REPORT OF THE REVIEW COMMITTEE ON ADVANCED EDUCATION IN GENERAL DENTISTRY, GENERAL PRACTICE RESIDENCY, DENTAL ANESTHESIOLOGY, ORAL MEDICINE AND OROFAcial PAIN EDUCATION TO THE COMMISSION ON DENTAL ACCREDITATION

Committee Chair: Dr. Jeffery Hicks. Committee Members: Dr. Doug Barnes, Dr. Michael Brennan, Dr. Tracy Dellinger, Dr. Joseph Giovannitti, Dr. Gary Heir, Dr. Neal Henning, Dr. Judith Messura, Dr. Evan Rosen, Dr. Michael Siegel (substitute as needed for discipline specific program review), Dr. William Stewart, Mr. Glenn Unser, and Dr. Michael Webb. Staff Members: Ms. Peggy Soeldner, manager, Advanced Dental Education and Ms. Bridget Blackwood, senior project assistant, Commission on Dental Accreditation (CODA). The meeting of the Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education (AGDOO RC) was held July 11-12, 2019 at ADA Headquarters, Chicago, Illinois.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry (Implemented July 2014) (p. 200): The Committee considered a summary report of the number of “must” statement citings and their distribution among the “must” statements in the current Advanced Education Programs in General Dentistry Accreditation Standards. This report presented the number of times areas of non-compliance were cited by visiting committees conducting site visits from July 2014 through July 2018. Analysis of the data indicates that a total of 70 citings of non-compliance were made. Of these, ten (10) were related to Standard 1 – Institutional and Program Effectiveness; 36 were related to Standard 2 – Educational Program; six (6) were related to Standard 3 – Faculty and Staff; ten (10) were related to Standard 4 – Educational Support Services; and eight (8) were related to Standard 5 – Patient Care Services. Analysis of the data further indicates that the most frequently cited Standard, with six (6) citings, was Standard 2-2 c, related to periodontal therapy. The second most frequently cited Standards, with four (4) citings each, were Standard 2-5c, related to evaluations of off-service rotations and Standard 4-5b, related to the program’s description of the educational experience. The revised Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry was adopted in August 2018 with immediate implementation. Therefore, this report concludes the Frequency of Citings for the Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry implemented July 2014.

Recommendation: This report is informational in nature and no action is required.
Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry (Implemented August 2018) (p. 201): Accreditation Standards for Advanced Dental Education Programs in Advanced Education in General Dentistry (AEGD) were approved by the Commission on Dental Accreditation at its August 2018 meeting with immediate implementation. This report presented the number of times areas of non-compliance were cited by visiting committees conducting site visits August 1, 2018 through October 31, 2018. During that time period, five (5) AEGD site visits were conducted by visiting committees of the Commission utilizing the August 2018 Standards. Analysis of the data indicated there were two (2) areas of non-compliance cited in Standard 2-5. Due to the limited number of site visits, a trend in the data cannot be identified. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (p. 202): The Committee considered a summary report of the number of “must” statement citings and their distribution among the “must” statements in the current Advanced Dental Education Programs in Dental Anesthesiology Accreditation Standards. This report presented the number of times areas of non-compliance were cited by visiting committees conducting site visits from January 2007 through October 2018. An analysis of the site visit reports indicated a total of ten (10) citings of non-compliance were noted in the reports. Analysis of the data indicates that the most recently cited Standard is Standard 1-5, written agreements, with four (4) citations. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in General Practice Residency (Implemented July 2014) (p. 203): The Committee considered a summary report of the number of “must” statement citings and their distribution among the “must” statements in the current Advanced Dental Education Programs in General Practice Residency Accreditation Standards. This report presented the number of times areas of non-compliance were cited by visiting committees conducting site visits from July 2014 through October 2018. Analysis of the data indicated that a total of 160 citings of non-compliance were made. Of these, 14 were related to Standard 1 – Institutional and Program Effectiveness; 100 were related to Standard 2 – Educational Program; 19 were related to Standard 3 – Faculty and Staff; 11 were related to Standard 4 – Educational Support Services and 16 were related to Standard 5 – Patient Care Services. Further analysis of the data indicated that the most frequently cited Standard, with 15 citings was Standard 2-2 c, related to periodontal therapy. The second most frequently cited Standard with 10 citings, was Standard 2-11 d, related to preparing the inpatient record. The third most frequently cited Standards, with seven (7) each,
was Standard 3-9 a, related to residents regularly performing the tasks of allied dental personnel and clerical staff and Standard 5-4 related to basic life support. The revised Accreditation Standards for Advanced Dental Education Programs in General Practice Residency was adopted in August 2018 with immediate implementation. Therefore, this report concludes the Frequency of Citings for the Accreditation Standards for Advanced Dental Education Programs in General Practice Residency implemented July 2014.

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

**Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in General Practice Residency (Implemented August 2018) (p. 204):** Accreditation Standards for Advanced Dental Education Programs in General Practice Residency (GPR) were approved by the Commission on Dental Accreditation at its August 2018 meeting with immediate implementation. This report presents the number of times areas of non-compliance were cited by visiting committees conducting site visits August 1, 2018 through October 31, 2018. During that time period, 10 GPR site visits have been conducted by visiting committees of the Commission utilizing the August 2018 Standards. At the time of this report, there were five (5) areas of non-compliance, two (2) of which were cited in Standard 4-5b. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

**Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Oral Medicine (p. 205):** The Committee considered a summary report of the number of “must” statement citings and their distribution among the “must” statements in the current Advanced Dental Education Programs in Oral Medicine Accreditation Standards. This report presents the number of times areas of non-compliance were cited by visiting committees conducting site visits from July 2014 through October 2018. During that time period six (6) Oral Medicine site visits were conducted. Analysis of the data indicated seven (7) areas of non-compliance were cited during the reporting period. The most frequently cited Standard was Standard 1, Institutional and Program Effectiveness, with a total of three (3) citings. Specifically, Standard 1-11, Standard 1-5 and 1-8 were each cited one (1) time. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citings of individual Standards.

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

**Informational Report on Frequency of Citings of Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain (p. 206):** The Committee considered a summary report of the number of “must” statement citings and their distribution among the “must” statements in the current Advanced Dental Education Programs in Orofacial Pain Accreditation Standards. This report presents the number of times areas of non-compliance
were cited by visiting committees conducting site visits from July 2017 through October 2018. Due to the limited number of site visits, a trend in the data cannot be identified. The Commission will continue to receive reports annually summarizing the updated data on the frequency of citations of individual Standards.

**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 Dental Anesthesiology (p. 207):** At its Summer 2018 meeting, the Commission directed circulation of the proposed revision to Standard 3-2 of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (Appendix 1, Policy Report p. 207) to the communities of interest for a period of one (1) year with hearings at the October 2018 American Dental Association (ADA) and March 2019 American Dental Education Association (ADEA) annual meetings, with comments reviewed at the Commission’s Summer 2019 meeting. No (0) oral comments were received at the 2018 ADA Hearing or at the 2019 ADEA Hearing. Two (2) written comments were received by the Commission office prior to June 1, 2019 deadline (Appendix 2, Policy Report p. 207).

Following discussion, the AGDOO RC recommended approval of the proposed revision. Because the proposed revision has been circulated to the communities of interest for one (1) year, the AGDOO RC believed implementation, effective January 1, 2020, allows sufficient time for educational programs to ensure compliance with the revision.

**Recommendation:** It is recommended that the Commission on Dental Accreditation adopt the proposed revision of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology (Appendix 1) for implementation January 1, 2020.


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 one-year program will be assessed after four (4) years. In accordance with this policy, the Validity and Reliability Study for Accreditation Standards for Advanced Dental Education Programs in Oral Medicine was initiated in Spring 2019 with the results to be reviewed at the Summer 2019 meeting of the Commission.
At this meeting, the AGDOO RC reviewed the results of the survey, as well as written comments gathered (Appendix 2, Policy Report p. 208). The Review Committee noted that a total of 1,167 individuals were invited by email to complete the online survey on April 25, 2019. In order to increase the response rate, follow-up mailings were administered to all non-respondents on May 6 and May 15, 2019. Data collection ended on May 20, 2019, yielding 283 respondents, for an overall adjusted response rate of 24.4% (excluding 11 individuals whose email addresses were undeliverable). The AGDOO RC noted the survey was sent to 14 directors and site visitors of Oral Medicine education programs and a total of nine (9) opened the survey; and eight (8) completed it, yielding a response rate of 57.1% and a survey abandon rate of 11.1%.

Through discussion of the findings, the AGDOO RC noticed that among all “must” statements, between 62% and 88% of the Oral Medicine program directors and site visitors who responded indicated the standards were “Sufficiently demanding.” In addition, no more than one (1) respondent in this group (12.5%) identified any standard as “Too demanding.” The AGDOO RC also noted that six (6) Standards were identified as “Not demanding” by the highest percentage of the Oral Medicine program directors and site visitors who completed the survey and included Standards related to program duration, part-time residents, overall program goals and objectives, and facilities and learning resources.

As a result of analysis of the survey data and written comments, the AGDOO RC concluded that revisions to the Accreditation Standards are not warranted at this time. The AGDOO RC recommended that the Standards be updated to reflect the conduct of the Validity and Reliability Study (Appendix 2), in order to demonstrate completion of the required periodic review and to begin collecting information on frequency of citings and document revision history on new standards following the completion of the study.

**Recommendation:** It is recommended that the Commission on Dental Accreditation retain the current language of the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine (Appendix 2) and related documents, with immediate implementation, as a result of the Validity and Reliability Study.

**Consideration of Proposed Revision to Accreditation Standards Definition of Terms Related to Special Needs (p. 209):** On May 28, 2019, the Commission on Dental Accreditation (CODA) received a request from the Special Care Dentistry Association (SCDA) asking its review committees to consider the standardization of a definition for “Special Needs” across the various Accreditation Standards under the Commission’s purview instead of using different iterations of the definition of special needs. The Special Care Dentistry Association believed that the definition of special needs in many of the educational program Accreditation Standards is missing vulnerable older adults and proposed a definition for “Special Needs” that is derived from the Dental Education Standards (Appendix 1, Policy Report p. 209).

The AGDOO RC considered the proposed revision to the Accreditation Standards Definition of Terms submitted by the Special Care Dentistry Association. The AGDOO RC appreciates the
importance of terminology to define patients with special needs, including a uniform approach to
these terms. As such, the AGDOO RC noted that the advanced dental education disciplines
of advanced education in general dentistry, general practice residency, dental anesthesiology, and
orofacial pain currently include a definition for “patients with special needs” that is similar to the
language proposed by the SCDA; the advanced dental education discipline of oral medicine does
not include a definition for “patients with special needs.”

Through discussion, the AGDOO RC agreed the current definition does not directly address
cognitive impairment and believes the addition of this language is warranted. Further, the
AGDOO RC agreed the definition is missing vulnerable older adults, but believes including
language “vulnerable older adults” is limiting and could be expanded to include other vulnerable
populations, in addition to older adults.

Following considerable discussion, the AGDOO RC recommends the definition of “Patients with
special needs” found in the Accreditation Standards for advanced education in general dentistry,
general practice residency, dental anesthesiology and orofacial pain be revised to reflect the
following:

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

Further, since the proposed modification is found in the Definition of Terms, and not in a “must”
statement, the AGDOO RC believes this revision could be implemented immediately without
circulation to communities of interest.

As noted previously, the Accreditation Standards for Advanced Dental Education Programs in
Oral Medicine does not include a definition for “patients with special needs.” In addition, the
Accreditation Standards do not reference “patients with special needs” or other patient
populations included in the definition of “patients with special needs.” Therefore, the AGDOO
RC believed the addition of the definition is not warranted.

**Recommendation:** It is recommended that the Commission on Dental Accreditation
adopt the proposed revision to the definition of “Patients with Special Needs” found in
the Accreditation Standards for Advanced Dental Education Programs in Advanced
Education in General Dentistry, General Practice Residency, Dental Anesthesiology, and
Orofacial Pain, as noted above, with immediate implementation.
It is further recommended that the Commission on Dental Accreditation direct that the Accreditation Standards for Advanced Dental Education Programs in Oral Medicine be retained as written.

NEW BUSINESS

Consideration of Proposed Addition to Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain: The AGDOO RC learned that the current Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain does not include the Accreditation Standard related to immunization of residents, faculty and support staff, which is found in the Accreditation Standards for all disciplines under CODA’s purview. To ensure consistency among all Accreditation Standards, the AGDOO RC believed the Standard, as noted below should be added to the Accreditation Standards and accompanying CODA documents with immediate implementation.

Health Services

4-10 Residents, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of patients and dental personnel.

Examples of evidence to demonstrate compliance may include:
Immunization policy and procedure documents

Recommendation: It is recommended that the Commission on Dental Accreditation adopt the proposed new Standard 4-10 of the Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain, as noted above, with immediate implementation.

CONSIDERATION OF MATTERS RELATING TO MORE THAN ONE REVIEW COMMITTEE

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

CONSIDERATION OF SITE VISITOR APPOINTMENTS TO THE COMMISSION ON DENTAL ACCREDITATION IN THE AREAS OF ADVANCED EDUCATION IN GENERAL DENTISTRY AND GENERAL PRACTICE RESIDENCY EDUCATION

The Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education considered site
visitor appointments for 2019-2020 in the areas of advanced education in general dentistry and general practice residency. 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. Jeffery Hicks
Chair, Review Committee on Advanced Education in General Dentistry, General Practice Residency, Dental Anesthesiology, Oral Medicine and Orofacial Pain Education
Commission on Dental Accreditation

At its Summer 2018 meeting, the Commission directed that the proposed revisions to Standard 3-2 of the Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology be distributed to the appropriate communities of interest for review and comment, with comment due June 1, 2019, for review at the Summer 2019 Commission meeting.

This document represents the proposed changes made based upon review of comment received from communities of interest from August 2, 2018 through June 1, 2019. This document will be considered by the Commission in Summer 2019.

Proposed Revised Standards Additions are Underlined; Deletions are Stricken

Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology
STANDARD 3 – FACULTY AND STAFF

(underline indicates addition; strikethrough indicates deletion)

3-2 The program director must be board certified in dental anesthesiology. Program directors appointed after January 1, 2020, who have not previously served as program directors, must be board certified in dental anesthesiology. The program director must have completed a CODA-accredited 36-month two-year anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2 of these Accreditation Standards, and have had at least two years of recent additional continuous significant practice of general anesthesia. A two-year anesthesiology residency for dentists completed prior to July 1, 2018 is acceptable. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable, provided that continuous significant practice of general anesthesia in the previous two years is documented. Dental anesthesiology program directors appointed after January 1, 2013 must have completed the training noted above.

Intent: The anesthesiology residency is intended to be a continuous, structured residency program devoted exclusively to anesthesiology. Significant general anesthesia experience can be documented by continuous practice of intubated and/or non-intubated general anesthesia and involving anesthesia for dentistry, of at least two days per week and/or 200 cases each year.

Examples of Evidence to demonstrate compliance may include:
Certificate of completion of anesthesiology residency
Copy of board certification certificate
Letter from board attesting to current/active board certification
Description of additional dental anesthesiology experience
Standards Following Validity and Reliability Study
Additions are Underlined
Deletions are Stricken

Accreditation Standards for Advanced Dental Education Programs in Oral Medicine
Accreditation Standards For
Advanced Dental Education Programs in
Oral Medicine

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

(312) 440-4653
www.ada.org/coda
# Accreditation Standards for Advanced Dental Education Programs in Oral Medicine

## Document Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2, 2019</td>
<td>Accreditation Standards for Advanced Dental Education Programs in Oral Medicine</td>
<td>Adopted and Implemented</td>
</tr>
<tr>
<td>January 30, 2014</td>
<td>Accreditation Standards for Advanced General Dentistry Education Programs in Oral Medicine</td>
<td>Approved</td>
</tr>
<tr>
<td>July 1, 2014</td>
<td>Accreditation Standards for Advanced General Dentistry Education Programs in Oral Medicine</td>
<td>Implemented</td>
</tr>
<tr>
<td>February 6, 2015</td>
<td>Revised Standard 1-1</td>
<td>Adopted, Implemented</td>
</tr>
<tr>
<td>February 6, 2015</td>
<td>Revised Standard 5-4</td>
<td>Adopted, Implemented</td>
</tr>
<tr>
<td>February 6, 2015</td>
<td>Addition of intent statement to Standard 5-4</td>
<td>Adopted, Implemented</td>
</tr>
<tr>
<td>August 7, 2015</td>
<td>Revision of term “student/resident” to “resident”; addition of definition of “student/resident.”</td>
<td>Approved, Implemented</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>Revised Accreditation Status Definitions</td>
<td>Approved, Implemented</td>
</tr>
<tr>
<td>August 5, 2016</td>
<td>Revised Mission Statement</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>Revised Mission Statement</td>
<td>Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Accreditation Status Definitions</td>
<td>Approved, Implemented</td>
</tr>
<tr>
<td>August 4, 2017</td>
<td>Revised Standards 1-5, 1-10, 1-11, 2-2, 2-5, 2-9, 2-12, 2-19, 3-3, 3-7, 5-2, 5-4, 5-5, and 5-6 and new Standard 3-10</td>
<td>Adopted</td>
</tr>
<tr>
<td>July 1, 2018</td>
<td>Revised Standards 1-5, 1-10, 1-11, 2-2, 2-5, 2-9, 2-12, 2-19, 3-3, 3-7, 5-2, 5-4, 5-5, and 5-6 and new Standard 3-10</td>
<td>Implemented</td>
</tr>
<tr>
<td>August 3, 2018</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Adopted</td>
</tr>
<tr>
<td>January 1, 2019</td>
<td>Revised Terminology Related to Advanced Education Programs</td>
<td>Implemented</td>
</tr>
</tbody>
</table>
# Table of Contents

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

**Standards:**

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

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

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

Programs That Are Fully Operational

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

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

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

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

Revised: 8/17; 2/16; 5/12; 1/99; Reaffirmed: 8/13; 8/10, 7/0; 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 agencies.
granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).
Introduction

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

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

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

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

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

1. Act as a primary care provider for individuals with chronic, recurrent and medically related disorders of the oral and maxillofacial region, at a level and depth beyond the level of pre-doctoral education.
2. Provide consultative services to physicians and dentists treating patients with chronic, recurrent and medically related disorders of the oral and maxillofacial region.
3. Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
4. Function effectively and efficiently in multiple health care environments and within interdisciplinary health care teams.
5. Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making and technology-based information retrieval systems.
6. Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
7. Understand the oral health needs of communities and engage in community service.
Definition of Terms

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

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

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

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

**Levels of Skills:**

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

**Other Terms:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1-6 The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution.

1-7 The medical staff bylaws, rules and regulations of the sponsoring, co-sponsoring or affiliated hospital must ensure that dental staff members are eligible for medical staff membership and privileges.

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

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

1-8 Residents must have the same privileges and responsibilities provided residents in other professional education programs.

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

1-9 Resources and time must be provided for the proper achievement of educational obligations.

**Intent:** The educational mission should not be compromised by reliance on residents to fulfill institutional service, teaching or research obligations.

1-10 The program must have written overall program goals and objectives which emphasize:
1) oral medicine,
2) resident education,
3) patient care,
4) community service, and
5) research.

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

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

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

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

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

The outcomes process should include each of the following:
1. development of clear, measurable goals and objectives consistent with the program's purpose/mission,
2. implementation of procedures for evaluating the extent to which the goals and objectives are met,
3. collection of data in an ongoing and systematic manner,
4. analysis of the data collected and sharing of the results with appropriate audiences,
5. identification and implementation of corrective actions to strengthen the program and
6. review of the assessment plan, revision as appropriate and continuation of the cyclical process.
Examples of evidence to demonstrate compliance may include:
Written overall program goals and objectives
Outcomes assessment plan and measures
Outcomes results
Annual review of outcomes results
Meeting minutes where outcomes are discussed
Decisions based on outcomes results
Records of successful completion of the American Board of Oral Medicine examination

Ethics and Professionalism

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

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

Curriculum Content

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

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

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

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

Program Duration

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

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

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

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

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

**Biomedical Sciences**

**2-8** Education in the biomedical sciences **must** provide the scientific basis needed to understand and carry out the diagnostic and therapeutic skills required of the clinical, academic and research aspects of oral medicine.

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

**2-9** A distinct written curriculum **must** be provided in internal medicine.

**2-10** Formal instruction in the biomedical sciences **must** enable graduates to:

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

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

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

**Examples of evidence to demonstrate compliance may include:**
Course outlines
Didactic Schedules
Resident Evaluations

**2-11** Formal instruction **must** be provided in each of the following:

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

b) pathogenesis and epidemiology of orofacial diseases and disorders;

c) concepts of molecular biology and molecular basis of genetics;
d) aspects of internal medicine and pathology necessary to diagnose and treat orofacial diseases;

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

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

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

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

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

Clinical Sciences

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

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

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

c) establish a differential diagnosis and formulate an appropriate working diagnosis, prognosis, and management plan pertaining but not limited to:
   1. oral mucosal disorders,
   2. medically complex patients,
   3. salivary gland disorders,
   4. acute and chronic orofacial pain, and
   5. orofacial neurosensory disorders.

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

e) ameliorate the adverse effects of prescription and over-the-counter products and medical and/or dental therapy;
f) communicate effectively with patients and health care professionals regarding the nature, rationale, advantages, disadvantages, risks and benefits of the recommended treatment;

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

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

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

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

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

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

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

2-16 The educational program must ensure that each resident prepares and presents departmental clinical conferences.

2-17 Clinical medical experiences must be provided via rotation through various relevant medical services and participation in hospital rounds.
**Intent:** At least two months of the total program length should be in hospital medical service rotations.

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

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

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

a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;

b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and

c) evaluations performed by the designated supervisor.

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

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

Description and schedule of rotations
Written objectives of rotations
Resident evaluations

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

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

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

Course outlines
STANDARD 3 – FACULTY AND STAFF

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

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

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

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

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

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

Oral Medicine Standards
-20-
**Intent:** Faculty should have current knowledge at a level appropriate to their teaching responsibilities. The faculty, collectively, should have competence in all areas of oral medicine covered in the program. The program is expected to develop criteria and qualifications that would enable a faculty member to be responsible for a particular area of oral medicine if that faculty member is not trained in oral medicine. The program is expected to evaluate non-discipline specific faculty members who will be responsible for a particular area and document that they meet the program’s criteria and qualifications.

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

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

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

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

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

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

**Examples of evidence to demonstrate compliance may include:**
- Faculty clinic schedules
- Patient records
3-6 Full-time faculty **must** have adequate time to develop and foster advances in their own education and capabilities in order to ensure their constant improvement as teachers, clinicians and/or researchers.

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

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

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

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

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

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

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

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

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

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

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

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

4-2 All residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

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

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

4-3 The program must document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including, but not limited to, radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases. Policies must be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on blood-borne and infectious diseases must be made available to applicants for admission and patients.

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

4-4 The program’s policies **must** ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained to comply with local, state and federal regulatory agencies.

Examples of evidence to demonstrate compliance may include:
Confidentiality policies
STANDARD 5 – ADVANCED EDUCATION RESIDENTS

Selection of Residents

5-1 Applicants must have one of the following qualifications to be eligible to enter the advanced dental education program in oral medicine:

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

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

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

5-2 Specific written criteria, policies and procedures must be followed when admitting residents.

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

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

5-3 Admission of residents with advanced standing must be based on the same standards of achievement required by residents regularly enrolled in the program.

5-4 Residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by residents regularly enrolled in the program.

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

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

Evaluation

5-5 The program’s resident evaluation system must assure that, through the director and faculty, each program:

a) periodically, but at least two times annually, evaluates and documents the resident’s progress toward achieving the program’s written goals and objectives or competencies for resident training using appropriate written criteria and procedures;
b) provides residents with an assessment of their performance after each evaluation; and
c) maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Intent: The program should employ evaluation methods that measure a resident’s skills or behavior at a given time. It is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standards 2-10, 2-12 and 2-14. Where deficiencies are noted, corrective actions are taken. The final resident evaluation or final measurement of educational outcomes may count as one of the two annual evaluations.

Examples of evidence to demonstrate compliance may include:
Written evaluation criteria and process
Resident evaluations
Personal record of evaluation for each resident
Evidence that corrective actions have been taken
Due Process

5-6 There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints that parallel those established by the sponsoring institution.

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

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

5-7 The program’s description of the educational experience must be available in written form to program applicants and include:

a) a description of the curriculum and program requirements;
b) a list of goals, objectives, and competencies for resident training;
c) a description of the nature of assignments to other departments or institutions and teaching commitments; and
d) obligations and responsibilities to the institution, the program and program faculty.

**Intent:** The description should include information that allows the resident to understand the educational experience. This should also include information pertaining to: (1 tuition, stipend or other compensation; (2 vacation and sick time; (3 practice privileges and other activities outside the educational program; (4 professional liability coverage; (5 due process policy, and (6 the current accreditation status of the program.

Examples of evidence to demonstrate compliance may include:
Brochure or application documents
Description of information available to applicants who do not visit the program
Health Services

5-8 Residents, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and dental personnel.

**Intent:** Residents, faculty and support staff should have access to health care services.

Examples of evidence to demonstrate compliance may include:
Immunization policy and procedure documents
STANDARD 6 – RESEARCH

6-1 Residents must engage in research or scholarly activity.

*Intent:* The resident should understand research methodology, biostatistics and epidemiology. Residents should participate in journal club and research seminars that discuss ongoing research, future projects, and results. Residents in certificate programs should participate in scholarly activity and be encouraged to publish the results. Residents in degree programs should complete an original research project and be encouraged to publish the results.