INFORMATIONAL REPORT ON ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS PROGRAMS (RESIDENCY AND FELLOWSHIP) ANNUAL SURVEY CURRICULUM DATA

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 both orthodontics and dentofacial orthopedics residency programs and clinical fellowship training programs in craniofacial and special care orthodontics in alternate years. The most recent Curriculum Section was conducted in August/September 2020. Aggregate data of the most recent Curriculum Sections for review by the Review Committee on Orthodontics and Dentofacial Orthopedics Education as informational reports are provided in Appendix 1 and Appendix 2.

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education is requested to review the informational reports on aggregate data of its discipline-specific Annual Survey Curriculum Sections (Appendix 1 and Appendix 2).

Recommendation:

Prepared by: Ms. Jennifer E. Snow
Annual Survey Curriculum Section for Orthodontics Residency Programs

2020-21 Orthodontics and Dentofacial Orthopedics Curriculum Survey Results

This report includes data from all 68 Orthodontics and Dentofacial Orthopedics programs accredited in August 2020.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?

<table>
<thead>
<tr>
<th>Area</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Clinical (include related laboratory activity)</td>
<td>45.0</td>
<td>80.0</td>
<td>60.8</td>
<td>68</td>
</tr>
<tr>
<td>b. Didactic (include assigned laboratory activity)</td>
<td>8.0</td>
<td>41.0</td>
<td>23.2</td>
<td>68</td>
</tr>
<tr>
<td>c. Research</td>
<td>3.0</td>
<td>25.0</td>
<td>11.6</td>
<td>68</td>
</tr>
<tr>
<td>d. Teaching</td>
<td>0.0</td>
<td>10.0</td>
<td>4.1</td>
<td>68</td>
</tr>
<tr>
<td>e. Other, please specify</td>
<td>0.0</td>
<td>5.0</td>
<td>0.2</td>
<td>68</td>
</tr>
</tbody>
</table>

Other Area:

- Enrichment / National and regional meetings
- Lab
- Service
- Guest Speakers & Interdepartment Seminars
- Attending Local, Regional and National Meetings and Seminars
- Self-Study
- Craniofacial Center rotation; Orthognathic surgery case discussion; Attending surgery procedures; Departmental Grand Rounds; Research series presentation attendance.
22. In which of the following interdisciplinary approaches did students/residents receive instruction or gain clinical consultation experience during the past 24-month period for the management of dental patients?

<table>
<thead>
<tr>
<th>Receive Instruction/Gain Clinical Consultation Experience?</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Case history</td>
<td>100.0%</td>
<td>0.0%</td>
<td>68</td>
</tr>
<tr>
<td>b. Cephalometric analysis</td>
<td>100.0%</td>
<td>0.0%</td>
<td>68</td>
</tr>
<tr>
<td>c. Intraoral radiographs</td>
<td>98.5%</td>
<td>1.5%</td>
<td>68</td>
</tr>
<tr>
<td>d. Model Analysis</td>
<td>100.0%</td>
<td>0.0%</td>
<td>68</td>
</tr>
<tr>
<td>d1. Model Analysis: Plaster cast</td>
<td>88.2%</td>
<td>11.8%</td>
<td>68</td>
</tr>
<tr>
<td>d2. Model Analysis: Digital models</td>
<td>97.1%</td>
<td>2.9%</td>
<td>68</td>
</tr>
<tr>
<td>e. Photographics</td>
<td>100.0%</td>
<td>0.0%</td>
<td>68</td>
</tr>
<tr>
<td>f. Cone beam imaging</td>
<td>100.0%</td>
<td>0.0%</td>
<td>68</td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td>23.5%</td>
<td>76.5%</td>
<td>68</td>
</tr>
</tbody>
</table>

**Other Interdisciplinary Approach:**

- Surgical orthodontics
- Virtual 3D surgical planning
  1) CR-CO assessment, 2) TMJ tomograms
- Intraoral scanning
- Intraoral scanning, dental laser
- 3D Intraoral Scan
- Virtual orthognathic surgical treatment planning & Multi-disciplinary dental treatment provided in the hospital-based Dental Department setting
- Cleft Palate and Orthognathic Surgery
- 3D tx planning
- Laser
- In-house Aligners
- Interdisciplinary seminar series participate (Orthodontics, Periodontics and Prosthodontics; Oral maxillofacial surgery case discussions and treatment planning reviews.
- Digital treatment planning
- Perio-AEGD-OMFS Conferences
- Temporary Anchorage Device Placement
ITero scanner
23. What percentage of all patients are managed by the students/residents in each of the following treatment mechanisms?

<table>
<thead>
<tr>
<th>Treatment Mechanism</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Begg Appliance</td>
<td>0.0</td>
<td>10.0</td>
<td>0.1</td>
<td>68</td>
</tr>
<tr>
<td>b. Edgewise</td>
<td>0.0</td>
<td>95.0</td>
<td>77.1</td>
<td>68</td>
</tr>
<tr>
<td>c. Functional: Fixed</td>
<td>0.0</td>
<td>25.0</td>
<td>7.8</td>
<td>68</td>
</tr>
<tr>
<td>d. Functional: Removable</td>
<td>0.0</td>
<td>10.0</td>
<td>2.6</td>
<td>68</td>
</tr>
<tr>
<td>e. Universal</td>
<td>0.0</td>
<td>45.0</td>
<td>0.9</td>
<td>68</td>
</tr>
<tr>
<td>f. Aligners</td>
<td>0.0</td>
<td>40.0</td>
<td>10.4</td>
<td>68</td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td>0.0</td>
<td>65.0</td>
<td>1.2</td>
<td>68</td>
</tr>
</tbody>
</table>

**Other Treatment Mechanism:**

- Digitally customized brackets
- fixed lingual (Incognito)
- lingual
- SARPE/MARPE/RED/DECLEARC
- Lingual Appliances
- Straightwire
24. What clinical procedures exist to ensure program objectives are met? Check all that apply.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience with pre-surgical orthopedics for infants born with cleft lip and palate</td>
<td>51.5%</td>
</tr>
<tr>
<td>Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition</td>
<td>83.8%</td>
</tr>
<tr>
<td>Orthodontic management of patients with cleft or craniofacial anomalies</td>
<td>91.2%</td>
</tr>
<tr>
<td>Surgical/orthodontic treatment planning</td>
<td>98.5%</td>
</tr>
<tr>
<td>Pre- and post-surgical orthodontic management</td>
<td>98.5%</td>
</tr>
<tr>
<td>Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement</td>
<td>69.1%</td>
</tr>
<tr>
<td>Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs</td>
<td>97.1%</td>
</tr>
<tr>
<td>Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&amp;SC) patients</td>
<td>88.2%</td>
</tr>
<tr>
<td>Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&amp;SC patients</td>
<td>97.1%</td>
</tr>
<tr>
<td>Supervised participation in craniofacial team activities</td>
<td>86.8%</td>
</tr>
<tr>
<td>Participate in craniofacial team meetings</td>
<td>83.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

25. How many surgical orthodontic cases were managed with the active participation of the students/residents during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of surgical orthodontic cases</td>
<td>3.0</td>
<td>130.0</td>
<td>37.4</td>
</tr>
</tbody>
</table>

26. How many patients were managed by the students/residents during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>200.0</td>
<td>4100.0</td>
<td>1197.6</td>
</tr>
</tbody>
</table>
23(b) Edgewise includes Straight Wire appliances.

23: C&D have functionals initially followed by edgewise treatment 25: We have [REDACTED] residents per class ([REDACTED] for Class of 2022) and each resident is assigned [REDACTED] surgical cases (surgical includes: cleft surgery, craniofacial anomalies, as well as orthognathic surgical cases). Therefore [REDACTED] = 700, additionally, each resident is assigned 3 cleft lip/palate cases and any transfer/incomplete cases from the graduating class.

573 Active and 430 retention

734 is the number of active treatment patients and does not include screening examinations, dental development supervision and retention checks

Each student is assigned 50-70 patients, including about 5 transfer patients.

For question #26, this is the approximate number of patients treated by all 4 Residents in Periodontics and Orthodontics. Many of these patients are receiving care in both departments.

For question 25: Each year, each second year resident is required to completely diagnose and plan care for about 20-25 surgical-orthodontic patients. Of these, approximately 20 follow through with complete surgical-orthodontic care with our residents.

Number of patients managed by students include 90 patients treated in the Craniofacial clinic (Cleft lip and palate and craniofacial patients).

The number is lower than previous years due to COVID-19 interruptions.

The numbers above are based on current averages per student. Our students start the bulk of their patients during the spring and summer and have missed out on that season due to the shut down and limited reopening related to the COVID-19 pandemic.

The total managed number includes transfer patients. Less patients completed treatment due to COVID-19.

This includes all patients assigned to the 1st year residents, 2nd year residents, patients in active care and retention cases that have transferred from previous graduating class, and Oral Facial Anomaly cases.

We are a [REDACTED] program. We have a number of patients ready for surgery at the time of the pandemic shutdown and will be executing the surgeries with [REDACTED] and [REDACTED] as well as private practitioners this year.

We do a significant amount of Orthognathic Surgery, Cleft Palate Treatment and a few Craniofacial Patients (total 64) The clinic has 964 active patients and 406 patients in retention
27. What is the total number of patients with craniofacial abnormalities managed with the active participation of the students/residents during the 2019-20 academic year?

Minimum: 0
Maximum: 325
Mean: 44.6
Count: 68

28. Identify the total number of patients initiating active treatment that were assigned to the students/residents during the 2019-20 academic year.

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st year students/residents</td>
<td>20.0</td>
<td>1000.0</td>
<td>263.7</td>
<td>68</td>
</tr>
<tr>
<td>b. 2nd year students/residents</td>
<td>0.0</td>
<td>1121.0</td>
<td>122.8</td>
<td>68</td>
</tr>
<tr>
<td>c. 3rd year students/residents</td>
<td>0.0</td>
<td>906.0</td>
<td>47.0</td>
<td>68</td>
</tr>
</tbody>
</table>

29. How many patients completed active treatment by the students/residents during the 2019-20 academic year?

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st year students/residents</td>
<td>0.0</td>
<td>274.0</td>
<td>13.7</td>
<td>68</td>
</tr>
<tr>
<td>b. 2nd year students/residents</td>
<td>0.0</td>
<td>401.0</td>
<td>99.4</td>
<td>68</td>
</tr>
<tr>
<td>c. 3rd year students/residents</td>
<td>0.0</td>
<td>783.0</td>
<td>172.0</td>
<td>68</td>
</tr>
</tbody>
</table>
30. How many transferred active treatment and active retention patients were assigned to the students/residents during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>a. 1st year students/residents</th>
<th>Min</th>
<th>Max</th>
<th>Average</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Treatment</td>
<td>0</td>
<td>648</td>
<td>72.4</td>
<td>68</td>
</tr>
<tr>
<td>Active Retention</td>
<td>0</td>
<td>582</td>
<td>87.8</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. 2nd year students/residents</th>
<th>Min</th>
<th>Max</th>
<th>Average</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Treatment</td>
<td>0</td>
<td>1,460</td>
<td>171.6</td>
<td>68</td>
</tr>
<tr>
<td>Active Retention</td>
<td>0</td>
<td>557</td>
<td>128.9</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. 3rd year students/residents</th>
<th>Min</th>
<th>Max</th>
<th>Average</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Treatment</td>
<td>0</td>
<td>257</td>
<td>23.4</td>
<td>68</td>
</tr>
<tr>
<td>Active Retention</td>
<td>0</td>
<td>440</td>
<td>41.1</td>
<td>68</td>
</tr>
</tbody>
</table>

31. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the students/residents.

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number of faculty positions</td>
<td>2.0</td>
<td>26.0</td>
<td>12.6</td>
<td>68</td>
</tr>
<tr>
<td>b. Total number of hours per week</td>
<td>21.0</td>
<td>300.0</td>
<td>90.0</td>
<td>68</td>
</tr>
</tbody>
</table>
32. How often does the program conduct formal documented evaluations of student/resident clinical performance?

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>2.9%</td>
</tr>
<tr>
<td>Monthly</td>
<td>4.4%</td>
</tr>
<tr>
<td>Quarterly</td>
<td>13.2%</td>
</tr>
<tr>
<td>Biannually (i.e., twice a year)</td>
<td>75.0%</td>
</tr>
<tr>
<td>Annually</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

33. How often does the program conduct formal documented evaluations of faculty?

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>1.5%</td>
</tr>
<tr>
<td>Monthly</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quarterly</td>
<td>1.5%</td>
</tr>
<tr>
<td>Semiannually</td>
<td>29.4%</td>
</tr>
<tr>
<td>Annually</td>
<td>67.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

Comments from Orthodontics Curriculum Section page 2

31. We have 9 faculty of which 2 are full time and 7 that are part time and at least one day/week--clinic is 7 hours/day for 4 days and 4 hours for one day. Two faculty are in the clinic each session for a total of 60 hrs/week. Faculty are formally evaluated by the residents after every semester. For Question #31, the total number of faculty also includes non-clinical faculty who provide lectures.

Q30. Active retention patients are usually transferred from 3rd-year students to 1st-year students. Q31. The number of faculty members reported includes full-time/regular faculty as well as part-time faculty. Re: Question #29, The case count on "patients completing active treatment" by third year residents is significantly lower than historical expectation as a result of the temporary shut down of the clinic to elective treatment due to COVID19.

The department has a daily evaluation mechanism to assess the residents. Semi-annually the department also asks each faculty member to reassess each resident's performance. Feedback sessions are then scheduled with
each resident to discuss their evaluations. The daily assessments and the semi-annual assessments are discussed in these sessions.

The numbers above are based on average per student information. Orthodontic students now start about 40 patients (30 in first year and about 10 in second year) They debond about 30-50% of their starts and transfer them as active retention patients for 12 months. The remaining active treatment patients and recall patients are transferred by the graduating class to the rising second year students. This year there were more transfers in active treatment than usual because the third years were not able to debond the cases scheduled to be debonded in the spring of their final year.
## Annual Survey Curriculum Section for Orthodontics Fellowship Programs

### 2020-21 Clinical Fellowship in Craniofacial and Special Care Orthodontics Curriculum Survey Results

This report includes data from all 6 Clinical Fellowship in Craniofacial and Special Care Orthodontics programs accredited in August 2020.

### 21. What clinical procedures exist to ensure program objectives are met?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience with pre-surgical orthopedics for infants born with cleft lip and palate</td>
<td>100.0%</td>
</tr>
<tr>
<td>Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition</td>
<td>100.0%</td>
</tr>
<tr>
<td>Orthodontic management of patients with cleft or craniofacial anomalies</td>
<td>100.0%</td>
</tr>
<tr>
<td>Surgical/orthodontic treatment planning</td>
<td>100.0%</td>
</tr>
<tr>
<td>Pre- and post-surgical orthodontic management</td>
<td>100.0%</td>
</tr>
<tr>
<td>Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement</td>
<td>100.0%</td>
</tr>
<tr>
<td>Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs</td>
<td>100.0%</td>
</tr>
<tr>
<td>Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&amp;SC) patients</td>
<td>100.0%</td>
</tr>
<tr>
<td>Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&amp;SC patients</td>
<td>100.0%</td>
</tr>
<tr>
<td>Supervised participation in craniofacial team activities</td>
<td>100.0%</td>
</tr>
<tr>
<td>Participate in craniofacial team meetings</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Total** 6
22. Which of the following experiences exist in the program for each fellow?

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly scheduled grand rounds case presentations</td>
<td>100.0%</td>
</tr>
<tr>
<td>Historical and current scientific literature review</td>
<td>100.0%</td>
</tr>
<tr>
<td>Research methodology and biostatistics</td>
<td>83.3%</td>
</tr>
<tr>
<td>Training in the allied medical sciences and social services required to manage the unique needs of CFA&amp;SC patients and their families</td>
<td>83.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>
23. What is the average number of patients completing a full sequence of treatment logged by each fellow per year?

<table>
<thead>
<tr>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>35.0</td>
<td>21.0</td>
<td>5</td>
</tr>
</tbody>
</table>

Full sequence of treatment includes each of the following: pre-, post-, and long-term treatment, diagnosis and planning, use of specialized orthodontic appliances specifically for the management of CFA&SC patients; and retention.

24. How many orthognathic cases were managed with the active participation of the fellows during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Orthognathic cases</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.0</td>
<td>30.0</td>
<td>17.4</td>
<td>5</td>
</tr>
</tbody>
</table>

25. What is the total number of patients with craniofacial abnormalities managed with the active participation of the fellows during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Patients with craniofacial abnormalities</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100.0</td>
<td>552.0</td>
<td>276.8</td>
<td>5</td>
</tr>
</tbody>
</table>

26. How many patients were managed by the fellows during the 2019-20 academic year?

<table>
<thead>
<tr>
<th>Fellow</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fellow 1</td>
<td>100.0</td>
<td>552.0</td>
<td>289.8</td>
<td>5</td>
</tr>
<tr>
<td>b. Fellow 2</td>
<td>0.0</td>
<td>154.0</td>
<td>30.8</td>
<td>5</td>
</tr>
</tbody>
</table>
27. Identify the total number of patients initiating active treatment that were assigned to the fellows during the 2019-20 academic year.

<table>
<thead>
<tr>
<th>Patients initiating active treatment</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.0</td>
<td>55.0</td>
<td>39.6</td>
<td>5</td>
</tr>
</tbody>
</table>

28. How many transferred active treatment and retention patients were assigned to the fellows during the 2019-20 academic year?

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Active treatment</td>
<td>12.0</td>
<td>309.0</td>
<td>136.6</td>
<td>5</td>
</tr>
<tr>
<td>b. Active retention</td>
<td>12.0</td>
<td>219.0</td>
<td>90.0</td>
<td>5</td>
</tr>
</tbody>
</table>

29. How many patients completed active treatment by the fellows during the 2019-20 academic year?

Minimum: 10
Maximum: 50
Mean: 26.6
Count: 5
30. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the fellows.

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number of faculty positions</td>
<td>1.0</td>
<td>8.0</td>
<td>4.5</td>
<td>6</td>
</tr>
<tr>
<td>b. Total number of hours per week</td>
<td>22.0</td>
<td>204.0</td>
<td>82.7</td>
<td>6</td>
</tr>
</tbody>
</table>
31. How often does the program conduct formal documented evaluations of fellows' clinical performance?

<table>
<thead>
<tr>
<th>Evaluation Frequency - Fellows</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>0.0%</td>
</tr>
<tr>
<td>Monthly</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quarterly</td>
<td>33.3%</td>
</tr>
<tr>
<td>Semiannually</td>
<td>66.7%</td>
</tr>
<tr>
<td>Annually</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

32. How often does the program conduct formal documented evaluations of faculty?

<table>
<thead>
<tr>
<th>Evaluation Frequency - Faculty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>0.0%</td>
</tr>
<tr>
<td>Monthly</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quarterly</td>
<td>33.3%</td>
</tr>
<tr>
<td>Semiannually</td>
<td>50.0%</td>
</tr>
<tr>
<td>Annually</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

Comments from Craniofacial and Special Care Orthodontics Clinical Fellowships Curriculum Section page 2

[REDACTED] fellow was enrolled in 2019-20

These numbers are an estimate based on how COVID-19 has affected our clinic. Prior to the COVID-19 lockdown, we treated 450 patients and consulted on over 1000 patients per year. Currently, we are seeing about 15 patients per day, five days per week for a maximum of 300 patients. We are prioritizing patients who are already in treatment, trying to finish more patients and starting fewer patients because our capacity to see patients is limited given the social distancing restrictions and sharing of chairs and space with pediatric dentistry. There is a waiting list of start patients which we will start treating based on urgency and timing priority for their treatment.
33. Does anyone else treat the patients of the orthodontic fellows?

Craniofacial anomaly patients

<table>
<thead>
<tr>
<th>Treated by anyone else?</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Orthodontic students/residents</td>
<td>33.3%</td>
<td>66.7%</td>
<td>6</td>
</tr>
<tr>
<td>b. Postdoctoral students/residents in other types of programs</td>
<td>16.7%</td>
<td>83.3%</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of craniofacial anomaly patients treated by:</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Orthodontic students/residents</td>
<td>4.0</td>
<td>99.0</td>
<td>51.5</td>
<td>2</td>
</tr>
<tr>
<td>b. Postdoctoral students/residents in other types of programs</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>1</td>
</tr>
</tbody>
</table>

Special care needs patients

<table>
<thead>
<tr>
<th>Treated by anyone else?</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Orthodontic students/residents</td>
<td>33.3%</td>
<td>66.7%</td>
<td>6</td>
</tr>
<tr>
<td>b. Postdoctoral students/residents in other types of programs</td>
<td>16.7%</td>
<td>83.3%</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of special care needs patients treated by:</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Orthodontic students/residents - patients</td>
<td>4.0</td>
<td>19.0</td>
<td>11.5</td>
<td>2</td>
</tr>
<tr>
<td>b. Postdoctoral students/residents in other types of programs - patients</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>1</td>
</tr>
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Background: The Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics were adopted by the Commission on Dental Accreditation at its January 31, 2013 meeting for implementation January 1, 2014. The Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics were adopted and implemented by the Commission on Dental Accreditation at its August 7, 2015 meeting.

According to the Commission’s Policy on Assessing the Validity and Reliability of the Accreditation Standards, “the validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.” Thus, the validity and reliability of the standards for a two-year program will be assessed after five (5) years and the validity and reliability of the standards for a one-year program will be assessed after four (4) years. In accordance with this policy, the Validity and Reliability Studies of the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics and Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics were initiated in Summer/Fall 2019 with the results considered at the Winter 2020 meeting of the Commission.

In Winter 2020, the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) conducted an initial review of the validity and reliability study reports. The Review Committee concluded that further study of the survey data was warranted. The ORTHO RC believed a small workgroup should be formed to further study the reports and identify the residency and fellowship Accreditation Standards, if any, which warrant revision. The Commission concurred and directed the appointment of a workgroup composed of at least four (4) Orthodontics and Dentofacial Orthopedics Review Committee members and no more than two (2) additional individuals representing the American Association of Orthodontists (AAO) to further study the findings of the 2019 orthodontics residency and fellowship Validity and Reliability Studies and identify Accreditation Standards, if any, which warrant revision, with a report to the ORTHO RC and Commission in Summer 2020. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc Committee members included Dr. Brent Larson (ORTHO RC and Ad Hoc Committee chair), Dr. Patrick Foley (ORTHO RC), Dr. Sarandeep Huja (ORTHO RC), Dr. Onur Kadioglu (AAO), Dr. Steven Lindauer (ORTHO RC), and Dr. Kelton Stewart (AAO). The committee conducted its meeting on November 10, 2020.

The committee began with reviewing its charges, which included consideration of the use of the term “should” in both the residency and fellowship standards and consideration of proposed revisions to the
residency standards. The committee then conducted a high-level discussion of the results of the validity and reliability studies. Although the committee noted the response rate was low and there was a high abandonment rate, the study results did not identify any specific changes needed to the residency standards. In particular, the committee considered the comments related to research methodology and biostatistics within the fellowship study results. Since the fellowship is a 12-month program, and it is expected that students/fellows will have already received curriculum and experiences in research methodology and biostatistics in dental school and orthodontics and dentofacial orthopedics residency, the committee agreed with the comments and proposed elimination of Standard 4-3c as shown in the comprehensive document that reflects all proposed revisions to the fellowship standards as a result of the committee’s charges (Appendix 1). The proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics as submitted by the Ad Hoc Committee as a result of its charges is found in Appendix 5, Policy Report p. 1103.

Summary: At this meeting, the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) and the Commission are requested to consider the proposed revisions to the Accreditation Standards for Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (Appendix 1) as submitted by the Ad Hoc Committee. The ORTHO RC may propose further revisions to the Accreditation Standards. Alternatively, the ORTHO RC may recommend the proposed revisions be circulated to the communities of interest for review and comment. Hearings could be conducted at the October 2021 American Dental Association (ADA) Annual Meeting and the March 2021 American Dental Education Association (ADEA) Annual Session. Comments could be reviewed at the Commission’s Winter 2022 meeting. It should be noted that the proposed revisions to the residency standards are presented in Policy Report p. 1103.

Recommendation:

Prepared by: Ms. Jennifer E. Snow
Commission on Dental Accreditation

Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics

Submitted by the Ad Hoc Committee on Orthodontics and Dentofacial Orthopedics Residency and Fellowship Standards Revisions

Proposed Revisions to Standards
Additions are Underlined
Strikethroughs indicate Deletions
Accreditation Standards for
Clinical Fellowship Training Programs in
Craniofacial and Special Care Orthodontics
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-4653
www.ada.org/coda

Craniofacial and Special Care Orthodontics Fellowship Standards
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### Document Revision History

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<th>Item</th>
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<td>August 7, 2015</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics</td>
<td>Adopted and Implemented</td>
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<tr>
<td>August 7, 2015</td>
<td>Revision to Policy on Reporting Program Changes in Accredited Programs</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revised Policy on Enrollment Increases in Advanced Dental Specialty Programs</td>
<td>Adopted and Implemented</td>
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<tr>
<td>February 5, 2016</td>
<td>Revision to Standard 6.2.2</td>
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<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
<td>Adopted and Implemented</td>
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<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
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<td>January 1, 2017</td>
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<td>August 4, 2017</td>
<td>Revision to Standard 1, Affiliations</td>
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<td>July 1, 2018</td>
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<tr>
<td>August 3, 2018</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Adopted</td>
</tr>
<tr>
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<tr>
<td>TBD</td>
<td>Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics</td>
<td>Adopted</td>
</tr>
<tr>
<td>TBD</td>
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**Craniofacial and Special Care Orthodontics Fellowship Standards**

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Mission Statement of the Commission on Dental Accreditation

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

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

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

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

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

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

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

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

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

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

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

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

Denial: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.
Report on Validity and Reliability Study for Orthodontics Fellowship Programs
Orthodontics and Dentofacial Orthopedics RC
CODA Winter 2021

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

Craniofacial and Special Care Orthodontics Fellowship Standards
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Preface

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

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

A fellowship in craniofacial and special needs orthodontics is a planned post-residency program that contains advanced education and training in a focused area of the discipline of orthodontics. The focused areas include:

- Cleft lip/palate patient care;
- Syndromic patient care;
- Orthognathic Surgery;
- Craniofacial Surgery and Special Care Orthodontics.

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

This document constitutes the standards by which the Commission on Dental Accreditation and its site visitors will evaluate fellowship programs in each discipline for accreditation purposes. The general and discipline specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the essential educational content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by fellowships in the particular discipline.

General standards are identified by the use of a single numerical listing (e.g., I). Discipline-specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Craniofacial and Special Care Orthodontics Accreditation Standards

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

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

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

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

**Levels of Knowledge:**

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

- **Understanding:** Adequate knowledge with the ability to apply.

- **Familiarity:** A simplified knowledge for the purpose of orientation and recognition of general principles.

**Levels of Skills:**

- **Proficient:** The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.

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

- **Exposed:** The level of skill attained by observation of or participation in a particular activity.
Other Terms:

Institution (or organizational unit of an institution): a dental, medical or public health school, patient care facility, or other entity that engages in advanced dental education.

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

The program must develop clearly stated goals and objectives appropriate to advanced dental education, addressing education, patient care, research and service. Planning for, evaluation of and improvement of educational quality for the program must be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of fellowship student achievement.

Intent: The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of Craniofacial and Special Care Orthodontics and that one of the program goals is to comprehensively prepare competent individuals to initially practice Craniofacial and Special Care Orthodontics. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program’s purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f) review the assessment plan, revise as appropriate, and continue the cyclical process.

The financial resources must be sufficient to support the program’s stated goals and objectives.

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

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

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

Hospitals that sponsor fellowships must be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor
fellowships must be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of fellowship programs must assure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

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

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the program director must have the authority, responsibility, and privileges necessary to manage the program.

1-1 Fellowships which are based in institutions or centers that also sponsor orthodontic residency training programs must demonstrate that the fellowship and residency programs are not in conflict. The fellowship experience must not compete with the residency training program for cases. Separate statistics must be maintained for each program.

1-2 Members of the teaching staff participating in an accredited fellowship program must be able to practice the full scope of the discipline in the focused area and in accordance with their training, experience and demonstrated competence.
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

The primary sponsor of the fellowship program must accept full responsibility for the quality of education provided in all sites where educational activity occurs.

1-3 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-4 Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

a. Designation of a single program director;
b. The teaching staff;
c. The educational objectives of the program;
d. The period of assignment of students/fellows; and
e. Each institution’s financial commitment.

Intent: The items are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

1-5 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.

1-6 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

Intent: It is the responsibility of the program director to ensure that all faculty, including those at sites where educational activity occurs, are qualified.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Reporting and Approval of Sites Where Educational Activity Occurs found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by a director who has documented expertise in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics. Additionally, the program director must either be board certified in orthodontics or have previously served as a director in a craniofacial orthodontic fellowship program prior to January 1, 2008.

Examples of evidence to demonstrate compliance may include: Board certification certificate or current CV identifying previous directorship in a Craniofacial Orthodontic Fellowship and letter from the employing institution verifying service.

2-1 Program Director: The program must be directed by one individual. The responsibilities of the program director must include:

2-1.1 Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures.

2-1.2 Ensuring the provision of adequate physical facilities for the educational process.

2-1.3 Participation in selection and supervision of the teaching staff. Perform periodic, at least annual, written evaluations of the teaching staff.

2-1.4 Responsibility for adequate educational resource materials for education of the students/fellows, including access to adequate learning resources.

2-1.5 Responsibility for selection of students/fellows and ensuring that all appointed students/fellows meet the minimum eligibility requirements.

2-1.6 Maintenance of appropriate records of the program, including student/fellow and patient statistics, institutional agreements, and student/fellow records.

2-2 Teaching Staff: The teaching staff must be of adequate size and must provide for the following:

2-2.1 Provide direct supervision appropriate to a student’s/fellow’s competence, level of training, in all patient care settings.

2-3 Scholarly Activity of Faculty: There must be evidence of scholarly activity among the fellowship faculty. Such evidence may include:

a. Participation in clinical and/or basic research particularly in projects funded following peer review;
b. Publication of the results of innovative thought, data gathering research projects, and thorough reviews of controversial issues in peer-reviewed and scientific media;

c. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national level.

2-4 The program must show evidence of an ongoing faculty development process.

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

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

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

Facilities and resources must be adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

Intent: The facilities and resources (e.g., support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To assure health and safety for patients, students/fellows, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.

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

Intent: The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the students/fellows, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.

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

Intent: The program should have written policy that encourages (e.g., delineates the advantages of) immunization for students/fellows, faculty and appropriate support staff.

Students/Fellows, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

Intent: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.

The use of private office facilities as a means of providing clinical experiences in advanced dental education is not approved, unless the discipline has included language that defines the use of such facilities in its discipline-specific Standards.
Intent: Required orthodontic fellowship clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.

3-1 Adequate space must be designated specifically for the clinical fellowship training program in Craniofacial and Special Care Orthodontics.

Intent: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.

3-2 Facilities must permit the students/fellows to work effectively with trained allied dental personnel.

Intent: A program is expected to have auxiliaries available to assist the students/fellows so the program can meet the educational Standards.

Examples of evidence to demonstrate compliance may include:

- Schedule of dental assistants’ assignments

3-3 Radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. Imaging equipment must be available.

3-4 Students/Fellows in a Craniofacial and Special Care Orthodontic program must have access to adequate space, equipment, and physical facilities to do research.

Intent: Adequate space is necessary to do research, but does not need to be dedicated to craniofacial and special care orthodontic research.

3-5 Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/fellows to achieve the educational goals of the program.

Intent: The intent is to assure the students/fellows in Craniofacial and Special Care Orthodontics utilize their time for educational purposes.

3-6 Clinical facilities must be provided within the sponsoring, affiliated institution or surgical center to fulfill the educational needs of the program.

3-7 Sufficient space must be provided for storage of patient records, models and other related diagnostic materials.

3-8 These records and materials must be readily available to effectively document active treatment progress and immediate as well as long term post-treatment results.
Intent: Students/Fellows are expected to have easy access to active, post treatment, and retention records. These records should be complete.

Radiography equipment must be available and accessible to the craniofacial clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.

Intent: High quality radiographic images are essential for orthodontic and dentofacial orthopedic therapy. Three dimensional cone-beam CT images of the dentition, face and TMJs are acceptable if clinically indicated.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

The fellowship program must be designed to provide special knowledge and skills beyond residency training. Documentation of all program activities must be assured by the program director and available for review.

4-1 The fellowship program is a structured post-residency program which is designed to provide special knowledge and skills for management of Craniofacial Anomalies and Special Care (CFA&SC) patients. These patients have craniofacial anomalies that affect the face and stomatognathic system and require special care due to physical mental and/or psychological conditions. The goals of the fellowship program must be clearly identified and documented.

4-2 The duration of the fellowship program must be a minimum of twelve months.

4-3 The fellowship program must include a formally structured curriculum. The curriculum must include the following experiences for each student/fellow:

a. regularly scheduled grand rounds case presentations
b. historical and current scientific literature review
c. research methodology and biostatistics
d. training in the allied medical sciences and social services required to manage the unique needs of CFA&SC patients and their families

4-4 The fellowship program must provide a complete sequence of patient experiences which includes:

a. pre-treatment evaluation and orthodontic record taking;
b. diagnosis and treatment planning;
c. advanced training in the use of the specialized orthodontic appliances required for the management of CFA&SC patients;
d. retention and long-term post-treatment evaluation.

4-5 The student/fellow must maintain a treatment log of all patients under their care with associated treatment plans/ procedures performed and include at least the date of the procedure, patient name, patient identification number, and the outcome of the procedure, and long-term follow-up plans when applicable.
STANDARD 5 – STUDENTS/FELLOWS

ELIGIBILITY AND SELECTION

Orthodontists who have completed their formal orthodontic residency training are eligible for fellowship program consideration.

5-1 Nondiscriminatory policies **must** be followed in selecting students/fellows.

5-2 There **must** be no discrimination in the selection process based on professional degree(s).

Specific written criteria, policies and procedures **must** be followed when admitting students/fellows.

EVALUATION

A system of ongoing evaluation and advancement **must** assure that, through the director and faculty, each program:

a. Periodically, but at least semiannually, evaluates the knowledge, skills, ethical conduct and professional growth of its fellowship students, using appropriate written criteria and procedures;

b. Provide to fellowship students an assessment of their performance, at least semiannually;

c. Maintains a personal record of evaluation for each fellowship student which is accessible to the fellowship student and available for review during site visits.

**Intent:** A copy of the final written evaluation stating that the student/fellow has demonstrated competency to practice independently should be provided to each individual upon completion of the fellowship program.

DUE PROCESS

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

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the fellowship students **must** be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all fellowship students **must** be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.
STANDARD 6 - FELLOWSHIP PROGRAMS

Those enrolled in an accredited clinical fellowship program in Craniofacial Anomalies and Special Care (CFA&SC) orthodontics complete advanced training in a focused area:

6-1 Fellowship Program: A fellowship is a structured post-residency educational experience devoted to enhancement and acquisition of skills in a focused area and **must** be taught to a level of proficiency.

6-2 Craniofacial and Special Care Orthodontics:

Craniofacial is that area of orthodontics that treats patients with congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures. Special Care is that area of orthodontics that treats patients with special needs including disabilities and medically compromised patients who require comprehensive treatment.

6-2.1 Goals/Objectives: To provide comprehensive clinical and didactic training as the orthodontist, who works with a craniofacial team treating patients with a broad scope of craniofacial deformities and special needs situations.

6-2.2 Clinical Experience: Clinical experience **must** include the following procedures and **must** exist in sufficient number and variety to assure that objectives of the training are met:

a. experience with pre-surgical orthopedics for infants born with cleft lip and palate;

b. orthodontic therapy for patients with craniofacial deformities from the primary through adult dentition;

c. orthodontic management of patients with cleft or craniofacial anomalies;

d. surgical/orthodontic treatment planning;

e. pre and post surgical orthodontic management;

f. surgical splint design and construction;

g. observation of surgical procedures, including splint placement;

h. orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs;

i. participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists providing restorative services for CFA & SC patients;

Craniofacial and Special Care Orthodontics Fellowship Standards

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j. exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients.

k. supervised participation in craniofacial team activities.

l. participate in craniofacial team meetings.

Examples of Evidence to demonstrate compliance may include:

- Roster of who attends craniofacial team meetings
- Schedule as to how often the craniofacial team meets
- Sense of what is discussed at meetings of craniofacial team, e.g., meeting minutes.
STANDARD 7 - RESEARCH

Students/Fellows must engage in an evidence-based research project approved by the director of the program, which should include one or more of the following:

- 7.1 Analyses based on clinical case records.
- 7.2 Participation in clinical and/or basic research particularly in projects funded following peer review and Institutional Review Board (IRB) approval.
- 7.3 Publication of case reports or hypotheses-driven research in peer reviewed journals related to the field of Craniofacial Anomalies and Special Care (CFA&SC) orthodontics.
- 7.3 Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.

Examples of evidence to demonstrate compliance may include:

a. Basic Sciences or Clinical Research Investigation
b. Meta-Analyses or Systematic Reviews of scientific literature
c. Analyses based on clinical case records.
   Participation in clinical and/or basic research particularly in projects funded following peer review and Institutional Review Board (IRB) approval.
d. Publication of case reports or hypotheses-driven research in peer reviewed journals related to the field of Craniofacial Anomalies and Special Care (CFA&SC) orthodontics.
e. Presentation at scientific meetings and/or continuing education courses at the local, regional, or national and international levels.
CONSIDERATION OF THE USE OF THE TERM “SHOULD” WITHIN THE ACCREDITATION STANDARDS

Background: At its Summer 2019 meeting, the Commission directed the revision or addition, as applicable, of the definition of “Should,” as noted below, within the Definition of Terms used by the Commission in the Accreditation Standards for all disciplines within the Commission’s purview, with consideration of this change in Winter 2020, and application within a time frame to correlate with other revision activities. The revised definition of “Should” within the Definition of Terms, is as follows: Should: Indicates a method to achieve the standard; highly desirable, but not mandatory. Per the Commission’s directive, the revised definition of “Should” will be incorporated into the residency and fellowship standards resulting from the validity and reliability studies.

At its Winter 2020 meeting, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) determined and the Commission concurred that, because of the amount of data provided in the validity and reliability report, and to ensure an in-depth review of the instances of “Should,” it would be beneficial to combine this exercise with the validity and reliability study review with a report submitted for consideration at the Summer 2020 meeting of the ORTHO RC and Commission. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc Committee members included Dr. Brent Larson (ORTHO RC and Ad Hoc Committee chair), Dr. Patrick Foley (ORTHO RC), Dr. Sarandeep Huja (ORTHO RC), Dr. Onur Kadioglu (AAO), Dr. Steven Lindauer (ORTHO RC), and Dr. Kelton Stewart (AAO). The committee conducted its meeting on November 10, 2020. The committee reviewed its three (3) charges, held a high-level discussion of the results of the validity and reliability studies, and discussed proposed changes to the residency standards.

The committee considered the use of the term “should” in both the residency and fellowship standards. Following thorough discussion, the committee believed the use of the term “should” was appropriate as written in the residency standards. Upon review of the fellowship standards, the committee noted that the term “should” was found within three (3) separately numbered Standard 7-Research items and believed that these statements were more appropriate as “examples of evidence.” The committee believed that the reorganization of these non-required items to the “examples of evidence” would better align with the format of the Accreditation Standards and eliminate potential confusion, as is noted in the comprehensive Standards document reflecting proposed revisions to the fellowship standards as a result of the committee’s charges (Appendix 1, Policy Report p. 1101). The proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics as submitted by the Ad Hoc Committee as a result of its charges is found in Appendix 5, Policy Report p. 1103.
Summary: At this meeting, the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) and the Commission are requested to consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (Appendix 5, Policy Report p. 1103) and the Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (Appendix 1, Policy Report p. 1101) as submitted by the Ad Hoc Committee as a result of its charges.

Recommendation: This report in informational in nature and no action is requested.
CONSIDERATION OF PROPOSED REVISIONS TO THE ACCREDITATION
STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN
ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Background: At its Winter 2019 meeting, the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics from the American Association of Orthodontists.

The Committee considered the proposed revisions to the Orthodontics Standards and found the several proposed revisions pertaining to faculty/space resources all to be appropriate. The Committee also supported all of the proposed revisions that relate to the types of patients/conditions presenting for treatment.

The ORTHO RC concluded, and the Commission concurred, that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics, found in Appendix 1, be circulated to the communities of interest for review and comment for a period of one (1) year, including Hearings during the March 2019 American Dental Education Association (ADEA) and September 2019 American Dental Association (ADA) annual meetings, with comments reviewed at the ORTHO RC and Commission meetings in Winter 2020.

Two (2) comments were received at the 2019 ADEA Hearing (Appendix 2). Two (2) comments were received at the 2019 ADA Hearing (Appendix 3). Eight (8) written comments were received during the comment period (Appendix 4).

At its Winter 2020 meeting, the the Orthodontics and Dentofacial Orthopedics Review Committee (ORTHO RC) conducted an initial review of the proposed revisions and all comments received. The Review Committee concluded that further study of the proposed revisions was warranted. The ORTHO RC determined and the Commission concurred that, because of the amount of data provided in the validity and reliability reports, and to ensure an in-depth review of the proposed revisions to the residency standards, it would be beneficial to combine this exercise with the validity and reliability study review with a report submitted for consideration at the Summer 2020 meeting of the ORTHO RC and Commission. At its special, closed April 13, 2020 meeting to consider the impact of COVID-19 on CODA’s operations related to ongoing work of the Commission, the Commission directed that the Ad Hoc Committee for Orthodontics and Dentofacial Orthopedics be directed to submit an update report in Winter 2021 rather than Summer 2020.

The Ad Hoc Committee members included Dr. Brent Larson (ORTHO RC and Ad Hoc Committee chair), Dr. Patrick Foley (ORTHO RC), Dr. Sarandeep Huja (ORTHO RC), Dr. Onur Kadioglu (AAO), Dr. Steven Lindauer (ORTHO RC), and Dr. Kelton Stewart (AAO). The committee conducted its meeting on November 10, 2020. The committee reviewed its three (3)
charges and began its work with a high-level discussion of the results of the validity and reliability study and considered the use of the term “should” in the residency standards. The committee did not identify any specific changes needed to the standards through its first two (2) charges.

Next, the committee carefully considered the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics and all comments received. With regard to Standard 2-9, the committee considered the eight (8) comments in disagreement with the proposed revision requiring a minimum of one (1) full-time equivalent (FTE) faculty to four (4) students/residents for the entire program. Following discussion, the committee determined that students/residents may need more guidance and believed the proposed revision holds programs accountable to providing sufficient faculty coverage for student/resident oversight.

The committee also considered the five (5) comments disagreeing with the proposed revision to Standard 2-10 (requiring that, for clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents), noting the concerns with the validity of the ratio proposed and programs’ ability to implement it. The committee believed that the intent of the revision is to provide a quality clinical education with proper oversight. For example, the proposed revision would require that there be two (2) faculty in the clinic when there are nine (9) students/residents in the clinic. Programs could schedule clinic sessions in such a way as to avoid having all nine (9) students/residents in the clinic at the same time. In response to other comments received, the committee noted that the proposed addition of identifying patients with sleep-related breathing disorders/sleep apnea under Standard 4-3.4 is appropriate because it is in the AAO’s description of an orthodontist and therefore should be retained.

The intent of other proposed revisions was also discussed; for Standard 2-2 the committee affirmed that “full-time” should be defined by the institution (e.g., an institution could define full-time as a 30-hour work week) and noted that the program director may not be dedicated to the advanced dental education program in orthodontics for the entire time. The proposed addition to Standard 3-1, which states “For each clinic session to which a student/resident is assigned, the program must provide a minimum of one (1) clinic chair per student/resident,” was also reviewed. The committee clarified the intent of this addition to ensure each student/resident has a chair while seeing patients during his or her assigned time, not necessarily that the number of chairs must equal the total number of students/residents enrolled in the program.

Lastly, the committee noted that under the proposed addition to the examples of evidence for Standard 4-3.4, “ABO standards” should be changed to “ABO Assessment Tools” as a more accurate description. This was the only change made to the proposed revisions that previously circulated and garnered comments, and is noted in the comprehensive Standards document reflecting proposed revisions to the residency standards as a result of the committee’s charges (Appendix 5).
Summary: At this meeting, the Orthodontics and Dentofacial Orthopedics Education Review Committee and the Commission are asked to consider the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics submitted by the Ad Hoc Committee (Appendix 5). If further revisions are proposed to the document, 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:
At its Winter 2019 meeting, the Commission directed that the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics be distributed to the appropriate communities of interest for review and comment, with comment due December 1, 2019, for review at the Winter 2020 Commission meeting.

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

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

Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

**Intent:** The director of an orthodontic program is to be certified by the American Board of Orthodontics.

The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

**For board certified directors:** Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program’s effectiveness in meeting its goals.

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

2-1 The program must be directed by one individual.

2-2 The program director position must be full-time as defined by the institution.

2-23 There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.
**Intent:** The program director is expected to be intimately involved in all aspects of the program.

Examples of evidence to demonstrate compliance may include:

- Program’s director’s weekly schedule
- Institution’s definition of full-time and part-time commitment
- Program director’s job description

2-34 A majority of the discipline-specific instruction and supervision must be conducted by individuals who are educationally qualified in orthodontics and dentofacial orthopedics.

2-45 Besides maintaining clinical skills, the director must have teaching experience in orthodontics and dentofacial orthopedics. For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.

2-56 Periodic faculty meetings must be held for the proper function and improvement of an advanced dental education program in orthodontics and dentofacial orthopedics.

Examples of evidence to demonstrate compliance may include:

- Schedules and minutes of faculty meetings
- Action taken as a result of faculty meetings
- Records of attendance at faculty meetings

2-67 The faculty must have knowledge of the required biomedical sciences relating to orthodontics and dentofacial orthopedics. Clinical instruction and supervision in orthodontics and dentofacial orthopedics must be provided by individuals who have completed an advanced dental education program in orthodontics and dentofacial orthopedics approved by the Commission on Dental Accreditation (grandfathered), or by individuals who have equivalent education in orthodontics and dentofacial orthopedics.

2-78 In addition to their regular teaching responsibilities with the department, full-time faculty must have adequate time for their own professional development.
2-9 The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.

*Intent:* Full-time faculty have the obligation to teach, conduct research and provide service to the institution and/or profession.

Examples of evidence to demonstrate compliance may include:

- Weekly schedules of full-time faculty
- Curriculum vita of full-time faculty, including academic ranks
- Schedule of faculty commitments in teaching, research and service

2-810 For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty must be sufficient to provide full supervision of the clinical portion of the program.

2-11 The faculty covering clinic must be orthodontists.

2-92 Faculty evaluations must be conducted and documented at least annually. Examples of evidence to demonstrate compliance may include:

- Faculty evaluation records
- Credentials and advanced education of faculty
- Institution plan for professional development

2-1013 There must be evidence of an ongoing systematic procedure to evaluate the quality of treatment provided in the program.

Examples of evidence to demonstrate compliance may include:

- Records of case presentations and evaluation
- Patient charts available for audit
- Protocol for treatment

2-1114 The program director and faculty must prepare students/residents to pursue certification by the American Board of Orthodontics.
2-1114.a The program director must document the number of graduates who become certified by the American Board of Orthodontics.

2-1215 The program must show evidence of an ongoing faculty development process.

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

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

3-1 Adequate space must be designated specifically for the advanced dental education program in orthodontics and dentofacial orthopedics. For each clinic session to which a student/resident is assigned, the program must provide a minimum of one (1) clinic chair per student/resident.

Intent: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

4-3.4 A graduate of an advanced dental education program in orthodontics must be competent to:

a. Coordinate and document detailed interdisciplinary treatment plans which may include care from other providers, such as restorative dentists and oral and maxillofacial surgeons or other dental specialists;

b. Treat and manage developing dentofacial problems which can be minimized by appropriate timely intervention;

c. Use dentofacial orthopedics in the treatment of patients when appropriate;

d. Treat and manage major dentofacial abnormalities and coordinate care with oral and maxillofacial surgeons and other healthcare providers;

e. Provide all phases of orthodontic treatment including initiation, completion and retention;

f. Treat patients with at least one contemporary orthodontic technique;

g. Manage patients with functional occlusal and temporomandibular disorders;

h. Treat or manage the orthodontic aspects of patients with moderate and advanced periodontal problems;

i. Develop and document treatment plans using sound principles of appliance design and biomechanics;

j. Obtain and create long term files of quality images of patients using techniques of photography, radiology and cephalometrics, including computer techniques when appropriate;

k. Use dental materials knowledgeably in the fabrication and placement of fixed and removable appliances;

l. Develop and maintain a system of long-term treatment records as a foundation for understanding and planning treatment and retention procedures;

Intent: It is intended that the program teach one or more methods of comprehensive orthodontic treatment.

Orthodontics and Dentofacial Orthopedics Standards
m. Practice orthodontics in full compliance with accepted Standards of ethical behavior;

**Intent:** A program may be in compliance with the standard on ethical behavior when ethical behavior is acquired through continuous integration with other courses in the curriculum.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Case treatment records

n. Manage and motivate patients to participate fully with orthodontic treatment procedures; and

o. Study and critically evaluate the literature and other information pertaining to this field;

p. Identify patients with sleep-related breathing disorders/sleep apnea;

q. Identify patients with Craniofacial Anomalies and Cleft Lip and Palate;

r. Treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure; and

s. Treat and effectively manage Class II malocclusions, defined as a bilateral end-on or greater Class II molar or a unilateral full cusp Class II molar, through a non-surgical treatment approach.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Clinical outcomes assessment
- ABO standards: Discrepancy Index, Cast-Radiograph Evaluation, Case Management Forms
Commission on Dental Accreditation
Hearing on Accreditation Standards

2019 American Dental Education Association (ADEA) Annual Meeting
Chicago, Illinois
Saturday, March 16, 2019, 11:00 a.m. to 12:00 p.m.
Roosevelt 3A&B, East Tower, Concourse Level, Hyatt Regency Chicago

Commissioners in Attendance: Dr. Arthur Jee (chair), Dr. Steven Friedrichsen, Dr. Jeffery Hicks, Dr. Tariq Javed, Dr. James Katancik, and Dr. Bruce Rotter.

Staff: Dr. Sherin Tooks, director, CODA, and CODA Managers

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (Appendix 10)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carla Evans</td>
<td>Boston University</td>
<td>2-9, line 40 has a ratio and how it comes about is unclear. There is no evidence to support this number.</td>
</tr>
<tr>
<td>Rick Harrell</td>
<td>Georgia School of Orthodontics</td>
<td>Opposes a specific faculty ratio in 2-9 as it is unrealistic. OMS is the only other discipline that does this.</td>
</tr>
</tbody>
</table>
Commission on Dental Accreditation
Hearing on Accreditation Standards

2019 American Dental Association (ADA) Annual Meeting
San Francisco, California
Friday, September 6, 2019, 11:00 a.m. to 12:00 p.m.
Yerba Buena Salon 8, Marriott Marquis

Commissioners in Attendance:  Dr. Arthur Jee (chair), Dr. Steven Friedrichsen, Dr. Christopher Hasty, Dr. Monica Hebl, Dr. Tariq Javed, Dr. Timmothy Schwartz, Dr. Alan Stein, and Dr. Lawrence Wolinsky.

Staff: Dr. Sherin Tooks, director, CODA

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (Appendix 2)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raymond Cohlmia</td>
<td>Dean, University of Oklahoma College of Dentistry</td>
<td>Applaud CODA related to ratios but understand it will be difficult to attract faculty to achieve this. Applaud CODA for adding ratios but may be difficult and for Colleges. Standard 2-9, and 2-10, recommend delete the word “must” and recommend “shall”. This may cause stresses and concerns related to faculty recruitment.</td>
</tr>
<tr>
<td>David Sarrett</td>
<td>Dean, Virginia Commonwealth University</td>
<td>Agrees with prior speaker. Standard 2-10 seems like reasonable ratio. 2-9 should be eliminated due to difficulty imposed on programs. Would be okay with a statement similar to what is in the predoctoral standards, which gives some latitude, related to sufficient faculty. Standard 2-9 is too prescriptive as written.</td>
</tr>
</tbody>
</table>
March 21, 2019

Ms. Jennifer Snow
Manager, Advanced Dental Education
Commission on Dental Accreditation (CODA)

RE: Comments, Winter 2019 meeting, Proposed ORTHO Standards Revision

Dear Ms. Snow:

The following are comments in response to the Winter 2019 meeting, Proposed ORTHO Standards Revision. I am making these remarks from three perspectives: 1.) As someone who has been in private practice, graduate orthodontic education, and research for 43 years. 2.) Professor and Program Director at Seton University Advanced Education Program in Orthodontics and Dentofacial Orthopedics. 3.) From an educational point of view as a Ph.D. in Higher Education, University of Pittsburgh. As a disclaimer, to keep this correspondence as brief as possible, I cited limited and selective papers.

My first comment is concerning, **Standard 2-10 (page 4)** "For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure . . ." However, it may be more realistic to base this ratio on how many patients the resident is seeing per day, or time frame. For instance, in a mega-program with residents seeing (or starting 80-100+ patients) a large number of patients, maybe this ratio should be smaller, whereas in smaller programs (residents starting 40-60 patients) the ratio may be larger. Is this ratio arbitrary and capricious? Who recommended this ratio, from what point of view, and what is the evidence to support this view? Dr. Lysle Johnston, Jr. would often quote Dr. Carl Sagan, “extraordinary claims require extraordinary evidence,” the Sagan Standard.

Regarding **Standard 2-9 (page 3)** "The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components": Again, is this ratio arbitrary and capricious, or is there evidence to support this ratio for Advanced Education Programs in Orthodontic and Dentofacial Orthopedics and student learning?

There is already a shortage of "qualified enlightened teachers" in graduate orthodontic programs as Vaden (2016) and King (2015) pointed out. This will increase the burden on orthodontic programs to find additional faculty requiring increased revenue. Where will the additional faculty be found? If more faculty are needed to educate an orthodontist who has incurred a "huge" debt, this will make the educational debt even worse, since orthodontic programs will have to increase tuition to hire more faculty (Vaden 2016; King 2015; Behrents 2016). How would this ratio be adapted for 30 month programs where for 6 months there are two orthodontic classes and for the other 6 months there are 3 orthodontic classes?

I would argue that, for graduate programs, less academic/faculty supervision is needed since graduate students should be doing more of the work, the teacher acting as a guide. Professor Patrick Allit, PhD, Emory University, said, “Learners need to learn how to teach themselves”
(Allitt 2010). It has been said, of good education, that it is more important to look at what the students are doing classroom rather than what the teacher is doing. Especially at a graduate, post-doctoral level, students should be doing most of the work in the classroom. As Ambrose et al (2010) said: “Learning is not something done to students, but rather something students themselves do.” Another important aspect of learning is the ability of the learner to recognize and reassess his/her current knowledge, and then evaluate ways to improve. This is known as “metacognition”, or the ability to monitor one’s current level of understanding and evaluate when it needs to be amended and revised. Especially at a post-doctoral level, when it comes to learning, self-evaluation is often more useful than teacher evaluation. An extension of metacognition is the ability of students to teach “themselves” especially at a post-doctoral level. Teaching is about students, and a teacher is most successful when the students can say, “We did this ourselves” (Zull 2002). Covering too many topics, which focuses on isolated facts, is counterproductive to learning for understanding and subsequent transfer of knowledge. Simply stated, learning cannot be rushed. As Sousa (2017) stated, “less is more.” Also some aspects of orthodontic education are non-propositional, which is knowledge that is difficult to explain, and needs to be experienced.

**Standard 4.3r (page 8)**—“Treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure;”

Extraction cases are much more difficult to “find” since the orthodontic profession has currently been treating almost all cases non extraction. There are many factors prompting this such as:

- Invisalign/Smile Direct/Aligner treatments, which are more apt to be done non extraction.
- Competition, since non extraction is seen as conservative treatment and if extractions are proposed, the patient will readily find another orthodontist who will do the case non extraction.
- Various groups with hidden agendas (speakers for vendors).
- Extractions cause “damaged faces” and obstructive sleep apnea (OSA), which is contrary to the evidence as pointed out in the recent AAO White Paper: Obstructive Sleep Apnea and Orthodontics (2019).
- Some very brilliant and well educated orthodontists (Graham 2014) are making claims to consumer’s such as: (The following quote is from Dr. Graham’s book to consumers) “Almost all orthodontists corrected their patients’ crowded mouths by removing four permanent teeth in combination with braces. What we’ve observed over many years of relying on this relatively easy way to create space is that we’ve negatively impacted facial profiles. You might have even seen the telltale signs yourself without realizing it: large nose, thin lips, and large chin. It’s a profile alteration that’s become so prevalent that orthodontists have a name for it: the extraction profile. Understanding the correct biology of tooth movement has been quite a revelation for orthodontists. This understanding has allowed us to significantly decrease the number of extractions that we request. In fact, I went back and reviewed the last five hundred consecutive patients I’ve treated, and my extraction rate was 0.01 percent, a figure that frankly surprised me. Avoiding extractions allows us to create broad, beautiful smiles. “
- Most orthodontists have a poor understanding of evidence-based practice, terminology and concepts, and rely on seemingly expert opinion and colleagues (Madhavji et al 2011).
Huang et al (2018) pointed out that both medical and dental schools and postgraduate programs have failed in an attempt to teach evidence-based skills. “Although this situation is changing, the biggest influence on how trainees will practice is their clinical role models, few of whom are currently accomplished EBO practitioners.”

Although contrary to quality evidence (Rinchuse et al 2014; Rinchuse et al 2015), much of society and the dental community’s (including orthodontists) current view is, extractions for orthodontic purposes are extreme and harmful treatment. There has been a recent contingency of general dentists, and dental specialists, particularly, orthodontists and oral surgeons, who have been discouraging patients from having extractions in conjunction with orthodontic treatment, claiming that it flattens, dishes-in, damages faces and causes airway space constriction causing OSA (Obstructive Sleep Apnea). In our geographic area, there have been oral surgeons refusing to extract teeth for some of our faculty for these reasons, and subsequently patients have left our program to have treatment by other “non-extraction” orthodontists. This represents another challenge to extraction orthodontic treatment. Patients are being referred to this website, which is also on social media: www.damagedfaces.com
With these challenges to extraction treatment, where are orthodontic programs going to find many four premolar extraction cases? Who is going to challenge or change orthodontic practice to include more extractions cases? AAO, or ABO? Not very likely!

Having rigid standards for all programs without considering the uniqueness of each may develop automatons that lack creativity and diversity. Regarding healthcare, punctilious, inflexible and overzealous application of guidelines without regard to the detail of individual circumstances can be both harmful and inhumane (Greenhalgn 2016). This is also true for accreditation standards that are inflexible.

Sincerely,

Daniel Rinchuse, DMD, MS, MDS, PhD
Professor and Program Director
Advanced Education Program in Orthodontics and Dentofacial Orthopedic
Seton Hill University
Center for Orthodontics
2900 Seminary Drive, Building E
Greensburg, PA 15601

References:


Hi Sherin,
I have some comments regarding 2 suggested changes in the Orthodontic Standards. Below are the proposed changes and my comments:

Standard 2.9: The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.

My Comments:
I don't think that the intent of having full time faculty involved in all aspects of the program is achieved with this new requirement. There is no logic as to the number of 1 FTE to 4 residents. Proper coverage can be achieved with less supervision, since at times residents are performing long procedures such as bonding or records, where supervision is not as demanding. Such restriction would prevent the proper flow of operations.

2-810 For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure The number and time commitment of faculty must be is sufficient to provide full supervision of the clinical portion of the program.

My comments:
Again, there is no sense to such number. Orthodontists are able to in private practice have more than 8 chairs going, and they are working with dental assistants and not dentists. The work in a clinic may be such that residents are performing procedures that do not require as much supervision, and to “have” to add additional faculty just because of a requirement which has not been tested and is not based on any evidence, does not make sense. The program director is responsible for quality control and proper education, and should be trusted with implementing what is needed, instead of being micromanaged.

Thanks,

Martin

J. Martin Palomo DDS, MSD
Professor
Diplomate, American Board of Orthodontics
Orthodontic Residency Director
Case School of Dental Medicine - Orthodontics
9601 Chester Avenue
Standard 2.9: The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.

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October 1, 2019

Dr. Sherin Tooks
Director
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Dear Dr. Tooks:

This letter serves to provide comment and voice the Georgia School of Orthodontics’ opposition to the proposed revisions to the Accreditation Standards for Orthodontics and Dentofacial Orthopedics that will be reviewed at the Winter 2020 Commission meeting. Specifically, we are writing in opposition of the following:

2-9 The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.

2-10 For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program.

2-11 The faculty covering the clinic must be orthodontists.

It is our strong belief that these proposed revisions will detrimentally impact the efficient management of administering programs in Orthodontics and Dentofacial Orthopedics, and ultimately lead to a greater cost of education for orthodontic residents leading to an increase in student debt. Please see the memorandum included herein, which details our opposition against the passage of the proposed revisions.

Please do not hesitate to reach out to me should you have any questions or need additional information.

Best,

Georgia School of Orthodontics

By: Dr. Randy Kluender
Its: President & Chairman of the Board

By: Dr. Ricky Harrell
Its: Program Director
Memorandum in Opposition to Proposed Revisions to Accreditation Standards for Orthodontics and Dentofacial Orthopedics

Georgia School of Orthodontics firmly believes that the following proposed revisions will detrimentally impact Orthodontics and Dentofacial Orthopedics Programs ("Orthodontic Programs"), and ultimately lead to a greater cost of education for orthodontic residents:

2-9 The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.

2-10 For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program.

2-11 The faculty covering the clinic must be orthodontists.

The reasons for our opposition are stated below and include the overall lack of evidence to support the proposed specific faculty to resident ratios and the likely increase to the cost of orthodontic education.

I. No Evidence has been Provided to Support the Defined Faculty to Resident Ratio

The proposed revisions to Standards 2-9 and 2-10 cited above are without support to prove that the defined faculty to resident ratios will improve the quality of education provided by Orthodontic Programs. The AAO appointed a committee in 2017 to "thoroughly evaluate and suggest revisions to the standards as warranted to insure high quality orthodontic education". Furthermore, in January 2019 the CODA Review Committee on Orthodontics and Dentofacial Orthopedics Education met and discussed the proposed Standards revisions from the AAO and "the Committee found the several proposed revisions pertaining to faculty/space resources all to be appropriate". However, neither the AAO Committee nor the CODA Review Committee have provided any of the data or research reviewed in support of the proposed changes to the Standards. Indeed, without any evidence provided in support of the revisions, it appears the 1:4 program ratio and the 1:8 clinical ratio have been arbitrarily decided upon without thorough research into how this will in fact improve the quality of orthodontic education.

As the standards read today, there is no specific requirement for overall Orthodontic Program faculty to resident ratios. The Standards state the number and time commitment of faculty must be sufficient to provide for full supervision of the clinical portion of the Orthodontic Program. The Commission works with Orthodontic Programs on an individual basis during the Accreditation process to determine and set the ratio that works best for each specific Orthodontic Program, based on the size and other characteristics of each specific Orthodontic Program. This is an excellent way to ensure the right faculty to resident ratios for each Orthodontic Program. A one size fits all approach to clinical faculty to resident ratios for every Orthodontic Program does not take into account the uniqueness of each Orthodontic Program, nor its efficiencies. We believe a ratio may be used as a guideline but not mandated as a "must" statement.

1 Brent Larson, AAO President Correspondence to Jennifer Snow, CODA Manager of Advanced Dental Education, October 9, 2018
2 Commission on Dental Accreditation, CODA Winter 2019, Report of the Ortho RC, page 1100, subpage 1
In addition, proposed revision 2-11 fails to take into account the educational opportunities provided by other specialty clinical faculty. Periodontists, pediatric dentists, oral surgeons, and other specialties can provide exceptional interdisciplinary orthodontic training to residents in the clinical setting. If exposure to other specialties in clinical education must be in addition to requirements in the proposed revisions to 2-10 and 2-11, this will increase the cost of orthodontic education. This proposal is short-sighted and negatively impacts the quality and breadth of education provided to orthodontic residents.

GSO is opposed to the proposed revisions for Standards 2-9, 2-10, and 2-11 because there is no evidence to support the proposed ratios, they fail to consider the uniqueness of each Orthodontic Program, and they limit the educational opportunities that residents can be exposed to in the clinical setting.

II. No Other Similar Advanced Dental Education Program has these Faculty to Resident Ratio Requirements

There is only one other Advanced Dental Education Program that has specific faculty to resident ratio requirements, and that is Oral & Maxillofacial Surgery. The need for one full time equivalent oral and maxillofacial surgeon as defined by the institution per each authorized senior resident position is a well-supported ratio for a surgery program. However, no other Advanced Dental Education Program similar to Orthodontic and Dentofacial Orthopedics program has specific faculty to resident ratio requirements. The Commission has not provided any evidence supporting the need for a specific ratio for Orthodontics and Dentofacial Orthopedics, and it would be treating these Programs differently from the other similarly situated Advanced Dental Education Programs.

GSO is opposed to the proposed revisions for Standards 2-9 and 2-10 because the Commission would be treating Orthodontic Programs differently from other similar Advanced Dental Education Programs without providing research or justification.

III. Timeline for Implementation

In addition to the reasons stated above, GSO also opposes the revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics because of the consequences of the timeline for implementation. Requiring every Orthodontic Program to implement a specific faculty ratio at the same time will be exceptionally difficult, because studies have shown there is already a lack of orthodontic faculty in the United States:

“A crisis in orthodontic education exists today because of a shortage of qualified people seeking to pursue careers in academic orthodontics; 35% of orthodontic graduate programs in the United States report having at least 1 vacant faculty position… Faculty annual income was less than one half that of private practitioners matched by experience and geography. Faculty reported working an average of 25% more hours per week, and income per hour for full-time faculty was less than one third that of their private-practice colleagues. In addition, faculty perceived that they experienced more stress, encountered more bureaucracy, received less respect, and had a more difficult time achieving board certification than did private practitioners.”

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While this study was from 2003, the same issues for attracting full-time orthodontic faculty exist today: full-time orthodontists work more hours per week, experience clinical and academic stress, and are paid notably less than their private-practice colleagues.

While larger, well-funded Orthodontic Programs will likely not have an issue obtaining additional funding for salaries, the revisions could lead smaller Orthodontics Programs to close without a readily available pool of additional funding. Indeed, the average salary of orthodontic faculty will likely increase due to the shortage of potential faculty and lead to an increase in the cost of orthodontic education. Moreover, the sudden demand for more faculty could cause further hardship as some programs may not be able to hire more faculty to operate within the requirements of the proposed revisions for Standards 2-9, 2-10, 2-11.

GSO is opposed to the proposed revisions for Standards 2-9, 2-10, and 2-11 because they will cause an over-demand and under-supply of orthodontic faculty, causing some Orthodontic Programs to potentially close or lose their accreditation due to the lack of immediate additional funding and shortage of faculty created by the sudden supply and demand issues.

IV. Increases in the Cost of Orthodontic Education

The proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics will lead to increases in the cost of orthodontic education that will be borne by the orthodontic residents. As the Standards read today, the number and time commitment of faculty must be sufficient to provide for full supervision of the clinical portion of the Orthodontic Program. There is no requirement for overall Orthodontic Program faculty to resident ratios.

The way the current standards read undoubtedly produces a variety of overall Orthodontic Program and clinical faculty to student ratios in the CODA accredited Orthodontic Programs, based on the uniqueness of each Orthodontic Program. The faculty load in each Orthodontic Program plays a predominant role in the cost of running each Program. The cost of running each Orthodontic Program can be correlated to the tuition charged by each Program. Requiring an increase in the number of faculty will lead to an increase in the cost of operating Orthodontic Programs, which will lead to an increase in tuition rates charged to residents.

GSO is opposed to the proposed revisions for Standards 2-9, 2-10, and 2-11 because they will lead to an increase in the cost of orthodontic education due to rising costs of operating Orthodontic Programs, to be borne by the residents.

V. Conclusion

In summary, GSO is opposed to the proposed revisions for Standards 2-9, 2-10, and 2-11 for the following reasons:

1. There is no evidence to support the proposed ratios, they fail to take into account the uniqueness of each Orthodontic Program, and they limit the educational opportunities that residents can be exposed to in the clinical setting.

2. The Commission would be treating Orthodontic Programs differently from other similar Advanced Dental Education Programs without providing research or justification.

3. They will cause an over-demand and under-supply of orthodontic faculty, causing some Orthodontic Programs to potentially close or lose accreditation due to the lack of immediate
additional funding and potential shortage of faculty created by the sudden supply and demand issues.

4. They will lead to an increase in the cost of orthodontic education due to rising costs of operating Orthodontic Programs, to be borne by the residents.

For the above reasons, we urge the Commission to not pass the proposed revisions to the Accreditation Standards for Orthodontics and Dentofacial Orthopedics 2-9, 2-10, and 2-11 that will be reviewed at the Winter 2020 Commission meeting. Please do not hesitate to reach out to us should you have any questions or require any additional information.
Commission on Dental Accreditation

Proposed Revised Standards
Additions are Underlined
Strikethroughs indicate Deletions

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

**Intent:** The director of an orthodontic program is to be certified by the American Board of Orthodontics.

The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program’s effectiveness in meeting its goals.

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

2-1 The program must be directed by one individual.

2-2 The program director position must be full-time as defined by the institution.

2-23 There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.

Orthodontics and Dentofacial Orthopedics Standards
**Intent**: The program director is expected to be intimately involved in all aspects of the program.

Examples of evidence to demonstrate compliance may include:

- Program’s director’s weekly schedule
- Institution’s definition of full-time and part-time commitment
- Program director’s job description

2-34 A majority of the discipline-specific instruction and supervision must be conducted by individuals who are educationally qualified in orthodontics and dentofacial orthopedics.

2-45 Besides maintaining clinical skills, the director must have teaching experience in orthodontics and dentofacial orthopedics. For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.

2-56 Periodic faculty meetings must be held for the proper function and improvement of an advanced dental education program in orthodontics and dentofacial orthopedics.

Examples of evidence to demonstrate compliance may include:

- Schedules and minutes of faculty meetings
- Action taken as a result of faculty meetings
- Records of attendance at faculty meetings

2-67 The faculty must have knowledge of the required biomedical sciences relating to orthodontics and dentofacial orthopedics. Clinical instruction and supervision in orthodontics and dentofacial orthopedics must be provided by individuals who have completed an advanced dental education program in orthodontics and dentofacial orthopedics approved by the Commission on Dental Accreditation (grandfathered), or by individuals who have equivalent education in orthodontics and dentofacial orthopedics.

2-78 In addition to their regular teaching responsibilities with the department, full-time faculty must have adequate time for their own professional development.

2-9 The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.
**Intent:** Full-time faculty have the obligation to teach, conduct research and provide service to the institution and/or profession.

Examples of evidence to demonstrate compliance may include:

- Weekly schedules of full-time faculty
- Curriculum vita of full-time faculty, including academic ranks
- Schedule of faculty commitments in teaching, research and service

**2-810** For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty must be sufficient to provide full supervision of the clinical portion of the program.

**2-11** The faculty covering clinic must be orthodontists.

**2-912** Faculty evaluations must be conducted and documented at least annually.

Examples of evidence to demonstrate compliance may include:

- Faculty evaluation records
- Credentials and advanced education of faculty
- Institution plan for professional development

**2-1013** There must be evidence of an ongoing systematic procedure to evaluate the quality of treatment provided in the program.

Examples of evidence to demonstrate compliance may include:

- Records of case presentations and evaluation
- Patient charts available for audit
- Protocol for treatment

**2-1114** The program director and faculty must prepare students/residents to pursue certification by the American Board of Orthodontics.

**2-1114.a** The program director must document the number of graduates who become certified by the American Board of Orthodontics.

**2-1215** The program must show evidence of an ongoing faculty development process.
**Intent:** Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

3-1 Adequate space must be designated specifically for the advanced dental education program in orthodontics and dentofacial orthopedics. For each clinic session to which a student/resident is assigned, the program must provide a minimum of one (1) clinic chair per student/resident.

Intent: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

4-3.4 A graduate of an advanced dental education program in orthodontics must be competent to:

a. Coordinate and document detailed interdisciplinary treatment plans which may include care from other providers, such as restorative dentists and oral and maxillofacial surgeons or other dental specialists;

b. Treat and manage developing dentofacial problems which can be minimized by appropriate timely intervention;

c. Use dentofacial orthopedics in the treatment of patients when appropriate;

d. Treat and manage major dentofacial abnormalities and coordinate care with oral and maxillofacial surgeons and other healthcare providers;

e. Provide all phases of orthodontic treatment including initiation, completion and retention;

f. Treat patients with at least one contemporary orthodontic technique;

Intent: It is intended that the program teach one or more methods of comprehensive orthodontic treatment.

g. Manage patients with functional occlusal and temporomandibular disorders;

h. Treat or manage the orthodontic aspects of patients with moderate and advanced periodontal problems;

i. Develop and document treatment plans using sound principles of appliance design and biomechanics;

j. Obtain and create long term files of quality images of patients using techniques of photography, radiology and cephalometrics, including computer techniques when appropriate;

k. Use dental materials knowledgeably in the fabrication and placement of fixed and removable appliances;

l. Develop and maintain a system of long-term treatment records as a foundation for understanding and planning treatment and retention procedures;

m. Practice orthodontics in full compliance with accepted Standards of ethical behavior;
**Intent:** A program may be in compliance with the standard on ethical behavior when ethical behavior is acquired through continuous integration with other courses in the curriculum.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Case treatment records

n. **Manage and motivate patients to participate fully with orthodontic treatment procedures; and**

o. **Study and critically evaluate the literature and other information pertaining to this field:**

p. **Identify patients with sleep-related breathing disorders/sleep apnea:**

q. **Identify patients with Craniofacial Anomalies and Cleft Lip and Palate:**

r. **Treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure; and**

s. **Treat and effectively manage Class II malocclusions, defined as a bilateral end-on or greater Class II molar or a unilateral full cusp Class II molar, through a non-surgical treatment approach.**

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Clinical outcomes assessment
- ABO standards: Discrepancy Index, Cast-Radiograph Evaluation, Case Management Forms
REPORT OF THE REVIEW COMMITTEE ON ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. H. Garland Hershey. Committee Members: Dr. G. Frans Currier, Mr. David Cushing, Dr. Patrick Foley, Dr. James Hartsfield, and Dr. Wendy Woodall. Guests (Open Session Only): No guests attended the policy portion of the meeting. Staff Members: Ms. Jennifer Snow, manager, Advanced Dental Education and Mr. Christopher Castaneda, senior project assistant, Commission on Dental Accreditation (CODA). Dr. Sherin Tooks, director and Ms. Cathryn Albrecht, senior associate general counsel, CODA attended a portion of the meeting. The meeting of the Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) was held on January 11, 2019 at the ADA Headquarters, Chicago, Illinois.

CONSIDERATION OF MATTERS RELATED TO ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION

Informational Report on Orthodontics and Dentofacial Orthopedics Programs (Residency and Fellowship) Annual Survey Curriculum Data (p. 1100): The Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered the informational report on aggregate data of its discipline-specific Annual Survey Curriculum Sections. Upon review of the data, the ORTHO RC noted that it may revise its Curriculum Section instrument prior to its next implementation to ensure appropriate terminology with regard to the frequency of faculty evaluations. In addition, the ORTHO RC plans to review the instrument questions to ensure meaningful data collection in terms of mean, median, and maximum and minimum data points.

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

Consideration of Proposed Revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (p. 1101): The Review Committee on Orthodontics and Dentofacial Orthopedics Education (ORTHO RC) considered proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics from the American Association of Orthodontists (AAO) (Appendix 1, Policy Report p. 1101). The ORTHO RC noted that the AAO included a proposed revision to the Commission on Dental Accreditation Policy Statement on Site Visitor Training, which was forwarded to the Commission’s Standing Committee on Documentation and Policy for review.

The Committee considered the proposed revisions to the Orthodontics Standards and agreed they could be grouped into three (3) areas for discussion: required faculty/space resources; types of patients/conditions presenting for treatment; and specific treatment approaches/clinical techniques. The Committee found several proposed revisions pertaining to faculty/space resources all to be appropriate. The Committee also supported all of the proposed revisions that
relate to the types of patients/conditions presenting for treatment. After considerable discussion, the ORTHO RC determined that the addition of specific treatment techniques or clinical approaches was not consistent with the intentionally broad nature of the Accreditation Standards.

Following discussion, the ORTHO recommended that proposed revisions to the Accreditation Standards be circulated to the communities of interest for a period of one (1) year, with final review by the ORTHO RC and Commission in Winter 2020.

In summary, the ORTHO RC recommended the proposed revisions (Appendix 1) be circulated to the communities of interest for review and comment for a period of one (1) year, with Hearings conducted at the March 2019 American Dental Education Association and September 2019 American Dental Association annual meetings, with final review by the ORTHO RC and Commission in Winter 2020.

**Recommendation:** It is recommended that the Commission on Dental Accreditation direct circulation of the proposed revisions to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics (Appendix 1), to the communities of interest for review and comment for a period of one (1) year, with Hearings conducted at the March 2019 American Dental Education Association and September 2019 American Dental Association annual meetings, with comments reviewed at the Commission’s Winter 2020 meetings.

**Informational Report on the Conduct of Validity and Reliability Studies for the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics and Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics (p. 1102):** The Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics were adopted by the Commission on Dental Accreditation at its January 2013 meeting for implementation January 1, 2014. The Accreditation Standards for Clinical Fellowship Training Programs in Craniofacial and Special Care Orthodontics were adopted and implemented by the Commission on Dental Accreditation at its August 7, 2015 meeting.

As stated in the Commission’s “Policy on Assessing the Validity and Reliability of the Accreditation Standards” (Appendix 1, Policy Report p. 1102), the Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: *The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years.*
Thus, the validity and reliability of the new standards for a one-year program will be assessed after four years, while standards applying to programs four years in length will be assessed seven years after implementation.

The validity and reliability studies for orthodontics and dentofacial orthopedics (residency and fellowship) programs will be initiated in the summer/fall of 2019. Survey results would be considered at the Winter 2020 meetings of the Orthodontics and Dentofacial Orthopedics Review Committee and the Commission on Dental Accreditation.

In cooperation with the ADA’s Health Policy Institute (HPI), a timetable will be developed, surveys will be distributed to the audiences, and responses will be due to the HPI within two weeks of receipt of the survey. Sample formats of the surveys are presented in Appendix 2, Policy Report p. 1102 and Appendix 3, Policy Report p. 1102. Following a period of follow-up with non-respondents, the data will be tabulated and analysis completed by December 1, 2019. Commission staff will prepare reports with results of the studies for consideration by the Commission at its Winter 2020 meeting.

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

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

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

**CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREA OF ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS EDUCATION**

The Review Committee on Orthodontics and Dentofacial Orthopedics Education considered site visitor appointments for 2019-2020. The Committee’s recommendations on the appointments of individuals are included in a separate report.

**CONSIDERATION OF MATTERS RELATED TO ACCREDITATION STATUS**

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

Respectfully submitted,

Dr. H. Garland Hershey

Chair, Review Committee on Orthodontics and Dentofacial Orthopedics Education
Commission on Dental Accreditation  
Ms. Jennifer Snow, M.P.H.  
Advanced Specialty Education Manager  
211 E. Chicago Avenue  
Chicago, IL 60611

October 9, 2018

Dear CODA Commissioners,

The American Association of Orthodontists (AAO) requests the Commission on Dental Accreditation to consider the AAO’s recommendations to revise the CODA Standards for Orthodontics and Dentofacial Orthopedics and the CODA Evaluation and Operational Policies and Procedures.

An AAO-appointed Committee consisting of three Council on Education members, three Society of Educators members, one American Board of Orthodontics (ABO) member and one AAO Board of Trustee who teaches part time for a CODA accredited orthodontic residency program. It was this Committee’s responsibility to thoroughly evaluate and suggest revisions to the standards as warranted to insure high quality orthodontic education. The recommendations by the Committee were presented to the following groups for input between October 2017 and August 2018.

- AAO Council on Education
- AAO Council on Scientific Affairs
- The American Board of Orthodontists Symposium
- 180 orthodontic educators at the 2018 Rolf G. Behrens Educational Leadership Conference
- AAO Society of Educators
- Orthodontic Department Chairs and Program Directors
- AAO Board of Trustees

The recommendations offered for your consideration have been noted in the attached CODA Standards for Orthodontics and Dentofacial Orthopedics and the CODA Standards for Evaluation and Operational Policies and Procedures. A summary (Appendix I and II) of the suggested changes follow my signature. The AAO sincerely appreciates your time and review of these recommended revisions. We believe they will further our shared mission to serve the public and our profession as dental education and patient care evolve.

Sincerely,

Brent E. Larson, DDS, MS  
2018-2019 AAO President
Appendix I

Accreditation Standards for Advanced Specialty Education Programs in Orthopedics and Dentofacial Orthopedics

STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program’s effectiveness in meeting its goals.

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

2-1 The program must be directed by one individual.

2-2 There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.

2-3 The program director must be a full-time position with full-time as defined by the institution.

Program director’s job description

2-8 In addition to their regular teaching responsibilities with the department, full-time faculty must have adequate time for their own professional development. A minimum of 1 full time equivalent (FTE) faculty to 4 residents is required for the entire program.

Intent: Full-time faculty have the obligation to teach, conduct research and provide service to the institution and/or profession.

Examples of evidence to demonstrate compliance may include:
- Weekly schedules of full-time faculty
- Curriculum vita of full-time faculty, including academic ranks
- Schedule of faculty commitments in teaching, research and service

2-9 The number and time commitment of faculty must be sufficient to provide full supervision of the clinical portion of the program. For clinic coverage, a minimum of 1 faculty to 6 residents is recommended, but no less than 1 faculty to 8 residents is required.

2-10 The faculty covering clinic must be orthodontic specialists.
STANDARD 3 - FACILITIES AND RESOURCES

Intent: Required orthodontic clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.

3-1 Adequate space must be designated specifically for the advanced specialty education program in orthodontics and dentofacial orthopedics. **There must be a minimum of one clinic chair per resident in all orthodontic teaching facilities.**

STANDARD 4 - CURRICULUM AND PROGRAM DURATION

4-3.4 A graduate of an advanced specialty education program in orthodontics must be competent to:

a. Coordinate and document detailed interdisciplinary treatment plans which may include care from other providers, such as restorative dentists and oral and maxillofacial surgeons or other dental specialists;

b. Treat and manage developing dentofacial problems which can be minimized by appropriate timely intervention;

c. Use dentofacial orthopedics in the treatment of patients when appropriate;

d. Treat and manage major dentofacial abnormalities and coordinate care with oral and maxillofacial surgeons and other healthcare providers;

e. Provide all phases of orthodontic treatment including initiation, completion and retention;

f. Treat patients with at least one contemporary orthodontic technique;

*Intent: It is intended that the program teach one or more methods of comprehensive orthodontic treatment.*

g. Manage patients with functional occlusal and temporomandibular disorders;

h. Treat or manage the orthodontic aspects of patients with moderate and advanced periodontal problems;

i. Develop and document treatment plans using sound principles of appliance design and biomechanics;

j. Obtain and create long term files of quality images of patients using techniques of photography, radiology and cephalometrics,
including computer techniques when appropriate;

k. Use dental materials knowledgeably in the fabrication and placement of fixed and removable appliances; including the use of clear aligners in orthodontic treatment.

l. Develop and maintain a system of long-term treatment records as a foundation for understanding and planning treatment and retention procedures;

m. Practice orthodontics in full compliance with accepted Standards of ethical behavior;

Intent: A program may be in compliance with the standard on ethical behavior when ethical behavior is acquired through continuous integration with other courses in the curriculum.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Case treatment records

n. Manage and motivate patients to participate fully with orthodontic treatment procedures; and

o. Study and critically evaluate the literature and other information pertaining to this field.

p. Manage patients with sleep related breathing disorders /sleep apnea.

q. Use temporary skeletal anchorage devices.

r. Use and evaluate 3D imaging.

s. Treat patients with Craniofacial Anomalies and Cleft Lip and Palate – there is no clinical case requirement but a didactic curriculum must be a part of the program.

t. Treat and demonstrate effective management of malocclusions that require 4 quadrants of bicuspid extractions or of comparable space closure due to missing or agenesis of teeth.

u. Treat and demonstrate effective management of Class II malocclusions, as defined as a bilateral end-on or greater class II molar or a unilateral full cusp class II molar, through a non-surgical treatment approach.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Clinical outcomes assessment

The use of the ABO standards is one way that a program may demonstrate compliance through clinical outcomes assessment:
- Cast-Radiograph evaluation
- Case Management Forms
Supporting Curriculum. The orthodontic graduate must have understanding of:

- Biostatistics;
- History of Orthodontics and Dentofacial Orthopedics;
- Jurisprudence;
- Oral Physiology;
- Pain and Anxiety Control;
- Pediatrics;
- Periodontics;
- Pharmacology;
- Preventive Dentistry;
- Psychological Aspects of Orthodontic and Dentofacial Orthopedic Treatment;
- Public Health Aspects of Orthodontics and Dentofacial Orthopedics;
- Speech Pathology and Therapy;
- Practice Management; and
- The variety of recognized techniques used in contemporary orthodontic practice.

- The use of soft tissue lasers.

Examples of evidence to demonstrate compliance may include:

- Course outlines
Proposed Revisions to Orthodontics Standards
Orthodontics RC
CODA Winter 2021

Appendix 2

Evaluation & Operational Policies & Procedures

IV. POLICIES AND PROCEDURES RELATED TO ACCREDITATION OF PROGRAMS

K. SITE VISITORS

3. Policy Statement On Site Visitor Training: The Commission has a long history of a strong commitment to site visitor training and requires that all program evaluators receive training. Prior to participation, site visitors must demonstrate that they are knowledgeable about the Commission’s accreditation standards and its Evaluation and Operational Policies and Procedures. Initial and ongoing training takes place in several formats.

New site visitors **must** attend a two-day formal workshop that follows the format of an actual site visit. **When site visitors cannot attend this formal workshop, they must also** attend a site visit as trainees, accompanied by a Commission staff member or staff representative and a comparable experienced site visitor who provide ongoing training and guidance. All new site visitors are directed to the Commission’s on-line training program and are required to successfully complete the training program and site visitor final assessment.
November 22, 2019

Ms. Jennifer Snow,
19th Floor Manager,
Advanced Dental Education Commission on Dental Accreditation
211 East Chicago Avenue Chicago, IL 60611

Dear Ms. Snow:

Thank you for the opportunity to offer comments on the proposed changes to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics.

The intent of my letter is to strongly disagree with the implementation of proposed standards:

2-9: The program must ensure a minimum of 1 FTE faculty to 4 residents for the entire program, including clinical, didactic, administrative, and research components.

2-10: For clinic coverage, the program must ensure no less than 1 faculty to 8 residents.

My reasons for strong disagreement are based on my experience/participation in orthodontics and dentofacial orthopedics resident education for over 3 decades. I am currently the Chair of the Department of Orthodontics at the University of Colorado School of Dental Medicine.

The ratios identified in the proposed changes to the standards are not based upon any evidence, and do not guarantee a specific quality of education to students/residents, or the specific desired outcome of a qualified orthodontics graduate.

For those of us who have educated significant numbers of orthodontists, we are aware and continually review and modify several factors that influence the quality of resident education that are not associated with specific faculty to student ratios. These include the structure of the program, the length of the program, the number of starts each resident gets, the number of patients each resident sees per day, the opportunity to learn from the cases of other residents (likely increased in the larger programs), and the quality of the faculty (both full and part-time) that provide unique skills and experiences, to name a few.

At a time when there are many challenges and opportunities facing orthodontics programs, these are not forward-thinking changes to the current standards. They will do little to guarantee the quality of advanced dental education in orthodontics and dentofacial orthopedics, and instead will have the unintended consequences of negatively impacting several programs.

Sincerely,

W. Craig Shellhart, DDS, MS
Professor and Chair of Orthodontics
CU School of Dental Medicine, University of Colorado Anschutz Medical Campus
November 25, 2019

Commission on Dental Accreditation (CODA)
ATTN: Ms. Jennifer Snow, 19th Floor
Manager, Advanced Dental Education
211 East Chicago Avenue
Chicago, IL 60611

Sent via email: snowj@ada.org

Re: Appendix 10 - Proposed Revisions to the Accreditation Standards for Orthodontics and Dentofacial Orthopedics

Dear Ms. Snow,

Thank you for the opportunity to comment on the proposed changes to the accreditation standards for Advanced Education Programs in Orthodontics and Dentofacial Orthopedics. We applaud CODA’s effort to improve its standards by increasing its focus on students’ learning outcomes and faculty supervision. We firmly believe that this initiative is necessary in the current climate of higher education and considering the recent changes implemented in the specialty board certification process. With this in mind, we provide the following comments:

1) The Program director position must be full-time as defined by the institution

Advanced dental education has undergone substantial changes, most notably increased oversight, evidence-based curriculum and increased compliance demands. As a result, program directors need to be incredibly flexible to respond to the changing educational environment whilst at the same time ensure the presence of a framework that can address the needs of students, patients, faculty, staff and university administrators. It is our opinion that successfully fulfilling all of these requirements can be challenging on a part-time basis. Therefore, we strongly support this amendment, which will ensure program directors continue to be “intimately” involved in all aspects of the program as stated in Appendix 10. To the best of our knowledge, this recommended action has already been implemented by most CODA-accredited advanced education programs in order to prevent additional activities to disrupt the program director’s focus on his/her primary commitment. We don’t see why the guidelines should be any different for Orthodontics and Dentofacial Orthopedics.

2. The program must ensure a minimum of one (1) full-time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.
The proposed FTE is a reasonable estimate for most institutions.

3. For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number of faculty is sufficient to provide full supervision of the clinical portion of the program.

We understand that limiting the ratio of students to faculty is believed to enhance the potential for clinical learning. Nevertheless, the existing educational literature is still contradictory about the use of ratios to measure postgraduate clinical learning and the extent to which it actually affects the residents’ skills. In addition, how to determine appropriate levels for student-faculty ratios is a difficult question, as many models for clinical education currently exist. Even more importantly than the ratio is the implementation of clinical benchmarks to show successful progress through the clinical training of the program. Although this amendment is well meaning, we believe the commission will be better served to leave the ratio up to the sponsoring institution.

4. The faculty covering clinic must be orthodontists

We strongly support this amendment. It is important to ensure that clinical training is conducted by faculty who are qualified in the subject matter.

5. For each clinic session to which a student/resident is assigned, the program must provide a minimum of one (1) clinic chair per student/resident.

We agree that this is an important issue. The sponsoring institution must provide the program with clinical facilities sufficient in number and size conducive to student learning.

6. A graduate must be competent to identify patients with sleep-related breathing disorders/sleep apnea

The demand of integrating obstructive sleep apnea into orthodontic education is growing; however, the degree of which questionnaires and standard orthodontic records allow for accurate “identification” is controversial. Obstructive sleep apnea and other sleep-related breathing disorders can only be definitively diagnosed by a physician. Thus, we believe the scope of this amendment needs to be streamlined and defined more clearly. We propose a change in wording to “be competent to screen for patients at risk of sleep-related breathing disorders/sleep apnea” in order to better reflect the intention on the proposed amendment.

7. A graduate must be competent to identify patients with Craniofacial Anomalies and Cleft Lip and Palate
We support this amendment. Orthodontists’ scope of practice should include the diagnosis and management of patients with craniofacial anomalies and clefts.

8. A graduate must be competent to treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure

AND

9. A graduate must be competent to treat and effectively manage Class II malocclusions, defined as a bilateral end-on or greater Class II molar or a unilateral full cusp Class II molar, through a non-surgical treatment approach.

The ability to manage extraction spaces and class II malocclusions are crucial skills that all orthodontists should possess. In light of recent changes to the board certification process, we support these amendments and believe the proposed changes will further reinforce the rigor and ensure the consistency of CODA-accredited orthodontic programs.

10. Examples of evidence to demonstrate compliance include ABO standards: Discrepancy Index, Cast-Radiograph Evaluation, Case Management Forms.

Maximizing resident education requires attention to learning outcomes. The ABO standards are well validated methods to assess student achievement in the clinical skills domain. Therefore, we strongly support this amendment.

Thank you again for the ability to offer comments. We look forward to the outcomes of this process.

Sincerely,

Mary R Truhlar DDS, MS
Dean, School of Dental Medicine
mary.truhlar@stonybrookmedicine.edu
Office: 631.632.8950

Wellington J Rody Jr. DDS, MS
Chair, Department of Orthodontics and Pediatric Dentistry
Wellington.Rody@stonybrookmedicine.edu
Office: 631.632.3181
November 25, 2019

Ms. Jennifer Snow,
19th Floor Manager,
Advanced Dental Education Commission on Dental Accreditation
211 East Chicago Avenue Chicago, IL 60611

Dear Ms. Snow:

As faculty member for five and half years and the current Clinic Coordinator for the Orthodontics Department at the University of Colorado School of Dental Medicine, I strongly disagree with the implementation of proposed standards:

2-9: The program must ensure a minimum of 1 FTE faculty to 4 residents for the entire program, including clinical, didactic, administrative, and research components.

2-10: For clinic coverage, the program must ensure no less than 1 faculty to 8 residents.

As a graduate of this program and now faculty, I strongly oppose the ratios identified in the above proposed changes. I feel that the proposed changes do not guarantee a specific quality of education to students/residents or the specific desired outcome of a qualified orthodontics graduate.

As an advanced dental education in orthodontics and dentofacial orthopedic program, we strive and continually review all variables that influence the quality of resident education. These include the structure of the program, the length of the program, the number of starts each resident gets, the number of patients each resident sees per day, the opportunity to learn from the cases of other residents (which is likely increased in the larger programs), and the quality of the faculty (both full and part-time) that provide unique skills and experiences. I find that the quality in faculty/clinic instructors can be influenced by whether or not the individual is paid or not (much better quality when an instructor is paid). That being said, it would be an astronomical cost to our department to pay the salaries of the number required by the new proposal. By changing the ratios of faculty coverage there is little to no evidence that any program will benefit or improve resident education, but will have the potential for greater negative implications.

Thank you for the opportunity to offer comments on the proposed changes to the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics.

Sincerely,

Caitlin E. White, DMD, MS
Assistant Professor of Orthodontics
CU School of Dental Medicine, University of Colorado Anschutz Medical Campus
Ms. Jennifer Snow  
Manager of Advanced Dental Education  
Commission on Dental Accreditation  
211 East Chicago Avenue  
Chicago, IL 60611  

Re: Proposed ORTHODONTIC Standards Revision CODA Winter 2019

I am writing to request that the ORTHODONTIC Section reconsider one of the changes that has been proposed for the Winter 2009 session meeting.

Change 2-2, I would like to suggest that this change not be implemented and that the present 2-23 program director definition be kept as it is with sufficient time to devote to the program. While on first glance it appears, the change would be equitable it is really not. In surveying many programs there is a tremendous variation in what is considered full time from both academic institutions and medical center programs. The range is 2 days to 5 days a week. In the 5-day programs many of the positions are divided with time allotted to other duties. An example being protected time for research of 40%, private practice 20% and administration 40%. Therefore, the program is only getting basically 40% of the time devoted to it with 5 days a week full time person. In many hospital programs this time distribution is far more limiting. In all the CODA certified programs there is a variation as listed above and I think that as long as the program is managed well that the original definition is a better
working definition for the program director as there are many other factors that CODA looks at in certifying a program. It may be that an %FTE definition is more appropriate. In this time of difficulty attracting full time academic qualified faculty I do not think this is in the best interest of academic orthodontic training programs. Many of the programs presently in place have this issue by any stretch of the verbiage of time devoted to running an excellent graduate program. Since there is variation of a wide nature, I believe the definition of the program director time devoted to the program should remain as it is at this time. If, however, this is changed I would hope sufficient time is given for programs to rearrange the schedules. In addition, I would hope that the programs with directors running these programs would allow for a grandfather-in clause to retain the present directors until such time as they leave the program and a new director is appointed.

Thank you in advance for allowing me to express my concerns.
Richard D Faber

Richard D. Faber D.D.S., M.S.
Clinical Professor of Orthodontics
Director of Advanced Education Program in Orthodontics and Dentofacial Orthopedics
School of Dental Medicine
Room 114 Rockland Hall
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**Please take note of my new email address**

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July 17, 2019

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 2019 meeting, Council members considered and supported the proposed revisions to Standards 2, 3-1, and 4-3.4 of the Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics as requested by the American Association of Orthodontists (AAO).

The proposed revisions to the Orthodontics Standards address three (3) areas: required faculty/space resources; types of patients/conditions presenting for treatment; and specific treatment approaches/clinical techniques. The Council believes that the proposed revisions are appropriate.

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

Sincerely,

Rekha C. Gehani, D.D.S.  
Chair  
Council on Dental Education and Licensure

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

Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics

Submitted by the Ad Hoc Committee on Orthodontics and Dentofacial Orthopedics Residency and Fellowship Standards Revisions

Proposed Revisions to Standards
Additions are Underlined
Strikethroughs indicate Deletions
Accreditation Standards for
Advanced Dental Education Programs in
Orthodontics and Dentofacial Orthopedics

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

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<thead>
<tr>
<th>Date</th>
<th>Item</th>
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<tr>
<td>August 10, 2012</td>
<td>Revised Mission Statement</td>
<td>Adopted and Implemented</td>
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<tr>
<td>January 31, 2013</td>
<td>Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics</td>
<td>Adopted</td>
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<tr>
<td>January 31, 2013</td>
<td>Addition of Standard 2-12</td>
<td>Adopted</td>
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<tr>
<td>January 31, 2013</td>
<td>Revision to Policy on Accreditation of Off-Campus Sites</td>
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<td>Revision to Standard 5, Eligibility and Selection</td>
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<td>July 1, 2013</td>
<td>Addition of Standard 2-12</td>
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<tr>
<td>August 9, 2013</td>
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Mission Statement of the Commission on Dental Accreditation

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

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

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

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

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

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

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

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

Other Accreditation Actions:

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

Reaffirmed: 8/18; Adopted: 2/16

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

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

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

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

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

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

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

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

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

Accreditation is extended to institutions offering acceptable programs in the following disciplines of advanced dental education: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, advanced education in general dentistry, general practice residency, dental anesthesiology, oral medicine, and orofacial pain. Program accreditation will be withdrawn when the training program no longer conforms to the standards as specified in this document, when all first-year positions remain vacant for a period of two years or when a program fails to respond to requests for program information. Exceptions for non-enrollment may be made by the Commission for programs with “approval without reporting requirements” status upon receipt of a formal request from an institution stating reasons why the status of the program should not be withdrawn.

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

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

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

As a learned profession entrusted by the public to provide for its oral health and general well-
being, the profession provides care without regard to race, color, religion, gender, national origin,
age, disability, sexual orientation, status with respect to public assistance, or marital status.

The profession has a duty to consider patients’ preferences, and their social, economic and
emotional circumstances when providing care, as well as to attend to patients whose medical,
physical and psychological or social situation make it necessary to modify normal dental routines
in order to provide dental treatment. These individuals include, but are not limited to, people
with developmental disabilities, cognitive impairments, complex medical problems, significant
physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the
importance of educational processes and goals for comprehensive patient care and encourage
patient-centered approaches in teaching, research and oral health care delivery.

The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity,
fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional
Conduct and the ADEA Statement on Professionalism in Dental Education.

General standards are identified by the use of a single numerical listing (e.g., 1). Discipline-
specific standards are identified by the use of multiple numerical listings (e.g., 1-1, 1-1.2, 1-2).
Definitions of Terms Used in Orthodontic and Dentofacial Orthopedic Accreditation Standards

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

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

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

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

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

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

Graduates of discipline-specific advanced dental education programs provide unique services to the public. While there is some commonality with services provided by specialists and general dentists, as well as commonalities among the specialties, the educational standards developed to prepare graduates of discipline-specific advanced dental education programs for independent practice should not be viewed as a continuum from general dentistry. Each discipline defines the educational experience best suited to prepare its graduates to provide that unique service.

Competencies: Statements in the advanced dental education standards describing the knowledge, skills and values expected of graduates of discipline-specific advanced dental education programs.

Competent: Having the knowledge, skills and values required of the graduates to begin independent, unsupervised discipline-specific practice.
In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.

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

Other Terms:

Institution (or organizational unit of an institution): a dental, medical or public health school, patient care facility, or other entity that engages in advanced dental education.

Sponsoring institution: primary responsibility for advanced dental education programs.

Affiliated institution: support responsibility for advanced dental education programs.

Advanced dental education student/resident: a student/resident enrolled in an accredited advanced dental education program.

A degree-granting program a planned sequence of advanced courses leading to a master’s or doctoral degree granted by a recognized and accredited educational institution.

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in an advanced dental education program.

Student/Resident: The individual enrolled in an accredited advanced dental education program.

International Dental School: A dental school located outside the United States and Canada.

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

Formative Assessment*: guiding future learning, providing reassurance, promoting reflection, and shaping values; providing benchmarks to orient the learner who is approaching a relatively unstructured body of knowledge; and reinforcing students’ intrinsic motivation to learn and inspire them to set higher standards for themselves.
Summative Assessment*: making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility; and providing professional self-regulation and accountability.

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

The program must develop clearly stated goals and objectives appropriate to advanced dental education, addressing education, patient care, research and service. Planning for, evaluation of and improvement of educational quality for the program must be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.

Ethics and Professionalism

1-1 Graduates must receive instruction in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.

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

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement.

Intent: The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of orthodontics and dentofacial orthopedics and that one of the program goals is to comprehensively prepare competent individuals to initially practice orthodontics and dentofacial orthopedics. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program’s purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f) review the assessment plan, revise as appropriate, and continue the cyclical process.

The financial resources must be sufficient to support the program’s stated goals and objectives.

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

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

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

Advanced dental education programs **must** be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced dental education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid (CMS). Educational institutions that sponsor advanced dental education programs **must** be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced dental education programs **must** ensure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

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

The authority and final responsibility for curriculum development and approval, student/resident selection, faculty selection and administrative matters **must** rest within the sponsoring institution. The institution/program **must** have a formal system of quality assurance for programs that provide patient care.

The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director **must** have the authority, responsibility and privileges necessary to manage the program.
USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

The primary sponsor of the educational program must accept full responsibility for the quality of education provided in all sites where educational activity occurs.

1-2 All arrangements with sites where educational activity occurs, not owned by the sponsoring institution, must be formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved.

1-3 Documentary evidence of agreements, approved by the sponsoring and relevant major and minor activity sites not owned by the sponsoring institution, must be available. The following items must be covered in such inter-institutional agreements:

a. Designation of a single program director;
b. The teaching staff;
c. The educational objectives of the program;
d. The period of assignment of students/residents; and
e. Each institution’s financial commitment.

**Intent:** An “institution (or organizational unit of an institution)” is defined as a dental, medical or public health school, patient care facility, or other entity that engages in advanced dental education. The items are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

1-4 For each site where educational activity occurs, there must be an on-site clinical supervisor who is qualified by education and/or clinical experience in the curriculum areas for which they are responsible.

1-5 All faculty, including those at major and minor educational activity sites, must be calibrated to ensure consistency in training and evaluation of students/residents that supports the goals and objectives of the program.

**Intent:** It is the responsibility of the program director to ensure that all faculty, including those at sites where educational activity occurs, are qualified.

If the program utilizes off-campus sites for clinical experiences or didactic instruction, please review the Commission’s Policy on Accreditation of Off-Campus Sites found in the Evaluation and Operational Policies and Procedures manual (EOPP).
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by one director who is board certified in the respective advanced dental education discipline of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

Intent: The director of an orthodontic program is to be certified by the American Board of Orthodontics. The director of an advanced dental education program is to be certified by a nationally accepted certifying board in the advanced dental education discipline. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced dental education program in the respective discipline; letter from the previous employing institution verifying service)

The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program’s effectiveness in meeting its goals.

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

2-1 The program must be directed by one individual.

2-2 The program director position must be full-time as defined by the institution.

2-23 There must be evidence that sufficient time is devoted to the program by the director so that the educational and administrative responsibilities can be met.

Intent: The program director is expected to be intimately involved in all aspects of the program.
Examples of evidence to demonstrate compliance may include:

- Program’s director’s weekly schedule
- Institution’s definition of full-time and part-time commitment
- Program director’s job description

2-34 A majority of the discipline-specific instruction and supervision must be conducted by individuals who are educationally qualified in orthodontics and dentofacial orthopedics.

2-45 Besides maintaining clinical skills, the director must have teaching experience in orthodontics and dentofacial orthopedics. For all appointments after July 1, 2009, the director must have had teaching experience in an academic orthodontic departmental setting for a minimum of two (2) years.

2-56 Periodic faculty meetings must be held for the proper function and improvement of an advanced dental education program in orthodontics and dentofacial orthopedics.

Examples of evidence to demonstrate compliance may include:

- Schedules and minutes of faculty meetings
- Action taken as a result of faculty meetings
- Records of attendance at faculty meetings

2-67 The faculty must have knowledge of the required biomedical sciences relating to orthodontics and dentofacial orthopedics. Clinical instruction and supervision in orthodontics and dentofacial orthopedics must be provided by individuals who have completed an advanced dental education program in orthodontics and dentofacial orthopedics approved by the Commission on Dental Accreditation (grandfathered), or by individuals who have equivalent education in orthodontics and dentofacial orthopedics.

2-78 In addition to their regular teaching responsibilities with the department, full-time faculty must have adequate time for their own professional development.

2-9 The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components.
**Intent:** Full-time faculty have the obligation to teach, conduct research and provide service to the institution and/or profession.

Examples of evidence to demonstrate compliance may include:

- Weekly schedules of full-time faculty
- Curriculum vita of full-time faculty, including academic ranks
- Schedule of faculty commitments in teaching, research and service

2-810 **For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty must be is sufficient to provide full supervision of the clinical portion of the program.**

2-11 **The faculty covering clinic must be orthodontists.**

2-912 **Faculty evaluations must be conducted and documented at least annually.**

Examples of evidence to demonstrate compliance may include:

- Faculty evaluation records
- Credentials and advanced education of faculty
- Institution plan for professional development

2-1013 **There must be evidence of an ongoing systematic procedure to evaluate the quality of treatment provided in the program.**

Examples of evidence to demonstrate compliance may include:

- Records of case presentations and evaluation
- Patient charts available for audit
- Protocol for treatment

2-1114 **The program director and faculty must prepare students/residents to pursue certification by the American Board of Orthodontics.**

2-1114.a **The program director must document the number of graduates who become certified by the American Board of Orthodontics.**

2-1215 **The program must show evidence of an ongoing faculty development process.**
**Intent:** Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching, learning, and assessment
- Attendance at regional and national meetings that address contemporary issues in education and patient care
- Mentored experiences for new faculty
- Scholarly productivity
- Presentations at regional and national meetings
- Examples of curriculum innovation
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students/residents of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum
- Evidence of participation in continuing education activities
STANDARD 3 - FACILITIES AND RESOURCES

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

**Intent:** The facilities and resources (e.g.; support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, students/residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.

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

**Intent:** The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the students/residents, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.

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

**Intent:** The program should have written policy that encourages (e.g., delineates the advantages of) immunization for students/residents, faculty and appropriate support staff.

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

**Intent:** Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.
The use of private office facilities as a means of providing clinical experiences in advanced dental education is only approved when the discipline has included language that defines the use of such facilities in its discipline-specific standards.

**Intent**: Required orthodontic clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.

3-1 Adequate space must be designated specifically for the advanced dental education program in orthodontics and dentofacial orthopedics.  **For each clinic session to which a student/resident is assigned, the program must provide a minimum of one (1) clinic chair per student/resident.**

**Intent**: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.

3-2 Facilities must permit the students/residents to work effectively with trained allied dental personnel.

**Intent**: A program is expected to have auxiliaries available to assist the students/residents so the program can meet the educational Standards.

Examples of evidence to demonstrate compliance may include:

- Schedule of dental assistants’ assignments

3-3 Radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. Imaging equipment must be available.

3-4 Students/Residents in an orthodontic program must have access to adequate space, equipment, and physical facilities to do research.

**Intent**: Adequate space is necessary to do research, but does not need to be dedicated to orthodontic research.

3-5 Adequate secretarial, clerical, dental auxiliary and technical personnel must be provided to enable students/residents to achieve the educational goals of the program.

**Intent**: The intent is to ensure the students/residents utilize their time for educational purposes.
3-6 Clinical facilities must be provided within the sponsoring or affiliated institution to fulfill the educational needs of the program.

3-7 Sufficient space must be provided for storage of patient records, models and other related diagnostic materials.

3-8 These records and materials must be readily available to effectively document active treatment progress and immediate as well as long term post-treatment results.

**Intent:** Students/Residents are expected to have easy access to active, post treatment, and retention records. These records should be complete.

3-9 Digital radiography equipment must be available and accessible to the orthodontic clinic so that panoramic, cephalometric and other images can be provided for patients. Cone-beam volumetric images are also acceptable.

**Intent:** High quality radiographic images are essential for orthodontic and dentofacial orthopedic therapy. Three dimensional cone-beam CT images of the dentition, face and TMJs are acceptable if the equipment is convenient.
STANDARD 4 - CURRICULUM AND PROGRAM DURATION

Curriculum Approach: Evidence-Based Dentistry (EBD)

Evidence-based dentistry (EBD) is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient’s oral and medical condition and history, with the dentist’s clinical expertise and the patient’s treatment needs and preferences. *(Adopted by the American Association of Orthodontists House of Delegates 05/24/2005)*

The advanced dental education program must be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted Standards of the discipline’s practice as set forth in specific Standards contained in this document.

**Intent:** The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies Standards for the discipline.

Advanced dental education programs must include instruction or learning experiences in evidence-based practice. Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient’s oral and medical condition and history, with the dentist’s clinical expertise and the patient’s treatment needs and preferences.

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

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or “searching publication databases and appraisal of the evidence”)
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

The level of discipline-specific instruction in certificate and degree-granting programs must be comparable.
Intent: The intent is to ensure that the student/residents of these programs receive the same educational requirements as set forth in these Standards.

If an institution and/or program enrolls part-time students/residents, the institution must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents
must start and complete the program within a single institution, except when the program is
discontinued. The director of an accredited program who enrolls students/residents on a part-time
basis must assure that: (1) the educational experiences, including the clinical experiences and
responsibilities, are the same as required by full-time students/residents; and (2) there are an
equivalent number of months spent in the program.

4-1 Program Duration: Advanced dental education programs in orthodontics and
dentofacial orthopedics must be a minimum of twenty-four (24) months and 3700
scheduled hours in duration.

Examples of evidence to demonstrate compliance may include:

- Class schedules and outlines

4-2 Biomedical Sciences: A graduate of an advanced dental education program in
orthodontics must be competent to:

a. Develop treatment plans and diagnosis based on information about
   normal and abnormal growth and development;

b. Use the concepts gained in embryology and genetics in planning
treatment;

c. Include knowledge of anatomy and histology in planning and carrying out
treatment; and

d. Apply knowledge about the diagnosis, prevention and treatment of
   pathology of oral tissues.

Examples of evidence to demonstrate compliance may include:

- Course outlines and case treatment records
- Outcome assessment of clinical performance

4-3 Clinical Sciences:

4-3.1 Orthodontic treatment must be evidence-based. (EBD is an approach to
oral health care that requires the judicious integration of systematic assessments
of clinically relevant scientific evidence, relating to the patient’s oral and medical
condition and history, with the dentist’s clinical expertise and the patient’s
treatment needs and preferences.) (Adopted by the American Association of
Orthodontists House of Delegates 05/24/2005)

Examples of evidence to demonstrate compliance may include:

Orthodontics and Dentofacial Orthopedics Standards
• orthodontic literature applied to clinical treatment decisions
• integration of current systematic literature reviews with treatment conferences
• ethics applied to patient management

4-3.2 An advanced dental education program in orthodontics and dentofacial orthopedics requires extensive and comprehensive clinical experience, which must be representative of the character of orthodontic problems encountered in private practice.

**Intent:** The intent is to ensure there is diversity in the patient population so that the students/residents will learn to treat a variety of orthodontic problems from the primary to adult dentition.

Examples of evidence to demonstrate compliance may include:

• Case treatment records
• Percentage of each category of patient care

4-3.3 Experience must include treatment of all types of malocclusion, whether in the permanent or transitional dentitions, and should include treatment of the primary dentition when appropriate.

Examples of evidence to demonstrate compliance may include:

• Case treatment records

4-3.4 A graduate of an advanced dental education program in orthodontics must be competent to:

a. Coordinate and document detailed interdisciplinary treatment plans which may include care from other providers, such as restorative dentists and oral and maxillofacial surgeons or other dental specialists;

b. Treat and manage developing dentofacial problems which can be minimized by appropriate timely intervention;

c. Use dentofacial orthopedics in the treatment of patients when appropriate;
d. Treat and manage major dentofacial abnormalities and coordinate care with oral and maxillofacial surgeons and other healthcare providers;

e. Provide all phases of orthodontic treatment including initiation, completion and retention;

f. Treat patients with at least one contemporary orthodontic technique;

**Intent:** It is intended that the program teach one or more methods of comprehensive orthodontic treatment.

g. Manage patients with functional occlusal and temporomandibular disorders;

h. Treat or manage the orthodontic aspects of patients with moderate and advanced periodontal problems;

i. Develop and document treatment plans using sound principles of appliance design and biomechanics;

j. Obtain and create long term files of quality images of patients using techniques of photography, radiology and cephalometrics, including computer techniques when appropriate;

k. Use dental materials knowledgeably in the fabrication and placement of fixed and removable appliances;

l. Develop and maintain a system of long-term treatment records as a foundation for understanding and planning treatment and retention procedures;

m. Practice orthodontics in full compliance with accepted Standards of ethical behavior;

**Intent:** A program may be in compliance with the standard on ethical behavior when ethical behavior is acquired through continuous integration with other courses in the curriculum.

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

- Course outlines
- Case treatment records

n. Manage and motivate patients to participate fully with orthodontic treatment procedures; and

o. Study and critically evaluate the literature and other information pertaining to this field.
p. Identify patients with sleep-related breathing disorders/sleep apnea;

q. Identify patients with Craniofacial Anomalies and Cleft Lip and Palate;

r. Treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure; and

s. Treat and effectively manage Class II malocclusions, defined as a bilateral end-on or greater Class II molar or a unilateral full cusp Class II molar, through a non-surgical treatment approach.

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Clinical outcomes assessment
- ABO Assessment Tools: Discrepancy Index, Cast-Radiograph Evaluation, Case Management Forms

p. Manage patients with intellectual and developmental disabilities.

4-4 Supporting Curriculum. The orthodontic graduate must have understanding of:

a. Biostatistics;

b. History of Orthodontics and Dentofacial Orthopedics;

c. Jurisprudence;

d. Oral Physiology;

e. Pain and Anxiety Control;

f. Pediatrics;

g. Periodontics;

h. Pharmacology;

i. Preventive Dentistry;

j. Psychological Aspects of Orthodontic and Dentofacial Orthopedic Treatment;

k. Public Health Aspects of Orthodontics and Dentofacial Orthopedics;

l. Speech Pathology and Therapy;

m. Practice Management; and

n. The variety of recognized techniques used in contemporary orthodontic practice.

Examples of evidence to demonstrate compliance may include:
1. Course outlines
STANDARD 5 - ADVANCED DENTAL EDUCATION STUDENTS/RESIDENTS

ELIGIBILITY AND SELECTION

Eligible applicants to advanced dental education programs accredited by the Commission on Dental Accreditation must be graduates from:

a. Predoctoral dental programs in the U.S. accredited by the Commission on Dental Accreditation; or
b. Predoctoral dental programs in Canada accredited by the Commission on Dental Accreditation of Canada; or
c. International dental schools that provide equivalent educational background and standing as determined by the program.

Specific written criteria, policies and procedures must be followed when admitting students/residents.

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

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

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

Examples of evidence to demonstrate compliance may include:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
• course equivalency or other measures to demonstrate equal scope and level of knowledge
5-1 A committee of orthodontic faculty members must be responsible for the selection of students/residents for postdoctoral training unless the program is sponsored by a federal service utilizing a centralized student/resident selection process.

Examples of evidence to demonstrate compliance may include:

- Institutional/program policies on eligibility and selection
- Minutes from meetings of committee of orthodontic faculty members

**EVALUATION**

A system of ongoing evaluation and advancement must assure that, through the director and faculty, each program:

- Periodically, but at least semiannually, assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the discipline using formal evaluation methods;
- Provides to students/residents an assessment of their performance, at least semi annually;
- Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and
- Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.

**Intent:**
(a) The evaluation of competence is an ongoing process that requires a variety of assessments that can measure the acquisition of knowledge, skills and values necessary for discipline-specific practice. It is expected that programs develop and periodically review evaluation methods that include both formative and summative assessments.
(b) Student/Resident evaluations should be recorded and available in written form.
(c) Deficiencies should be identified in order to institute corrective measures.
(d) Student/Resident evaluation is documented in writing and is shared with the student/resident.

**DUE PROCESS**

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

At the time of enrollment, the advanced dental education students/residents must be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all advanced dental education students/residents must be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.

Intent: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a student/resident (for academic or disciplinary reasons). In addition to information on the program, students/residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the students/residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 - RESEARCH

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

6-1 Students/Residents must initiate and complete a research project to include critical review of the literature, development of a hypothesis and the design, statistical analysis and interpretation of data.

Examples of evidence to demonstrate compliance may include:

- List of student/resident scholarly activity
- List of student/resident research projects
- Copies of student/resident research protocol
- List of completed manuscripts that are result of student/resident research
- Copy of completed manuscripts that are result of student/resident research
- Student/Resident manuscripts submitted for publication
- List of published manuscripts
- Papers/manuscripts published by graduates after leaving program