My name is Winnie Furnari and I am a dental Hygienist in New York employed by NYU College of Dentistry as a clinical professor. I am writing in opposition to the change in Standard 1-1 page 17 lines 9-24 with the removal of the word research. Research serves as a validation for the science involved with the delivery of dental hygiene care. Dentistry on the whole can only benefit from this activity and therefore in the planning and assessment of dental hygiene education, research should stay in the standard. This way future members of the profession will be accustomed to performing, evaluating and implementing research in everyday practice and in the future advancement of dentistry.

Sincerely,

Winnie Furnari
I am writing regarding the proposed changes to Standard 3-6 requiring a BS degree in dental hygiene preclinic/clinical settings. This change would put a significant strain on community colleges where there is not likely to be funding for an advanced degree. Given that educational methodologies training is a requirement for all faculty, it is clear that faculty without a BS degree are well-prepared for clinical education settings. Additionally, community colleges would be at a disadvantage in comparison to bachelor degree programs where they can easily “feed” their open positions with graduating students. For these reasons, I strongly oppose this proposed change.

Sincerely,

Jean Conover
Jeann Conover, RDH, MS
Assistant Professor, Dental Hygiene
From: [Redacted]
Sent: Tuesday, October 20, 2020 6:30 PM
To: Tooks, Sherin <tookss@ada.org>
Subject: Discussion on Standards

I could not get my microphone to work with asked during the hearing. My comment is regarding DH Standard 3-2. I would like to see the Standard state only dental hygienists as program directors.

Sent from Windows Mail
November 30, 2020

As the director of the dental hygiene program at Midlands Technical College in Columbia, SC, I would like to submit comments concerning the proposed changes to the Accreditation Standards for Dental Hygiene Education Programs, in particular Standard 3-7.

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

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

All dental hygiene program faculty members must have:

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

Requiring all newly hired part-time clinical faculty to have a baccalaureate degree will place undue hardship on dental hygiene programs in states that do not offer this degree level in our discipline. South Carolina does have dental hygienists with baccalaureate degrees, but I would say the majority of these individuals do not possess this higher degree. As the requirement for licensure in South Carolina is graduation “from a dental hygiene institution approved by the American Dental Association (ADA) Commission on Dental Accreditation (CODA)” with no specification of the type of degree earned, most dental hygienists who attend school in our state earn the Associate of Applied Science in Dental Hygiene as this is the only degree level offered in our state. As this is the minimum requirement for a license to be awarded and the opportunity to pursue higher degrees in this particular field in South Carolina does not exist, many registered dental hygienists do not further their formal education to earn this degree.

With so few full-time teaching positions available in dental hygiene and little else to do with an advanced dental hygiene degree in our state, it is not reasonable to expect that anyone would take on the expense of out-of-state tuition for a part-time position. I realize that this proposal does not state that the baccalaureate degree must be in dental hygiene; but if a graduate of an AAS dental hygiene program transfers to an in-state 4-year institution, many of the credit hours will be lost as most institutions will not award credit for dental hygiene coursework.
Finally, I must wonder how such a change will actually benefit dental hygiene students in our program. By limiting instruction from faculty with a Bachelor’s degree, the students will inevitably be deprived of dental hygienists with Associate degrees who have vast practical knowledge that comes from working in the field for 20+ years. Along the same line of thinking, coursework that faculty must take in order to complete a BS degree is often completely outside the scope of dental hygiene. For example, one of our current part-time faculty is completing her BS degree in the spring. One of the courses she will be taking is Art History. While helping her to be a well-rounded citizen, how does that course benefit our dental hygiene students?

Due to the reasons noted above, the requirement that all clinical faculty to possess a baccalaureate degree will place a hardship on our program as it will be very difficult for us to find qualified personnel.

Sincerely submitted,

[Signature]

Lee Hines Muthig, BA, MSDH, CDA, RDH
Allied Dental Education Program Director
Midlands Technical College
November 20, 2020
Commission on Dental Accreditation
RE: Proposed Revisions to Dental Hygiene Standards
Due: Dec. 1, 2020 for Winter 2021 Commission Meeting

ATTN: Ms. Michelle Smith, RDH, MS
Manager, Allied Dental Education
Commission on Dental Accreditation
211 E Chicago Avenue
Chicago, IL 60611

After review of the proposed Revisions to Dental Hygiene Standards, I offer the following feedback on select proposed Standards for the CODA Winter 2020 Meeting from Weber State University:

<table>
<thead>
<tr>
<th>Proposed Standard Change</th>
<th>Comment/Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>We speak against this standard as written.</td>
</tr>
<tr>
<td></td>
<td>Research was omitted from the proposed standards, we recommend re-insertion; even broadly understood, the conduct and inclusion of research in an academic institution is the backbone of our professional endeavors.</td>
</tr>
<tr>
<td>1-2</td>
<td>We speak against this standard as written.</td>
</tr>
<tr>
<td></td>
<td>As proposed, the standard, intent and examples seem duplicative of existing standards.</td>
</tr>
<tr>
<td>2-6, 2-7</td>
<td>We suggest the commission offer a standardized form for the requested competencies and evaluation if it requires reporting this information in a singular document; in addition to the syllabi.</td>
</tr>
<tr>
<td>2-10</td>
<td>We speak against this standard as proposed.</td>
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<td></td>
<td>If clinical competence is determined by the faculty program, any required minimum hours of clinical experience is contradictory to this concept; further, the length of total hours available is dependent on the individual institutional academic calendar.</td>
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<td>2-15</td>
<td>We favor the inclusion of IPE within the profession, but request clarification from the Commission on the standard as proposed. While the value of IPE is recognized and supported &amp; the care provided by Dental Hygienists is arguably valuable, the Commission should more clearly identify the clinical IPE expectations related to this proposed Standard; otherwise, it may simply default to IPE activities confined to community based oral health projects.</td>
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<td>3-3</td>
<td>We speak against this standard as proposed/written. An Administrator of a Dental Hygiene Program <em>must</em> be a dental hygienist. Dental education provides minimal experience with dental hygiene education, including the background and skills necessary in primary prevention and therapeutics in the field of dental hygiene.</td>
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<td>3-5</td>
<td>We speak against the deletion of the standard. The deletion of this standard is detrimental to the ability of the program administrator, faculty, and the institution to provide students with a quality education.</td>
</tr>
<tr>
<td>3-6 Revised to 3-5, Faculty/Student Ratio</td>
<td>We speak against this standard as proposed/written. The ratio of pre-clinic and radiography lab faculty to students should be re-examined; especially with the availability of digital radiography &amp; available safety measures. The ratio should be considered 1:10 so it is equivalent to other lab sessions and/or can be determined by the program. Clinical sessions with patients should be retained at 1:5 ratio.</td>
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<tr>
<td>3-7 Revised to 3-6</td>
<td>We speak against this standard as proposed/written. We recommend the commission include part-time faculty 50% or higher, and Full time (100%) faculty of a dental hygiene program must possess a master’s degree or higher degree to assure competency in the discipline. The commission should be supportive of academic progression. The issue of faculty calibration for clinical evaluation may be better presented within its own standard as it is a separate issue.</td>
</tr>
</tbody>
</table>
We speak against the standard as written
The inclusion of modern dental radiography equipment is vital to not only the educational preparation of students, but the safety of patients.

Please let me know if you have any questions.

Sincerely,

Frances McConaughy RDH, MS
Chair and Professor
Weber State University
Comments to CODA on Appendix 2 Proposed Revisions to Dental Hygiene Standards

My name is Marilynn Rothen, a dental hygienist, who is a Clinical Associate Professor at the University of Washington School of Dentistry. In that role I’m the research manager of the School’s Dental Research Center and the Associate Director of the Master’s Degree Program for Dental Hygienists. My comments are in regards to the Proposed Revisions to Dental Hygiene Standards, Standard 1-1 – Planning and Assessment, page 17, lines 9-24.

I recommend that CODA reject the revision that removes the word “research” from the standard. Research is as foundational to dental hygiene education as is teaching, patient care, and service. It is the science on which these other elements are founded. It is critical that students understand that dental hygiene is a science-based profession and dental hygiene education is a science-based pedagogy. It is important that the research on which the science is based is included across the curriculum.

All dental hygienists need to be familiar with basic research principles and how to be consumers of scientific literature to support all the roles that dental hygienists are educated to fill whether in education, public health, research or clinical practice. This essential knowledge and skill is clear in regards to providing evidence-based patient care, but might be overlooked when considering how dental hygiene students engage in interprofessional education (IPE) with other professions and as practicing clinicians engaged in interprofessional practice (IPP). Dental hygiene students and dental hygiene practitioners will interface with other professions trained in providing evidence-based care based on research principles and the ability to be good consumers of the scientific literature. Dental hygiene students, and later as practitioners, need a basic education in research knowledge to align well on interprofessional teams.

Additionally, in many states dental hygienists are direct access providers of clinical care in various settings. In such situations, they need to be able to determine best practices based on sound scientific evidence. Their dental hygiene education is responsible to provide the basic skills to understand how to access and use the knowledge generated by research.

As educators, dental hygienists use research and research principles in their planning and assessment of programs, curriculum, and student learning outcomes. The proposed new Standard 1-2 recognizes the value of research in the intent statement that says the program should also support and cultivate the development of professionalism and ethical behavior by fostering, among other things, scholarship.

A culture of understanding and appreciation for research and its contributions to the science-based practice of the profession of dental hygiene needs to be
inculcated during the education process. As graduates dental hygienists will be prepared to be life long learners, remain knowledgeable practitioners, be future educators, researchers, public health providers or administrators. They will expect change; they will expect science to provide new knowledge and solve problems, with the goal of improved oral health for the public.

Thank you for your consideration of these comments.

Sincerely,

Marilynn Rothen, RDH, MS
Hello,

I am providing comments on several of the proposed changes to the Accreditation Standards for Dental Hygiene Programs.

1. **Please do not delete 2-24 d)**. This has been one of the best additions to the standards. As a result of this standard we have implemented several very effective clinical calibration activities that have involved *everyone* as they were *required* clinical calibration activities.

   2-24 The dental hygiene program must have a formal, written curriculum management plan, which includes:
   
   1. a) an *ongoing annual formal* curriculum review and evaluation process with input from faculty, students, administration and other appropriate sources;
   2. b) evaluation of the effectiveness of all courses as they support the program’s goals and competencies;
   3. c) a defined mechanism for coordinating instruction among dental hygiene program faculty.
   4. d) a defined mechanism to calibrate dental hygiene faculty for student clinical evaluation.

2. Please consider deleting or modifying 1-2. This seems excessive particularly for small dental hygiene programs. Professionalism is an evaluated component of student classroom and clinical performance. Concerns related to faculty and staff professionalism/ethical behavior is reflected in performance assessment. I don’t understand this example of evidence to demonstrate compliance: *Student, faculty, and patient groups* involved in promoting diversity, professionalism and/or leadership support for their activities. What does it mean to gather evidence about *patient groups* involved in promoting diversity, professionalism and/or leadership support for their activities?

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

   **Intent:**

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

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

   • Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available. *Student, faculty,*
and patient groups involved in promoting diversity, professionalism and leadership support for their activities

• Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment

Thank you for offering the opportunity to provide input to the proposed changes.

Best Regards,

Kathi Hock

Kathleen A. Hock, R.D.H., M.Ed.
Coordinator and Professor
Dental Hygiene Program
William Rainey Harper College

Do Your Part, Stay Apart.
Stay Safe, Stay Strong.

Please visit harpercollege.edu/advisory for the latest on Harper College’s COVID-19 response.