INFORMATIONAL REPORT ON FREQUENCY OF CITINGS OF ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

**Background:** The Accreditation Standards for Dental Education Programs were adopted by the Commission on Dental Accreditation at its August 6, 2010 meeting with implementation July 1, 2013. From the July 1, 2013 adoption date of these standards through October 31, 2018, 64 site visits were conducted by visiting committees of the Commission using these standards. It should be noted that during the period of August 6, 2010 through July 1, 2013, eight (8) dental education program (DDS/DMD) site visits were conducted, five (5) of which were evaluated based upon the new standards, before the date of implementation, at the programs’ request. If special (focused or comprehensive), pre-enrollment, or pre-graduation site visits were conducted during this period, citings from those visits are also included.

At the time of this report, the Standards include 69 “must” statements addressing 96 required areas of compliance. This report presents the number of times areas of non-compliance were cited by visiting committees conducting site visits during the period of August 6, 2010 through October 31, 2018.

**Analysis:** Appendix 1 summarizes the cumulative frequency of citings during the analysis period. The total number of citings is 114. The standards with the highest number of citings overall are: Standard 2 on Educational Program (63 citings) and Standard 5 on Patient Care Services (32 citings). The highest number of citings for a single area of compliance (with 9 citings) was Standard 2-24.h, regarding competency in the replacement of teeth including fixed, removable and dental implant prosthodontic therapies. Overall, Standard 2-24.a-o totaled 28 citings and is the most frequently cited Standard within dental education. The second most frequently cited Standard (with 25 citings total) was Standard 5-3.a-e, which requires programs to conduct a formal system of continuous quality improvement for patient care. There were nine (9) citings for Standard 1-Institutional Effectiveness, four (4) citings for Standard 3 Faculty and Staff, four (4) citings for Standard 4 Educational Support Services, and two (2) citings for Standard 6 Research Program. Of the 64 site visits conducted since the adoption of the current Accreditation Standards, 38 programs were in compliance with all requirements at the time of the site visit.

**Summary:** With the small number of citings no trend can be established at this time. However, the frequency of citing suggests that a majority of dental education programs are compliant with the Accreditation Standards at the time of a site visit.

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

Prepared by: Dr. Sherin Tooks
# ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

## Frequency of Citings Based on Required Areas of Compliance

Total Number of Programs Evaluated: 64  
August 6, 2010 through October 31, 2018

### STANDARD 1- INSTITUTIONAL EFFECTIVENESS – 12 Required Areas of Compliance

<table>
<thead>
<tr>
<th>Non-Compliance citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-1</td>
<td>The dental school <strong>must</strong> develop a clearly stated purpose/mission statement appropriate to dental education, addressing teaching, patient care, research and service.</td>
</tr>
<tr>
<td>3</td>
<td>1-2</td>
<td>Ongoing planning for, assessment of and improvement of educational quality and program effectiveness at the dental school <strong>must</strong> be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.</td>
</tr>
<tr>
<td>2</td>
<td>1-3</td>
<td>The dental education program <strong>must</strong> have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.</td>
</tr>
<tr>
<td>2</td>
<td>1-5</td>
<td>The financial resources <strong>must</strong> be sufficient to support the dental school’s stated purpose/mission, goals and objectives.</td>
</tr>
<tr>
<td>1</td>
<td>1-6</td>
<td>The sponsoring institution <strong>must</strong> ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.</td>
</tr>
</tbody>
</table>
Standard 2 - Educational Program - 44 Required Areas of Compliance

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2-1</td>
<td>In advance of each course or other unit of instruction, students <strong>must</strong> be provided written information about the goals and requirements of each course, the nature of the course content, the method(s) of evaluation to be used, and how grades and competency are determined.</td>
</tr>
<tr>
<td>5</td>
<td>2-5</td>
<td>The dental education program <strong>must</strong> employ student evaluation methods that measure its defined competencies.</td>
</tr>
<tr>
<td></td>
<td>2-8</td>
<td>The dental school <strong>must</strong> have a curriculum management plan that ensures:</td>
</tr>
<tr>
<td>1</td>
<td>a.</td>
<td>an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;</td>
</tr>
<tr>
<td></td>
<td>b.</td>
<td>evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;</td>
</tr>
<tr>
<td>1</td>
<td>c.</td>
<td>elimination of unwarranted repetition, outdated material, and unnecessary material;</td>
</tr>
<tr>
<td>1</td>
<td>d.</td>
<td>incorporation of emerging information and achievement of appropriate sequencing.</td>
</tr>
<tr>
<td>6</td>
<td>2-9</td>
<td>The dental school <strong>must</strong> ensure the availability of adequate patient experiences that afford all students the opportunity to achieve its stated competencies within a reasonable time.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>1</td>
<td>2-10</td>
<td>Graduates <strong>must</strong> be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry and research methodology.</td>
</tr>
<tr>
<td>1</td>
<td>2-16</td>
<td>Graduates <strong>must</strong> be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving and maintaining oral health.</td>
</tr>
<tr>
<td>3</td>
<td>2-17</td>
<td>Graduates <strong>must</strong> be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.</td>
</tr>
<tr>
<td>2</td>
<td>2-18</td>
<td>Graduates <strong>must</strong> be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.</td>
</tr>
<tr>
<td>6</td>
<td>2-19</td>
<td>Graduates <strong>must</strong> be competent in applying the basic principles and philosophies of practice management, models of oral health care delivery, and how to function successfully as the leader of the oral health care team.</td>
</tr>
<tr>
<td>4</td>
<td>2-20</td>
<td>Graduates <strong>must</strong> be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.</td>
</tr>
<tr>
<td>1</td>
<td>2-21</td>
<td>Graduates <strong>must</strong> be competent in the application of the principles of ethical decision making and professional responsibility.</td>
</tr>
<tr>
<td>Non-Compliance Citings</td>
<td>Accreditation Standard</td>
<td>Required Areas of Compliance</td>
</tr>
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<td>------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>1</td>
<td>2-23</td>
<td>Graduates <strong>must</strong> be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.</td>
</tr>
<tr>
<td></td>
<td>2-24</td>
<td>At a minimum, graduates <strong>must</strong> be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:</td>
</tr>
<tr>
<td>2</td>
<td>a.</td>
<td>patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;</td>
</tr>
<tr>
<td>1</td>
<td>b.</td>
<td>screening and risk assessment for head and neck cancer;</td>
</tr>
<tr>
<td>2</td>
<td>c.</td>
<td>recognizing the complexity of patient treatment and identifying when referral is indicated;</td>
</tr>
<tr>
<td></td>
<td>d.</td>
<td>health promotion and disease prevention;</td>
</tr>
<tr>
<td>1</td>
<td>e.</td>
<td>local anesthesia, and pain and anxiety control;</td>
</tr>
<tr>
<td>2</td>
<td>f.</td>
<td>restoration of teeth;</td>
</tr>
<tr>
<td>1</td>
<td>g.</td>
<td>communicating and managing dental laboratory procedures in support of patient care;</td>
</tr>
<tr>
<td>9</td>
<td>h.</td>
<td>replacement of teeth including fixed, removable and dental implant prosthodontic therapies;</td>
</tr>
<tr>
<td></td>
<td>i.</td>
<td>periodontal therapy;</td>
</tr>
<tr>
<td>1</td>
<td>j.</td>
<td>pulpal therapy;</td>
</tr>
<tr>
<td>2</td>
<td>k.</td>
<td>oral mucosal and osseous disorders;</td>
</tr>
<tr>
<td>1</td>
<td>l.</td>
<td>hard and soft tissue surgery;</td>
</tr>
</tbody>
</table>
### Non-Compliance Citings | Accreditation Standard | Required Areas of Compliance |
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>m.</td>
<td>dental emergencies;</td>
</tr>
<tr>
<td>1</td>
<td>n.</td>
<td>malocclusion and space management; and</td>
</tr>
<tr>
<td>3</td>
<td>o.</td>
<td>evaluation of the outcomes of treatment, recall strategies, and prognosis.</td>
</tr>
<tr>
<td>1</td>
<td>2-25</td>
<td>Graduates <strong>must</strong> be competent in assessing the treatment needs of patients with special needs.</td>
</tr>
<tr>
<td></td>
<td>2-26</td>
<td>Dental education programs <strong>must</strong> make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.</td>
</tr>
</tbody>
</table>

**STANDARD 3- FACULTY AND STAFF – 5 Required Areas of Compliance.**

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3-1</td>
<td>The number and distribution of faculty and staff <strong>must</strong> be sufficient to meet the dental school’s stated purpose/mission, goals and objectives.</td>
</tr>
<tr>
<td>1</td>
<td>3-2</td>
<td>The dental school <strong>must</strong> show evidence of an ongoing faculty development process.</td>
</tr>
<tr>
<td>1</td>
<td>3-3</td>
<td>Faculty <strong>must</strong> be ensured a form of governance that allows participation in the school’s decision-making processes.</td>
</tr>
</tbody>
</table>
STANDARD 4- EDUCATIONAL SUPPORT SERVICES – 18 Required Areas of Compliance.

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>4-5</td>
<td>The dental school <strong>must</strong> provide adequate and appropriately maintained facilities and learning resources to support the purpose/mission of the dental school and which are in conformance with applicable regulations.</td>
</tr>
<tr>
<td></td>
<td>4-7</td>
<td><strong>Student services must</strong> include the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. personal, academic and career counseling of students;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. assuring student participation on appropriate committees;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. providing appropriate information about the availability of financial aid and health services;</td>
</tr>
<tr>
<td>1</td>
<td>d.</td>
<td>developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;</td>
</tr>
<tr>
<td></td>
<td>e.</td>
<td>student advocacy;</td>
</tr>
<tr>
<td></td>
<td>f.</td>
<td>maintenance of the integrity of student performance and evaluation records; and</td>
</tr>
<tr>
<td></td>
<td>g.</td>
<td>instruction on personal debt management and financial planning.</td>
</tr>
</tbody>
</table>
STANDARD 5- PATIENT CARE SERVICES – 14 Required Areas of Compliance.

<table>
<thead>
<tr>
<th>Non-Compliance</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citings</td>
<td>5-3</td>
<td>The dental school <strong>must</strong> conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:</td>
</tr>
<tr>
<td>3</td>
<td>a.</td>
<td>standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;</td>
</tr>
<tr>
<td>5</td>
<td>b.</td>
<td>an ongoing review and analysis of compliance with the defined standards of care;</td>
</tr>
<tr>
<td>5</td>
<td>c.</td>
<td>an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;</td>
</tr>
<tr>
<td>6</td>
<td>d.</td>
<td>mechanisms to determine the cause(s) of treatment deficiencies; and</td>
</tr>
<tr>
<td>6</td>
<td>e.</td>
<td>implementation of corrective measures as appropriate.</td>
</tr>
<tr>
<td>1</td>
<td>5-5</td>
<td>The dental school <strong>must</strong> ensure that active patients have access to professional services at all times for the management of dental emergencies.</td>
</tr>
<tr>
<td>1</td>
<td>5-6</td>
<td>All students, faculty and support staff involved in the direct provision of patient care <strong>must</strong> be continuously certified in basic life support (B.L.S.), including cardiopulmonary resuscitation, and be able to manage common medical emergencies.</td>
</tr>
<tr>
<td>5</td>
<td>5-8</td>
<td>The dental school <strong>must</strong> establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and</td>
</tr>
</tbody>
</table>
### Required Areas of Compliance

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>biohazard control, and disposal of hazardous waste, consistent with accepted dental practice.</td>
</tr>
</tbody>
</table>

**STANDARD 6- RESEARCH PROGRAM** – 3 Required Areas of Compliance.

<table>
<thead>
<tr>
<th>Non-Compliance Citings</th>
<th>Accreditation Standard</th>
<th>Required Areas of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6-2</td>
<td>The dental school faculty, as appropriate to meet the school’s purpose/mission, goals and objectives, <strong>must</strong> engage in research or other forms of scholarly activity.</td>
</tr>
<tr>
<td>1</td>
<td>6-3</td>
<td>Dental education programs <strong>must</strong> provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.</td>
</tr>
</tbody>
</table>
INFORMATIONAL REPORT ON FREQUENCY OF CITINGS OF ACCREDITATION STANDARDS FOR DENTAL THERAPY EDUCATION PROGRAMS

**Background:** The Accreditation Standards for Dental Therapy Education Programs were adopted by the Commission on Dental Accreditation at its February 6, 2015 meeting with implementation August 7, 2015. From this date forward there have been no (0) site visits for Dental Therapy Education Programs. If special (focused or comprehensive), pre-enrollment, or pre-graduation site visits are conducted, citings from those visits will be included in this report.

At the time of this report, the Standards include 76 “must” statements addressing 157 required areas of compliance. When there are site visits of Dental Therapy Education Programs, this report will present the number of times areas of non-compliance were cited by visiting committees conducting site visits.

**Analysis:** Appendix 1 presents the individual “must” statements and required areas of compliance. Once there are site visits of Dental Therapy Education Programs, with recommendations, the non-compliance citings will be analyzed and summarized accordingly.

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

Prepared by: Dr. Sherin Tooks
ACCREDITATION STANDARDS FOR DENTAL THERAPY EDUCATION PROGRAMS

Frequency of Citings Based on Required Areas of Compliance

Total Number of Programs Evaluated: 0
August 7, 2015 through October 31, 2018

There have been no site visits for Dental Therapy Education Programs.

STANDARD 1- INSTITUTIONAL EFFECTIVENESS – 14 Required Areas of Compliance.

STANDARD 2- EDUCATIONAL PROGRAM - 73 Required Areas of Compliance.

STANDARD 3- FACULTY AND STAFF – 19 Required Areas of Compliance.

STANDARD 4- EDUCATIONAL SUPPORT SERVICES – 37 Required Areas of Compliance.

STANDARD 5- HEALTH, SAFETY, AND PATIENT CARE PROVISIONS – 14 Required Areas of Compliance.
CONSIDERATION OF PROPOSED REVISION TO STANDARD 2-24D OF THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

**Background:** At its Summer 2018 meeting, the Predoctoral Dental Education Review Committee (PREDOC RC) considered the proposed revision to Dental Education Standard 2-24 related to cariology, which was submitted by the American Academy of Cariology (AAC). The Review Committee noted that the AAC proposed the addition of “caries management” within Standard 2-24, along with a revision to standard 2-24f to revise “restoration of teeth” to “tooth-preserving restoration of teeth” and the inclusion of an intent statement within this standard.

Following lengthy discussion, the Review Committee found merit in the concept of emphasizing caries management as a component of general dentistry for which the graduate must demonstrate competence; therefore, the Committee recommended modification to Standard 2-24, with the addition of “including caries management” as part of subpart “d” related to “health promotion and disease prevention.” The PREDOC RC further recommended that the proposed revision be circulated to the communities of interest for comment. The Commission concurred and directed that the proposed revision (Appendix 1) be circulated to the communities of interest for a period of one (1) year, including hearings during the October 2018 American Dental Association (ADA) and March 2019 American Dental Education Association (ADEA) annual meetings, with further consideration at the Commission’s Summer 2019 meeting.

As directed by the Commission, the proposed revised Standards (Appendix 1) were circulated for comment through June 1, 2019. No (0) comments were received at the 2018 ADA Hearing. One (1) comment was received at the 2019 ADEA Hearing (Appendix 2). The Commission office received five (5) written comments prior to the June 1, 2019 deadline (Appendix 3).

**Summary:** At this meeting, the Predoctoral Dental Education Review Committee and the Commission are asked to consider the proposed revision to Standard 2-24d of the Accreditation Standards for Dental Education Programs (Appendix 1) and all of the comments received prior to the June 1, 2019 deadline (Appendices 2 and 3). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revision is adopted, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
At its Summer 2018 meeting, the Commission directed that the proposed revision to Standard 2-24d of the Accreditation Standards for Dental Education Programs 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.

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

ATTN: Dr. Sherin Tooks, 19th Floor
Director
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Additions are Underlined

Standard 2-24d of the Accreditation Standards For Dental Education Programs
STANDARD 2-EDUCATIONAL PROGRAM

2-24 At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:
   a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;
   b. screening and risk assessment for head and neck cancer;
   c. recognizing the complexity of patient treatment and identifying when referral is indicated;
   d. health promotion and disease prevention
   e. local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;
   f. restoration of teeth;
   g. communicating and managing dental laboratory procedures in support of patient care;
   h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;
   i. periodontal therapy;
   j. pulpal therapy;
   k. oral mucosal and osseous disorders;
   l. hard and soft tissue surgery;
   m. dental emergencies;
   n. malocclusion and space management; and
   o. evaluation of the outcomes of treatment, recall strategies, and prognosis

Intent:
Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school’s goals, resources, accepted general practitioner responsibilities and other influencing factors. The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice. Programs should assess overall competency, not simply individual competencies in order to measure the graduate’s readiness to enter the practice of general dentistry.
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 Dental Education Programs, Standard 2-24 (Appendix 2)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margareta Fontana</td>
<td>Pres, American Council on Cariology</td>
<td>In favor of proposed change. Dental caries goes beyond prevention. Change is important to the core of dental school and an important change.</td>
</tr>
</tbody>
</table>
February 07, 2019

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

Dear Doctor Jee:

A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, at its January 2019 meeting, Council members considered the proposed revisions to Standards 2-24 and 2-25 of the Accreditation Standards for Dental Education Programs.

Regarding Standard 2-24 related to cariology, the Council believes that broad competency statements should not include specific procedures assumed to be included in the competency. Therefore, the Council does not support the proposed revision to Standard 2-24d to include the addition of the term “caries management.”

The Council also reviewed the proposed change to Standard 2-25 associated with enhancing dental education programs in relation to education of students to provide care for people with intellectual and developmental disabilities. The Council believes that the intent statement is not clear and urges the Commission to revise the statement, providing further clarification of the intent of Standard 2-25.

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

RCG:ap:eg
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
January 28, 2019

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

Dear Dr. Tooks,

Thank you for the opportunity to review and comment on the proposed changes to the Dental Education Program Standard Educational Program 2-24d and 2-25. On January 22, 2019 the UMKC School of Dentistry Curriculum Committee carefully reviewed the addition of “including caries management” to Standard 2-24d. Following a discussion of the components of caries management, for instance, it may include fluoride therapy all the way through placing a restoration, the committee respectfully asks the Commission to consider moving the phrase “caries management” to 2-24f to read:

2-24 f. caries management and the restoration of teeth;

The Committee also reviewed the proposed change to Standard 2-25. Following a discussion, the Committee offered support to the proposed change, noting the term “managing” the treatment of patients with special needs provides a broader approach to the care of the special needs patient.

Please let me know if you have any questions. The Committee members thank you for the opportunity to respond to these proposed changes.

Sincerely,

[Signature]

Dr. Liz Kaz  
Associate Dean for Academic Affairs

cc: Marsha A. Pyle, DDS, MEd  
Dean and Professor
March 23, 2019

Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Dr. Tooks,

This year a change to Standard 2-24 to include caries management was proposed. I am writing this letter on behalf of the faculty at The Dental College of Georgia at Augusta University in support of the change to Standard 2-24.

Significant changes have been made in dental education over the past several decades in managing caries, including formal risk assessment and minimally invasive techniques, among others, which are not currently included in the standards.

This change does not represent an undue burden on our college; rather, it represents the opportunity to reinforce with faculty and students that this topic is recognized as an important part of their education.

We strongly encourage the Commission on Dental Accreditation to adopt this change to align the Standards with current best standards in dental education and practice.

Sincerely,

Carol A. Lefebvre, DDS, MS
Dean and Professor
March 29, 2019

Sherin Tooks, Ed.D., M.S.
Director, Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL  60611

Dear Dr. Tooks:

This year a change to Standard 2-24 to include caries management was proposed, and I would like to offer my support in favor of it.

Dental caries is the most common oral disease in humans and the most common disease managed by dentists. It seems therefore logical that some reference to caries and caries management would appear in our Accreditation Standards. Significant changes have been made in dental education over the past several decades for managing caries, including formal risk assessment and minimally invasive techniques, among others, which are not currently included in the standards.

The recommended change would not represent an undue burden on our school; rather, it represents the opportunity to reinforce what is happening in our school and, it is my understanding, in the clear majority of dental schools. With faculty and students, this topic is recognized as an important part of their education.

We strongly encourage the Commission on Dental Accreditation to adopt this change to align the Standards with current widely used standards and current best practices in dental education and practice.

Sincerely,

David C. Johnsen, DDS, MS
Dean
University of Pittsburgh School of Dental Medicine comments regarding proposed changes to Standard 2-24d and 2-25.

**CODA proposal:**

**2-24.** At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

- **d.** health promotion and disease prevention, *including caries management*

The University of Pittsburgh School of Dental Medicine strongly supports the intent of the proposed change to Standard 2-24d to emphasize more contemporary, conservative approaches to caries management. In addition, we believe it is timely to also emphasize evidence-based approaches to caries prevention and diagnosis. To achieve this, we believe it needs to be highlighted by making it a separate standard within 2-24 rather than attaching it to an existing standard, thereby providing equal importance with standards related to pulpal disease, periodontal disease, etc.

**2-24.** At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

- **a.** patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;
- **b.** screening and risk assessment for head and neck cancer;
- **c.** recognizing the complexity of patient treatment and identifying when referral is indicated;
- **d.** health promotion and disease prevention;
- **e.** local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;
- **f. contemporary approaches to caries prevention, diagnosis, and disease management**
- **g.** restoration of teeth;
- **h.** communicating and managing dental laboratory procedures in support of patient care;
- **i.** replacement of teeth including fixed, removable and dental implant prosthodontic therapies;
- **j.** periodontal therapy;
- **k.** pulpal therapy;
- **l.** oral mucosal and osseous disorders;
- **m.** hard and soft tissue surgery;
- **n.** dental emergencies;
- **o.** malocclusion and space management; and
- **p.** evaluation of the outcomes of treatment, recall strategies, and prognosis

**CODA proposal:**

**2-25.** Graduates must be competent in assessing and managing the treatment needs of patients with special needs.

The School of Dental Medicine supports this proposed change and would like to suggest a modification to the term “special needs” to read as indicated below. The term “special health care needs” is broader and is more consistent with the language used by the American Academy of Pediatric Dentistry (AAPD).

**2-25.** Graduates must be competent in assessing and managing the treatment needs of patients with special *health care* needs.

Thank you for your consideration of these comments.
CONSIDERATION OF PROPOSED REVISION TO STANDARD 2-25 OF THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

**Background:** At its Winter 2018 meeting, the Commission on Dental Accreditation (CODA) directed that its 14 Review Committees consider the National Council on Disability Issue Brief “Neglect for Too Long: Dental Care for People with Intellectual and Developmental Disabilities.” Therefore, at its Summer 2018 meeting, the Predoctoral Dental Education Review Committee (PREDOC RC) considered the Issue Brief as well as a June 2018 letter from the Alliance for Disability Health Care Education in support of the Issue Brief. The PREDOC RC also considered correspondence from the Special Care Dentistry Association and an additional communication submitted by the National Council on Disability.

Following discussion, the Review Committee concluded that the Accreditation Standards for Dental Education Programs could be enhanced in relation to the education of students/residents to provide care for people with intellectual and developmental disabilities. The PREDOC RC believed that dental education programs should ensure graduates are competent to assess and manage the treatment of patients with special needs. Management of a patient with special needs could include treatment of the patient or management of the care through referral for services, as appropriate. The PREDOC RC recommended that the proposed revision to Standard 2-25 be circulated to the communities of interest for comment. The Commission concurred and directed that the proposed revision (Appendix 1) be circulated to the communities of interest for a period of one (1) year, including hearings during the October 2018 American Dental Association (ADA) and March 2019 American Dental Education Association (ADEA) annual meetings, with further consideration at the Commission’s Summer 2019 meeting.

As directed by the Commission, the proposed revised Standards (Appendix 1) were circulated for comment through June 1, 2019. No (0) comments were received at the 2018 ADA Hearing. Two (2) comments were received at the 2019 ADEA Hearing (Appendix 2). The Commission office received five (5) written comments prior to the June 1, 2019 deadline (Appendix 3).

**Summary:** At this meeting, the Predoctoral Dental Education Review Committee and the Commission are asked to consider the proposed revision to Standard 2-25 of the Accreditation Standards for Dental Education Programs (Appendix 1) and all of the comments received prior to the June 1, 2019 deadline (Appendices 2 and 3). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
Commission on Dental Accreditation

At its Summer 2018 meeting, the Commission directed that the proposed revision to Standard 2-25 of the Accreditation Standards for Dental Education Programs 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.

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

ATTN: Dr. Sherin Tookss, 19th Floor
Director
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Additions are Underlined
Strikethroughs indicate Deletions

Standard 2-25 of the Accreditation Standards For Dental Education Programs
STANDARD 2-EDUCATIONAL PROGRAM

Graduates **must** be competent in assessing and managing the treatment needs of patients with special needs.

**Intent:**
An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The assessment should emphasize the importance of non-dental considerations, including use of respectful nomenclature and supported decision making. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques, and assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.
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 Dental Education Programs, Standard 2-25 (Appendix 3)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amged Solomon</td>
<td>National Council on Disability</td>
<td>Current dental students are not sufficiently trained in treatment of patients with intellectual and developmental disabilities. Very little to no training. 2-24 should be changed to not only assess but manage the treatment of these patients. Upon doing so, millions of Americans will have the treatment they are entitled to. The ADA recently changed the Code of Professional Conduct to state that patients can’t be turned away, which is adopted in state law. If not implemented, many patients will lose care.</td>
</tr>
<tr>
<td>Leon Assael</td>
<td></td>
<td>There should be consistency among all disciplines related to care for patients with disability. There should be building blocks.</td>
</tr>
</tbody>
</table>
An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

November 15, 2018

Dr. Sherin Tooks
Director, Commission on Dental Accreditation (CODA)
211 East Chicago Avenue
Chicago, Illinois 60611

Dear Dr. Tooks,

I write to you today to draw CODA’s attention to the recent revision by the American Dental Association (ADA) of its Principles of Ethics & Code of Professional Responsibility, voted on by the ADA House of Delegates on October 22, 2019. The ADA Code now dictates that a dental care provider may not deny care to a patient based on the patient’s disability, and that any provider in need of another’s skills, knowledge, equipment or expertise has an obligation to consult with or refer that patient with a disability to that provider. Accordingly, it is imperative that CODA revise its curricula standards at Standard 2-24 to require that students learn and train in the treatment management of patients with intellectual and developmental disabilities as was recommended by NCD in its letter to CODA dated January 23, 2018.

These revisions to the ADA Code and accompanying Advisory Opinion, passed by the ADA House of Delegates in October 2018, are as follows (additions underscored, deletions stricken through):

4.A. PATIENT SELECTION.

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient’s race, creed, color, gender, sexual orientation, or sexual identity, or national origin or disability.

ADVISORY OPINION

4.4.1. PATIENTS WITH DISABILITIES OR BLOODBORNE PATHOGENS.

A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual is infected with Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on the same basis as they are made with other patients. As is the case with all patients, when considering the treatment of patients with a physical, intellectual or developmental disability or disabilities, including patients infected with Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, or are otherwise medically compromised, the individual dentist should determine if he or she has the need of another’s skills, knowledge, equipment or expertise, and if so, consultation or referral pursuant to Section 2.B hereof is indicated. Decisions regarding the type of dental treatment provided, or referrals made or suggested, should be made on the same basis as they are made with other patients. The dentist should also determine, after consultation with the patient’s physician, if appropriate, if the patient’s health status would be significantly compromised by the provision of dental treatment.

NCD notes that a provider’s ability to provide treatment to patients with disabilities, including intellectual and developmental disabilities, and a provider’s ability to find and confer with a provider that has the education and training to provide treatment to those patients, largely depends on CODA’s affirmative decision to change the relevant standard to help ensure members of the dental profession remain in compliance with their current professional responsibility and ethics requirements.

Thank you for your time and consideration of this issue. Please contact Amedg S. Soliman, NCD Attorney Advisor, at asoliman@ncd.gov or 202-272-2116, as needed. We look forward to further discussion on this important issue.

Sincerely,

Neil Romano
Chairman

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Amedg S. Soliman, Esquire
Attorney Advisor
National Council on Disability
1331 F Street, NW, Suite 850
Washington, DC 20004
Tele: (202) 272-2116
Fax: (202) 272-2022
Website: www.ncd.gov

The National Council on Disability is an independent federal agency that promotes policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, and empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.
November 15, 2018

Dr. Sherin Tooks
Director, Commission on Dental Accreditation (CODA)
211 East Chicago Avenue
Chicago, Illinois 60611

Dear Dr. Tooks,

I write to you today to draw CODA’s attention to the recent revision by the American Dental Association (ADA) of its Principles of Ethics & Code of Professional Responsibility, voted on by the ADA House of Delegates on October 22, 2018. The ADA Code now dictates that a dental care provider may not deny care to a patient based on the patient’s disability, and that any provider in need of another’s skills, knowledge, equipment or expertise has an obligation to consult with or refer that patient with a disability to that provider. Accordingly, it is imperative that CODA revise its curricula standards at Standard 2-24 to require that students learn and train in the treatment management of patients with intellectual and developmental disabilities as was recommended by NCD in its letter to CODA dated January 23, 2018.

These revisions to the ADA Code and accompanying Advisory Opinion, passed by the ADA House of Delegates in October 2018, are as follows (additions underscored, deletions stricken through):

**4.A. PATIENT SELECTION.**

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient’s race, creed, color, gender, sexual orientation, or gender identity, or national origin or disability.

**ADVISORY OPINION**

**4.A.1. PATIENTS WITH DISABILITIES OR BLOODBORNE PATHOGENS.**

A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual is infected with Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on—
same basis as they are made with other patients. As is the case with all patients, when considering the treatment of patients with a physical, intellectual or developmental disability or disabilities, including patients infected with Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, or are otherwise medically compromised, the individual dentist should determine if he or she has the need of another’s skills, knowledge, equipment or experience expertise, and if so, consultation or referral pursuant to Section 2.B hereof is indicated. Decisions regarding the type of dental treatment provided, or referrals made or suggested, should be made on the same basis as they are made with other patients. The dentist should also determine, after consultation with the patient’s physician, if appropriate, if the patient’s health status would be significantly compromised by the provision of dental treatment.

NCD notes that a provider’s ability to provide treatment to patients with disabilities, including intellectual and developmental disabilities, and a provider’s ability to find and confer with a provider that has the education and training to provide treatment to those patients, largely depends on CODA’s affirmative decision to change the relevant standard to help ensure members of the dental profession remain in compliance with their current professional responsibility and ethics requirements.

Thank you for your time and consideration of this issue. Please contact Amged M. Soliman, NCD Attorney Advisor, at asoliman@ncd.gov or 202-272-2116, as needed. We look forward to further discussion on this important issue.

Sincerely,

Neil Romano
Chairman
February 07, 2019

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

Dear Doctor Jee:

A duty of the ADA Council on Dental Education and Licensure is to act as the agency of the Association in matters related to the accreditation of dental, advanced dental and allied dental education programs. Accordingly, at its January 2019 meeting, Council members considered the proposed revisions to Standards 2-24 and 2-25 of the Accreditation Standards for Dental Education Programs.

Regarding Standard 2-24 related to cariology, the Council believes that broad competency statements should not include specific procedures assumed to be included in the competency. Therefore, the Council does not support the proposed revision to Standard 2-24d to include the addition of the term “caries management.”

The Council also reviewed the proposed change to Standard 2-25 associated with enhancing dental education programs in relation to education of students to provide care for people with intellectual and developmental disabilities. The Council believes that the intent statement is not clear and urges the Commission to revise the statement, providing further clarification of the intent of Standard 2-25.

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

RCG:ap:eg  
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
January 28, 2019

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

Dear Dr. Tooks,

Thank you for the opportunity to review and comment on the proposed changes to the Dental Education Program Standard Educational Program 2-24d and 2-25. On January 22, 2019 the UMKC School of Dentistry Curriculum Committee carefully reviewed the addition of "including caries management" to Standard 2-24d. Following a discussion of the components of caries management, for instance, it may include fluoride therapy all the way through placing a restoration, the committee respectfully asks the Commission to consider moving the phrase "caries management" to 2-24f to read:

2-24 f. caries management and the restoration of teeth;

The Committee also reviewed the proposed change to Standard 2-25. Following a discussion, the Committee offered support to the proposed change, noting the term "managing" the treatment of patients with special needs provides a broader approach to the care of the special needs patient.

Please let me know if you have any questions. The Committee members thank you for the opportunity to respond to these proposed changes.

Sincerely,

Dr. Liz Kaz
Associate Dean for Academic Affairs

cc: Marsha A. Pyle, DDS, MEd
Dean and Professor
University of Pittsburgh School of Dental Medicine comments regarding proposed changes to Standard 2-24d and 2-25.

CODA proposal: 2-24. At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

d. health promotion and disease prevention, including caries management

The University of Pittsburgh School of Dental Medicine strongly supports the intent of the proposed change to Standard 2-24d to emphasize more contemporary, conservative approaches to caries management. In addition, we believe it is timely to also emphasize evidence-based approaches to caries prevention and diagnosis. To achieve this, we believe it needs to be highlighted by making it a separate standard within 2-24 rather than attaching it to an existing standard, thereby providing equal importance with standards related to pulpal disease, periodontal disease, etc.

2-24. At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;
b. screening and risk assessment for head and neck cancer;
c. recognizing the complexity of patient treatment and identifying when referral is indicated;
d. health promotion and disease prevention;
e. local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;
f. contemporary approaches to caries prevention, diagnosis, and disease management
g. restoration of teeth;
h. communicating and managing dental laboratory procedures in support of patient care;
i. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;
j. periodontal therapy;
k. pulpal therapy;
l. oral mucosal and osseous disorders;
m. hard and soft tissue surgery;
n. dental emergencies;
o. malocclusion and space management; and
p. evaluation of the outcomes of treatment, recall strategies, and prognosis

CODA proposal: 2-25. Graduates must be competent in assessing and managing the treatment needs of patients with special needs.

The School of Dental Medicine supports this proposed change and would like to suggest a modification to the term “special needs” to read as indicated below. The term “special health care needs” is broader and is more consistent with the language used by the American Academy of Pediatric Dentistry (AAPD).

2-25. Graduates must be competent in assessing and managing the treatment needs of patients with special health care needs.

Thank you for your consideration of these comments.
Jean O’Donnell, DMD, MEd
Associate Dean for Academic Affairs
University of Pittsburgh School of Dental Medicine
Pittsburgh PA 15261
412.648.8672
jao4@pitt.edu
May 23, 2019

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Attention: Dr. Sherin Tooks, 19th Floor Director

Dear Members of the Commission on Dental Accreditation,

The Special Care Dentistry Association (SCDA) is responding to several proposed standards in the Dental Education Programs, Dental Assisting Education Programs, Dental Hygiene Education Programs, Advanced Education in Orthodontics and Dentofacial Orthopedics, and Advanced Education in Periodontics Education Programs. Special Care Dentistry Association is a national organization which represents educators, private practice clinicians, and their dental teams who treat older adult patients, patients with special needs, and hospital based dentistry programs.

Pre-doctoral Education Programs Standard 2-25: The Special Care Dentistry Association (SCDA) is responding to the proposed revision of Standard 2-25 of the Accreditation Standards for Pre-doctoral Education Programs. We as an organization give support to the proposed revision of Standard 2-25. We believe it is imperative and CODA’s obligation to ensure that dental students gain clinical experience treating patients with special needs. These patients are living out in the community and an insufficient number of specialists exist to be able to treat all of these patients. Therefore, the general practitioner is the primary care dentist for many of these patients. It is imperative that dental students are exposed and trained to treat and serve patients with special needs. However, we also recommend Standard 2-25 be further revised as follows: Graduate must be competent in assessing, managing, and treating patients with special needs.” We also recommend the intent statement include the following: “Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.” We thank you very much for your consideration of this proposed revision as it will greatly strengthen the education experience dental students receive and better prepare students for the real world.

Dental Assisting Education Programs Standard 2-13: The Special Care Dentistry Association is responding to the proposed revision of Standard 2-13 of the Accreditation Standards for Dental Assisting Education Programs. We as an organization give our full support to the proposed revision of Standard 2-13. We believe it is imperative and CODA’s obligation to ensure that dental assisting students gain experience clinically assisting patients with special needs. These patients are living in the community and an insufficient number of specialists exist to be able to treat all of these patients. Therefore, the general practitioner is the primary care dentist for many of these patients. It is imperative that dental assisting students are trained to treat and serve the patients with special needs. We thank you very much for your consideration of this
proposed revision as it will greatly strengthen the education experience dental assisting
students receive and better prepare students for the real world.

**Dental Hygiene Standard 2-12:** The Special Care Dentistry Association is responding to the
proposed revision of Standard 2-12 of the Accreditation Standards for Hygiene Education
Programs. We as an organization **give our full support to the proposed revision of Standard 2-
12.** We believe it is imperative and CODA’s obligation to ensure that dental hygiene students
gain experience clinically treating geriatric patients and patients with special needs. These
patients are living in the community and an insufficient number of specialists exist to be able to
treat all of these patients. Therefore, the general practitioner is the primary care dentist for
many of these patients. It is imperative that dental hygiene students are exposed and trained to
treat patients with special needs. We thank you very much for your consideration of this
proposed revision as it will greatly strengthen the education experience dental hygiene students
receive and better prepare students for the real world.

**Advanced Education Programs in Orthodontics and Dentofacial Orthopedics Standard 4-3.4
(p):** The Special Care Dentistry Association (SCDA) is responding to the proposed revision of
Standard 4-3.4 (p) of the Accreditation Standards for Advanced Education Programs in
Orthodontics and Dentofacial Orthopedics. We as an organization **give our full support to the
proposed revision of Standard 4-3.4(p).** We believe it is imperative and CODA’s obligation to
ensure that orthodontic students gain experience clinically treating patients with special needs.
These patients often develop malocclusions that are in need of orthodontic treatment to
improve their general health, ability to eat, risk of trauma, and improve their ability to breathe.
It is imperative that orthodontic students are exposed and trained to treat and serve the
patients with special needs. We thank you very much for your consideration of this proposed
revision as it will greatly strengthen the education experience orthodontic students receive and
better prepare students for the real world.

**Advanced Dental Education Programs in Periodontics Standard 4-12:** The Special Care Dentistry
Association is responding to the proposed revision of Standard 4-12 of the Accreditation
Standards for Advanced Dental Education Programs in Periodontics. We as an organization **support to the proposed revision of Standard 4-12.** We believe it is imperative and CODA’s
obligation to ensure educational programs are providing instruction on the management of
patients with disabilities to an understanding. **However, we also recommend that the standards be revised further to go beyond just a level of understanding** and instead
recommend periodontist gain clinical experience managing the needs of patients with
disabilities. We believe the current revision is a step in the right direction, but we recommend
further revision of the current standard.

Overall, we believe these proposed modifications to the accreditation standards are a step in
the right direction. However, we also ask CODA to consider standardizing the definition of
special needs across the different accredited programs instead of using different iterations of
the definition of special needs. The proposed definition below is derived from the Pre-doctoral
Education Standards. This definition includes vulnerable older adults, which are missing from many other Education Programs Standards.

**Proposed definition of Special Needs for all accredited programs:** Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment as well as modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and vulnerable older adults.

Sincere Regards,

David J. Miller, DDS, FACD, FICD, FPFA
President
Special Care Dentistry Association
CONSIDERATION OF PROPOSED REVISION TO STANDARD 2-3 OF THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

Background: At its Winter 2019 meeting, the Review Committee on Predoctoral Dental Education (PREDOC RC) considered letters from two (2) dental education programs expressing concern related to the prohibited use of international sites where educational activity occurs for educational experiences in predoctoral dental education programs. The Review Committee noted that, from Summer 2017 to Summer 2018, the Commission studied a request from four (4) dental school deans requesting that CODA develop new policies and procedures to allow U.S. dental education programs to collaborate with international dental education programs or to open standalone dental education programs internationally. In Summer 2018, CODA determined that it would not direct the establishment of an accreditation process for the use of international sites where educational activity occurs for U.S.-based, CODA-accredited programs. The Commission noted that dental education programs may permit students to participate in international experiences (e.g., mission trips, etc.); however, these are not CODA-approved educational experiences and should not be used as such.

Following discussion of the two letters, the PREDOC RC believed that international sites should not be used to provide education related to program goals, objectives or educational requirements. The Committee believed that use of international sites for supplemental (non-educational) experiences, such as mission trips, to enrich a student’s experience, is permissible as long as the international enrichment does not interfere with the educational program (program content or length). In other words, the supplemental/enrichment international experience should occur outside of the educational program. The Review Committee also noted that Standard 2-3 states “The curriculum must include at least four academic years of instruction or its equivalent.” The PREDOC RC discussed competency-based education, including the potential for some students to excel within a competency-based format. However, the PREDOC RC believed that in accordance with the standards, the educational curriculum should satisfy program and institutional expectations as defined for the program length (the “academic year”) as mandated by the institution, program, and Accreditation Standards. Additionally, it was noted that institutional and federal regulations, including those related to financial aid, may dictate the expectation of program length and student attendance requirements. Additional concerns include, but are not limited to, legal and regulatory requirements, oversight of the educational experience, and calibration of faculty. To encourage international experiences without impacting the educational program, the PREDOC RC believed that each institution could determine the allowable co-curricular enrichment time in accordance with program and institutional attendance policies and procedures, applying this time equitably to students based on program policies.

The PREDOC RC affirmed: 1) the expectation that a dental education program be at least four academic years of instruction or its equivalent, 2) that international enrichment experiences not interfere with curricular content and length, and 3) that co-curricular (extracurricular) international enrichment experiences be provided in accordance with institutional and programmatic policies on attendance and applied equitably to all students within the established policies for eligibility to participate. The PREDOC RC believed that an intent statement within
Standard 2-3 could clarify the Commission’s expectation related to the use of international supplemental/enrichment sites, which aligns with CODA’s Policy on Reporting and Use of Sites Where Educational Activity Occurs. The PREDOC RC recommended, and the Commission concurred, that the proposed revision to Standard 2-3 (Appendix 1) be circulated to the communities of interest for six (6) months, with a hearing at the American Dental Education Association (ADEA) March 2019 meeting, with review of comments at the Summer 2019 meeting of the Predoctoral Dental Education Review Committee and Commission.

As directed by the Commission, the proposed revised Standard 2-3 (Appendix 1) was circulated for comment through June 1, 2019. One (1) comment was received at the 2019 ADEA Hearing (Appendix 2). The Commission office received seven (7) written comments prior to the June 1, 2019 deadline (Appendix 3). One (1) comment was received after the deadline (Appendix 4). The Review Committee and Commission may determine whether comments received after the deadline should be considered in the deliberations.

**Summary:** At this meeting, the Predoctoral Dental Education Review Committee and the Commission are asked to consider the proposed revision to Standard 2-3 of the Accreditation Standards for Dental Education Programs (Appendix 1) and all of the comments received prior to the June 1, 2019 deadline (Appendices 2 and 3). The Review Committee and Commission may also wish to consider comments received following the Commission’s deadline (Appendix 4). If further revisions are proposed, the Commission may wish to circulate the proposed changes to the communities of interest for an additional comment period. Alternately, if the proposed revisions are adopted, the Commission may wish to consider an implementation date.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
Commission on Dental Accreditation

At its Winter 2019 meeting, the Commission directed that the proposed revision to Standard 2-3 of the Accreditation Standards for Dental Education Programs 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.

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

ATTN: Dr. Sherin Tooks, 19th Floor
Director
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Proposed Revised Standards
Additions are Underlined

Standard 2-3 of the Accreditation Standards For Dental Education Programs

DEP Standards
STANDARD 2-EDUCATIONAL PROGRAM

Curriculum Management

2-3 The curriculum must include at least four academic years of instruction or its equivalent.

Intent:
The program may offer international supplemental/enrichment experiences; however, the use of these experiences may not interfere with the curricular content, requirements, or program length of the dental education program. International supplemental/enrichment experiences are offered in accordance with institutional and program policies on attendance, and applicable regulatory requirements. Programs should insure that student participation in international supplemental/enrichment experiences is applied equitably to all students within the program’s established student eligibility policies and procedures.
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 Dental Education Programs, Standard 2-3 (Appendix 9)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>Caswell Evans</td>
<td>University of Illinois at</td>
<td>This would be a deterrent to international experiences in this global era. The University has a globalization platform and the College of Dentistry has followed in that mission. Some difficulty with standard is that it ties to a four-year curriculum. We have schools that complete a curriculum in 3 years, not 4. The intent of international as extracurricular needs better definition and is an impediment to international dental education. Needs more definition and precision.</td>
</tr>
</tbody>
</table>
Dear Dr. Tooks,

I am writing in regards to the proposed changes to Standard 2-3.

In compliance with Standard 2-3, all U.S. accredited dental schools must provide the equivalent of four academic years of instruction. The addition of the proposed intent statement brings confusion to the process. Would rotations to international experiences count if properly documented to CODA standards for an off-site clinic? Would rotation through an international institution accredited by CODA be recognized as equal with in-country experiences? Do electives or required enrichment courses, when allowed within the academic program, count as curriculum time, and thus credit, if taken outside the U.S.? Certainly, it is important to assure that students are receiving an education to the U.S. standards wherever they are attending. Perhaps clarity through establishing documentation of rigor would better serve to address any concerns.

Requiring clear preplacement documentation, with assessment tools appropriate to ensure equity in educational assignment, and perhaps adding a process such as a live video evaluation piece of the program site, might strengthen the current CODA documentation while allowing students to study with leaders in the dental field. It would be a travesty to disallow an accelerated student in an elective course with interests in research, material sciences, special patient care, cleft palate treatment, trauma, public health application in global venues, discipline specific advanced education, etc., the opportunity to pursue these inquiries with world-renown experts during curricular time. Preclearance of that student’s progress, program offerings, credentialing of faculty, and suitability of the site could be assured prior to approval. All qualified students should be eligible to enroll in compliance with established policies and procedures of the sponsoring U.S. school. This provides enrichment to the curriculum while maintaining high educational accreditation standards.

For these reasons I would request that the proposed standard as currently stated not be adopted at this time. Revisiting the 2-3 statement to address any concerns through review and documentation of the international site would better serve the accreditation and educational goals.

Thank you for your consideration,

Wendy

Wendy Woodall, D.D.S.
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ATTN: Dr. Sherin Tooks, 19th Floor
Director, Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Dear Dr. Tooks,

My name is Alan Law. I am an endodontist, adjunct faculty at the past President of the American Board of Endodontics (ABE), Vice President of the American Association of Endodontists (AAE), and a Fellow of the American College of Dentists and the International College of Dentists. As it relates to this letter, I am also a former student who participated in an international dental exchange program. I am writing this letter to urge you and the other commissioners at CODA to support Global Exchange programs as part of dental curriculum.

When I was a dental student at the [university], a faculty member approached me and asked if I would be interested in spending ten weeks at the Royal London dental school in London. I had never travelled abroad, so the prospect of spending ten weeks in a foreign country was both intimidating and intriguing. Reflecting on my experience, I can say without hesitation it changed my academic and professional path, and it made me a better clinician and citizen of the world.

My ten weeks abroad exposed me to new teaching philosophies, a different health care system, and helped me relate to others with different perspectives. At the Royal London dental school, I experienced Socratic teaching for the first time, which challenged me to be more questioning of what I read. This inquisitiveness eventually led to me pursue a Ph.D. after dental school. Additionally, my exposure to alternative dental care led me to collaborate in creating a multi-specialty dental specialty practice which, to this day, is still fairly unique in the United States. Finally, my exposure to international students and institutions helped me expand beyond my comfort zone, pushing me to become board certified in my specialty, encourage others to become board certified as President of the ABE, and take on a leadership position in the AAE. Without my experience abroad, I never would have felt as comfortable giving presentations internationally. To date, I have given eight presentations abroad, in five countries.

In addition to the professional realizations that would not have been possible without my global experience, I gained cultural awareness. At a time when it is more important than ever to appreciate the value derived from diverse backgrounds and perspectives, I am so grateful that I was exposed to international health care and education early in my professional career. Undoubtedly, it has made me a better informed and understanding citizen of our country and the world.
As I reflect on my Global Exchange experience, I am so grateful for the opportunity and perspective it gave me. I would not be who I am personally and professionally without the experience, and I am confident that my experience is not unique. I urge to support the Global Exchange program as part of the curriculum at the [University Name] and other institutions.

Sincerely,

Alan S. Law DDS, PhD, FICD, FACD
President, The Dental Specialists
Past President, American Board of Endodontics
Vice President, American Association of Endodontists
Adjunct Association Professor, University of Minnesota
May 22, 2019

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

Dear Dr. Tooks:

Thank you for the opportunity to provide comment on changes to the CODA Accreditation Standards.

Specifically, we are responding to the request for comment on the proposed revision to Standard 2-3 of the Accreditation Standards for Dental Education Programs as directed at the Commission’s Winter 2019 meeting for consideration at its Summer 2019 meeting.

Following agreement by a majority of the ADEA Council of Deans (ADEA COD) Administrative Board members, and based on feedback obtained at ADEA COD business meetings during the 2019 ADEA Annual Session & Exhibition in Chicago, we submit the attached revision to the Standards for consideration by the Pre-Doctoral Review Committee and Commission.

It is recommended that the proposed Intent Statement for Standard 2-3 be relocated as a second paragraph in the Intent Statement for Standard 2-26 and that the Intent Statement wording be revised as noted in the attachment.

The revised wording will support the intended clarification of the appropriate role of supplemental experiences within the dental education programs. The relocation to Standard 2-26 is a logical location for the Intent Statement language related to these activities.

In a separate communication, a number of the Associate Deans of Academic Affairs have expressed support for removing the Intent Statement from Standard 2-3 and adding similar modified language to the Intent Statement of Standard 2-26.

I appreciate your consideration of our recommendation and would be happy to provide additional clarification if needed. I also would be remiss in not thanking you personally for attending the ADEA COD business meeting in March to provide the Council with first-hand information and the opportunity to ask questions.

Sincerely,

Richard W. Valachovic, D.M.D., M.P.H.
President and CEO
Proposing: Have 2-3 stand without an intent statement and modify the intent statement:

2-3 The curriculum must include at least four academic years of instruction or its equivalent.

Intent: currently none

CODA proposed intent statement: The program may offer international supplemental/enrichment experiences; however, the use of these experiences may not interfere with the curricular content, requirements, or program length of the dental education program. International supplemental/enrichment experiences are offered in accordance with institutional and program policies on attendance, and applicable regulatory requirements. Programs should ensure that student participation in international supplemental/enrichment experiences is applied equitably to all students within the program’s established student eligibility policies and procedures.

2-26

Dental education programs must make available opportunities and encourage students to engage in service-learning experiences and/or community-based learning experiences.

Intent: Service-learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

The program may equitably offer (for all eligible students) supplemental/enrichment experiences (i.e. episodic patient care events, service-learning opportunities, limited international rotations) to interested students which provide the students with salient educational benefits. These supplemental/enrichment experiences should meet institutional and program policies on attendance and applicable regulatory requirements and be designed so they do not interfere with the curricular content or requirements of program length.
May 28, 2019

Sherin Tooks, Ed.D, M.S.
Director, Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Dear Dr. Tooks,

We thank you for the opportunity to comment on the intent statement for Standard 2-3 of the Accreditation Standards for Dental Education Programs related to international supplemental/enrichment experiences. We are writing to express our support for international experiences for dental students and urge the Commission to reconsider how these educational activities nurture the development of a dental workforce better equipped to keep pace with pressing oral health challenges in a globalizing world. Students, trainees, and educators are working to respond to global forces affecting our profession. Today’s students view themselves as global citizens and demand opportunities that expand their definition of community to include local and global settings. They recognize their patient populations will be more diverse, more mobile, and more global than any generation prior. One study reported that a leading reason students engage in international experiences is to gain an immersive and global understanding of health, treatment, and disease. (Lambert et al.)

The Lancet Commission on Health Professions Education for the 21st Century called for transformative education in an interconnected world. Dental education is also ‘going global.’ Just as diseases and their risk factors cross borders, dental education is becoming ‘borderless’ as written in a 2017 blog of the American Dental Education Association. As such, dental schools are increasing the number and quality of international experiences offered to dental students. As of 2016, the ADA reported that 65% of dental schools offered international experiences for their students, an increase from 53% in 2009. These experiences have been shown to improve cultural awareness, increase likelihood of working with diverse and underserved populations, and grow interest in public health.

We see this discussion of the intent statement for Standard 2-3 as an opportunity to position U.S. dental education as a leader in an interconnected and globalizing world. It will help to ensure important measures are in place such as faculty calibration, legal and regulatory requirements, and appropriate and adequate oversight. However, we hope that the intent will ultimately entail a thoughtful and critical process that will address the needs that inspired the intent statement while also considering potential unintended consequences, such as total elimination of valuable education experiences currently in place. Our concern is that as written, the current Standard and its intent are too restrictive, will require that valuable programs be eliminated, and could force students to seek international opportunities outside of their dental schools. Evidence shows that activities without faculty mentorship, and not tied to any curricular framework, result in
less educational rigor, less oversight, increased risks to students and patients, and ethical challenges that negatively impacting host communities, such as students practicing outside of their scope of practice or inadequate follow up for services provided (Benzian, et. al; Ivanhoff, et. al; Seymour, et. al). As such, there is a risk that the intent statement as currently written will backfire and actually result in the opposite outcome to that originally intended.

In summary, we believe the proposed revision has opened the door for a timely and necessary discussion around international experiences for U.S. dental students. We recommend, prior to adopting the final statement, the Commission assemble an advisory council consisting of experts, including, but not limited to dental educators who currently sponsor or have historically sponsored, international experiences for dental students. This panel should discuss the rationale behind the intent statement as well as the unintended consequences that could arise as a result of the enforcement of the Standard as written. We hope that a solution can be found that addresses the concerns behind the statement while continuing to allow for international opportunities for dental students. We believe a collaborative and inclusive approach can lead to a new revision of the standard that would benefit our dental students and the global dental workforce.

Sincerely,

Mary Tavares, DMD, MPH
President, AAPHD

Cc: Dr. E. Angeles Martinez Mier
    Dr. Michelle McQuistan
    Dr. Brittany Seymour

References:


May 22, 2019

From:

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4000 E Campus Loop South
Lincoln, NE 68583
To: Dr. Sherin Tooks, EdD, MS
   Director, Commission on Dental Accreditation
   211 East Chicago Avenue, 19th Fl.
   Chicago, IL 60611

Dear Dr. Tooks,

At its Winter 2019 meeting, the Commission directed that the proposed revision to Standard 2-3 of the Accreditation Standards for Dental Education Programs 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. CODA proposes the following change to Standard 2 – 3 of the Accreditation Standards for Dental Education Programs:

2-3

The curriculum must include at least four academic years of instruction or its equivalent.

Intent: currently none

CODA proposed intent statement: The program may offer international supplemental/enrichment experiences; however, the use of these experiences may not interfere with the curricular content, requirements, or program length of the dental education program. International supplemental/enrichment experiences are offered in accordance with institutional and program policies on attendance, and applicable regulatory requirements. Programs should insure that student participation in international supplemental/enrichment experiences is applied equitably to all students within the program’s established student eligibility policies and procedures.

The Associate Deans represented in this letter disagree with this proposed change and are offering additional support to the Council of Deans response to this proposed Standard change.

We are making the following comment for the record: Have Standard 2-3 stand without an intent statement and modify the intent statement of Standard 2-26 as noted below in blue.

2-26

Dental education programs must make available opportunities and encourage students to engage in service-learning experiences and/or community-based learning experiences.
Intent: Service-learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

The program may equitably offer supplemental/enrichment experiences (i.e. episodic patient care events, service-learning opportunities, and limited international rotations) to interested students, which provide the students with salient educational benefits. These supplemental/enrichment experiences should meet institutional and program policies on attendance and applicable regulatory requirements and be designed so they do not interfere with the curricular content or requirements of program length.

Thank you for your time and consideration in this matter.

Sincerely,

Dr. Elizabeth A. Andrews, DDS, MS
Associate Dean for Academic Affairs
Western University College of Dental Medicine

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   Dental College of Georgia at Augusta University

Dr. Wendy Woodall, DDS  
   Associate Dean of Academic Affairs  
   Woody L. Hunt School of Dental Medicine  
   Texas Tech University Health Sciences Center El Paso
May 29, 2019

Sherin Tooks, Ed.D, M.S.
Commission on Dental Accreditation
211 E. Chicago Ave.
Suite 1900
Chicago, Illinois 60611

Dear Dr. Tooks;

I am writing in response to the proposed changes to the “intent statements” for the CODA Pre-Doctoral Education Standards 2-3 and 2-26.

I am aware that the Council of Deans through its governing board has voted to support the proposed intent statement for 2-26 and is requesting that the Commission on Dental Accreditation (CODA) adopt the suggested language for 2-26 in-lieu of the draft intent statement for 2-3. I have attached a copy of their proposed draft language.

The heightened sensitivity surrounding discussions on this topic appears to revolve around the perception among deans that since their programs are “competency based” that the programs have significant latitude under the program length requirement set forth under standard 2-3 and that achieving competency demonstrates the “equivalency” of the program under standard 2-3.

I have significant concerns regarding the Department of Education (DOE) guidance and standards for credit hour accrual and whether these “supplemental and/or enrichment” experiences that occur during the academic semester where the student is “registered” allow the student to maintain their status as an enrolled student when there is no oversite of these activities by the accrediting agency. I have been advised that these “supplemental and/or enrichment experiences” during the registered academic term that are not an “official” part of the academic experience, and therefore participation in these programs of extended duration during the academic term could affect eligibility for federal financial aid.

CODA was established in 1975 and is nationally recognized by the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs. As the “sole agency” to accredit dental education programs, program oversite from institutional accreditors frequently does not cover the granularity of the issue at hand.

I write in support of the language in 2-3 “International supplemental/enrichment experiences are offered in accordance with institutional and program policies on attendance, and applicable regulatory requirements.”
In addition, I propose that the statement include “applicable regulatory requirements including but not limited to DOE requirements for credit hour accrual and maintenance of full-time enrollment status for federal financial aid eligibility, if such experiential program occurs during the registered academic term.”

Despite the fact that “USDE’s recommendation that the program’s institutional accreditor should be consulted by the program and should approve the international site as a substantive change prior to CODA’s approval,” discussions among the deans seems to suggest that by making these programs “supplemental and/or enrichment” the program would avoid accreditation oversite, even if the experience occurred during the registered academic term.

In previous meeting minutes, it was noted that “CODA should verify that any U.S.-based program establishing an international site demonstrates that the institutional accreditor has approved the international branch or training location before CODA considers such a request.” Based on my experience as a dental educator with over 30 years experience and as a program administrator with nearly 20 years experience, the institutional accreditors do not evaluate these programs with the level of scrutiny assumed by the CODA process. I urge CODA to assert its oversite for any international program - including those that are “supplemental and/or enrichment experiences”- that occurs during a term of academic study where the student is currently “registered” as defined by the federal financial aid guidelines.

Such oversite for “supplemental/enrichment programs” would not occur during periods between semesters/terms where the student is not enrolled in a credit/degree earning program.

Current practices where various accredited pre-doctoral programs are providing oversite for “supplemental/enrichment” experiences during the academic term are avoiding any oversite, because the parent institution presumes that since the programs are exempt from CODA oversite, then there is no reason to involve the institutional accreditor. I urge the Commission to preserve the level of control and standardization in US Pre-Doctoral Education that is the benchmark for dental education accreditation.

This control and standardization is important for a number of reasons including the variability in scrutiny by institutional accreditors. I appreciate the opportunity to offer comment.

Very truly yours,

Mert N. Aksu, DDS, JD, MHSA
Diplomate American Board of Dental Public Health
Professor and Dean
Proposing: Have 2-3 stand without an intent statement and modify the intent statement of 2-26.

2-3 The curriculum must include at least four academic years of instruction or its equivalent.

Intent: currently none

CODA proposed intent statement: The program may offer international supplemental/enrichment experiences; however, the use of these experiences may not interfere with the curricular content, requirements, or program length of the dental education program. International supplemental/enrichment experiences are offered in accordance with institutional and program policies on attendance, and applicable regulatory requirements. Programs should insure that student participation in international supplemental/enrichment experiences is applied equitably to all students within the program's established student eligibility policies and procedures.

2-26

Dental education programs must make available opportunities and encourage students to engage in service-learning experiences and/or community-based learning experiences.

Intent: Service-learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

The program may equitably offer supplemental/enrichment experiences (i.e. episodic patient care events, service-learning opportunities, limited international rotations) to interested students which provide the students with salient educational benefits. These supplemental/enrichment experiences should meet institutional and program policies on attendance and applicable regulatory requirements and be designed so they do not interfere with the curricular content or requirements of program length.
Dear Dr. Tooks,

My name is Dr. Allison Forbes and I had the pleasure of participating in the Global exchange program at the University of [City]. In the fall of 2017 I headed overseas to study dentistry as a dental student. This experience abroad in Germany allowed me to develop essential skills for my success professionally and personally. I am now able to view and approach dentistry from a different angle and treat a more diverse group of patients. It helped me develop skills to be a better leader in the school, the community, the profession and the world. Studying dentistry in another country is an extremely rare experience which I hold very dear to my heart. I feel so fortunate to have had that experience and I hope that other students in the future will be able to as well.

This kind of experiential learning can't be taught in a classroom and is what is obtainable when you study abroad. Through my extensive work with ASDA and as a previous trustee for the [University Name] Dental Association, I am also integrally engaged in advocacy for issues that matter to students, dentists, and the patients. Access to care is the issue that matters most to me and my patients. Working and learning about other countries public health system was illuminating and now I have continued my public service in a GPR program that serves a diverse and underserved area. I hope to work in public health dentistry or dental education and eventually incorporate service into the foundation of my future private practice. I also hope to establish a dental service organization relationship abroad to share my knowledge and skills through long-term international outreach. I think it is a professional and personal responsibility to help others in the world. I know that studying abroad in dental school reinforced my lifelong commitment to learning and to the service of others.

Seeing a different part of the world, a different culture, and meeting different people allows you to shift your perspective. We see this benefit every day in dental school and residency when we learn from the expertise of a variety of professors and attendings. You can learn something new from every single dentist you meet. Dentistry is subjective and you need to look at a problem from all angles to formulate the best solution. Seeing treatment planning from a different perspective abroad allows me to look at cases from a new angle. Appreciating and understanding the perspectives of others awards you a world view, so you can better treat a wide diversity of patients. Interpersonal relations are the source of meaning to life, which is why I find dentistry to be such an enriching career and traveling to be so illuminating. My time abroad allowed me to work better interprofessional, within my dental team, with my patients, and all people.

My previous time studying abroad stimulated and developed my passion for dentistry and for understanding the perspectives of other people. Simply put, it was the best experience of my life and has significantly shaped who I am and where I am today. All of my personal and professional goals benefited from the invaluable privilege of studying, living and practicing dentistry in a foreign country. If you have any questions about my experience let me know!
Sincerely
Allison Forbes DDS

--
Dr. Allison Forbes DDS
June 19, 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. The Council has considered and supports the proposed addition of an intent statement supporting Standard 2-3 of the Accreditation Standards for Dental Education Programs related to the prohibited use of international sites where educational activity occurs for educational experiences in predoctoral dental education programs.

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

Sincerely,

[Signature]

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
CONSIDERATION OF PROPOSED REVISION TO ACCREDITATION STANDARDS DEFINITION OF TERMS RELATED TO SPECIAL NEEDS

Background: On May 28, 2019, the Commission on Dental Accreditation (CODA) received a request from the Special Care Dentistry Association (SCDA) 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’s request is found in Appendix 1.

The Special Care Dentistry Association believes that the definition of special needs in many of the educational program Accreditation Standards is missing vulnerable older adults. The SCDA has proposed a definition for “Special Needs” that is derived from the Dental Education Standards.

Summary: The Predoctoral Dental Education Review Committee and Commission are requested to consider the proposed revision to the Accreditation Standards Definition of Terms (Appendix 1) submitted by the Special Care Dentistry Association. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks
May 23, 2019

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Attention: Dr. Sherin Tooks, 19th Floor Director

Dear Members of the Commission on Dental Accreditation,

The Special Care Dentistry Association (SCDA) is responding to several proposed standards in the Dental Education Programs, Dental Assisting Education Programs, Dental Hygiene Education Programs, Advanced Education in Orthodontics and Dentofacial Orthopedics, and Advanced Education in Periodontics Education Programs. Special Care Dentistry Association is a national organization which represents educators, private practice clinicians, and their dental teams who treat older adult patients, patients with special needs, and hospital based dentistry programs.

**Pre-doctoral Education Programs Standard 2-25:*** The Special Care Dentistry Association (SCDA) is responding to the proposed revision of Standard 2-25 of the Accreditation Standards for Pre-doctoral Education Programs. We as an organization *give support to the proposed revision of Standard 2-25.* We believe it is imperative and CODA’s obligation to ensure that dental students gain clinical experience treating patients with special needs. These patients are living out in the community and an insufficient number of specialists exist to be able to treat all of these patients. Therefore, the general practitioner is the primary care dentist for many of these patients. It is imperative that dental students are exposed and trained to treat and serve patients with special needs. However, *we also recommend Standard 2-25 be further revised as follows:* Graduate must be competent in assessing, managing, and treating patients with special needs.” We also recommend the intent statement include the following: “Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.” We thank you very much for your consideration of this proposed revision as it will greatly strengthen the education experience dental students receive and better prepare students for the real world.

**Dental Assisting Education Programs Standard 2-13:** The Special Care Dentistry Association is responding to the proposed revision of Standard 2-13 of the Accreditation Standards for Dental Assisting Education Programs. We as an organization *give our full support to the proposed revision of Standard 2-13.* We believe it is imperative and CODA’s obligation to ensure that dental assisting students gain experience clinically assisting patients with special needs. These patients are living in the community and an insufficient number of specialists exist to be able to treat all of these patients. Therefore, the general practitioner is the primary care dentist for many of these patients. It is imperative that dental assisting students are trained to treat and serve the patients with special needs. We thank you very much for your consideration of this
proposed revision as it will greatly strengthen the education experience dental assisting students receive and better prepare students for the real world.

**Dental Hygiene Standard 2-12:** The Special Care Dentistry Association is responding to the proposed revision of Standard 2-12 of the Accreditation Standards for Hygiene Education Programs. We as an organization give our full support to the proposed revision of Standard 2-12. We believe it is imperative and CODA’s obligation to ensure that dental hygiene students gain experience clinically treating geriatric patients and patients with special needs. These patients are living in the community and an insufficient number of specialists exist to be able to treat all of these patients. Therefore, the general practitioner is the primary care dentist for many of these patients. It is imperative that dental hygiene students are exposed and trained to treat patients with special needs. We thank you very much for your consideration of this proposed revision as it will greatly strengthen the education experience dental hygiene students receive and better prepare students for the real world.

**Advanced Education Programs in Orthodontics and Dentofacial Orthopedics Standard 4-3.4 (p):** The Special Care Dentistry Association (SCDA) is responding to the proposed revision of Standard 4-3.4 (p) of the Accreditation Standards for Advanced Education Programs in Orthodontics and Dentofacial Orthopedics. We as an organization give our full support to the proposed revision of Standard 4-3.4(p). We believe it is imperative and CODA’s obligation to ensure that orthodontic students gain experience clinically treating patients with special needs. These patients often develop malocclusions that are in need of orthodontic treatment to improve their general health, ability to eat, risk of trauma, and improve their ability to breathe. It is imperative that orthodontic students are exposed and trained to treat and serve the patients with special needs. We thank you very much for your consideration of this proposed revision as it will greatly strengthen the education experience orthodontic students receive and better prepare students for the real world.

**Advanced Dental Education Programs in Periodontics Standard 4-12:** The Special Care Dentistry Association is responding to the proposed revision of Standard 4-12 of the Accreditation Standards for Advanced Dental Education Programs in Periodontics. We as an organization support the proposed revision of Standard 4-12. We believe it is imperative and CODA’s obligation to ensure educational programs are providing instruction on the management of patients with disabilities to an understanding. However, we also recommend that the standards be revised further to go beyond just a level of understanding and instead recommend periodontist gain clinical experience managing the needs of patients with disabilities. We believe the current revision is a step in the right direction, but we recommend further revision of the current standard.

Overall, we believe these proposed modifications to the accreditation standards are a step in the right direction. However, we also ask CODA to consider standardizing the definition of special needs across the different accredited programs instead of using different iterations of the definition of special needs. The proposed definition below is derived from the Pre-doctoral...
Education Standards. This definition includes vulnerable older adults, which are missing from many other Education Programs Standards.

**Proposed definition of Special Needs for all accredited programs**: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment as well as modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical conditions, significant physical limitations, and vulnerable older adults.

Sincere Regards,

David J. Miller, DDS, FACD, FICD, FPFA
President
Special Care Dentistry Association
CONSIDERATION OF PROPOSED REVISION TO THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS RELATED TO TEMPOROMANDIBULAR DISORDERS

Background: On May 31, 2019, the Commission on Dental Accreditation (CODA) received a request on behalf of the American Academy of Orofacial Pain (AAOP) proposing a revision to the CODA Accreditation Standards for Dental Education Programs to include a minimal clinical competency requirement for the management of temporomandibular disorders (TMD). The American Academy of Orofacial Pain’s request is found in Appendix 1.

The American Academy of Orofacial Pain believes that all dentists should be familiar with prevention, diagnosis, and initial management of TMD; therefore, inclusion of a clinical competency should be required for all dental students.

Summary: The Predoctoral Dental Education Review Committee and Commission are requested to consider the proposed revision to the Accreditation Standards for Dental Education Programs (Appendix 1) submitted by the American Academy of Orofacial Pain. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks
May 31, 2019

Sherin Tooks, Ed.D, M.S.
Director, Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Dear Dr. Tooks,

My name is Hong Chen and I am a Clinical Assistant Professor at the University of Iowa College of Dentistry, Department of Preventive and Community Dentistry. I am writing on behalf of the American Academy of Orofacial Pain (AAOP) to propose a revision to the CODA Accreditation Standards for Predoctoral Dental Education to include minimal clinical competency requirements for the management of temporomandibular disorders (TMD).

Recently, while developing pertinent predoctoral course material, my colleagues and I were very surprised to see that the management of TMD was not included as a minimum clinical competency requirement for dental students. We are concerned about this, because TMD is a common complaint among dental patients. It is the second most common pain condition in our patient population (toothache is #1), often initiated by dental care and extractions, and, therefore, it warrants inclusion in the standards to ensure all dentists are familiar with prevention, diagnosis, and initial management.

Here is some additional supporting information.

1. The oro-facial and temporomandibular complex is an integrated system that performs important oral functions. Teeth, temporomandibular joints, muscles of mastication, and other oro-facial hard and soft tissues are essential components of this complex system. Without ANY clinical competency requirements pertaining to the dysfunction of the major parts of this complex (i.e., TMD), it is possible that many students are receiving no or little instruction, which could result in dental graduates who are not qualified to provide care to restore or maintain the functions of this system.

2. TMD is a common group of conditions that affects dental patients of all ages.
   a. The prevalence of painful TMD is about 5-10% from the adolescent years to old age, with an annual incidence rate of 4% [1-4].
   b. In the pediatric dental population, joint noises, hypermobility of joints, sports injuries, and behavioral issues (e.g., bruxism) are common issues that contribute to TMD.

3. Approximately 20-30% of dental patients develop jaw pain after dental treatments [5]. Therefore, risk assessment, jaw protection, and prevention of iatrogenic TMD are important basic skills for dental students and general dentists to master.
4. TMD can significantly affect oral functions that can have profound impact on oral health and general health.
   a. Patients with TMD commonly have limitations to performing jaw-related functions, such as biting, chewing, talking, yawning, singing, and maintaining normal facial expressions such as laughing and smiling.
   b. Due to jaw pain and limited range of motion, many patients with TMD have limitations in maintaining oral hygiene (i.e., brushing and flossing) and in obtaining dental treatment.
   c. Due to significantly impaired jaw functions, TMD patients can also have difficulties in obtaining adequate nutrition and maintaining normal weight. TMD complications can also result in low self-esteem and reduced social interactions. All of these comorbidities associated with TMD can have significant impact on general health and psychosocial well-being.

Because of the significant impact of TMD on patients and on the society, the National Academies of Sciences, Engineering, and Medicine has formed a committee looking at TMD issues. A general report from this committee will be published in 2020 (https://www8.nationalacademies.org/pa/projectview.aspx?key=51490).

5. Dental professionals have a significant role in managing and preventing TMD and chronic pain and disability. Chronic pain, including TMD pain, is the most common reason for seeking health care, and is a significant public health problem in the US [6]. Co-existing chronic pain issues such as headaches, myofascial pain, osteoarthritis, and fibromyalgia are very common in the TMD population. At the national level, improving prevention, care, and education for acute and chronic pain is of high priority. The National Pain Strategy recommended to “improve discipline-specific core competencies, including basic knowledge, assessment, effective team-based care, empathy, and cultural competency” and “encourages educational program accreditation bodies and professional licensure boards to require pain teaching and clinician learning at the undergraduate and graduate levels.” (https://www.iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf, accessed on May 29th, 2019). Among all health care professionals, general dentists represent the “primary care” workforce in evaluating, managing, and preventing orofacial pain conditions. Knowledge and clinical skills in screening, risk assessment, early intervention, and prevention for TMD are essential for dental students and general dentists.

Because of the concerns above, we propose to add the following phrase to the predoctoral CODA Standard 2-24 to ensure minimal clinical competency in TMD management:

“screening, risk assessment, prevention, and early intervention of temporomandibular disorders.”

We are happy to provide further assistance regarding this issue. Please feel free to contact me at hong-chen@uiowa.edu or contact Dr. Gary Heir at heirgm@sdm.rutgers.edu.

Thank you for your consideration.
Best regards,

Hong Chen, DDS, MS
Fellow, American Academy of Orofacial Pain
Member, American Pain Society
Member, American Association of Public Health Dentistry
Clinical Assistant Professor
Dept. of Preventive and Community Dentistry, University of Iowa College of Dentistry
hong-chen@uiowa.edu
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Cc:
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Rutgers, the State University of New Jersey
President, American Board of Orofacial Pain
Section Editor (Pain Management) -The Journal of the American Dental Association
Off: 973-972-6460/Clinic: 973-972-3418/Fax: 973-972-2674

References


CONSIDERATION OF PROPOSED REVISION TO STANDARD 2-24N OF THE ACCREDITATION STANDARDS FOR DENTAL EDUCATION PROGRAMS

**Background:** On June 10, 2019, the Commission on Dental Accreditation (CODA) received a request from Dr. Carla Evans, a current member of the Predoctoral Dental Education Review Committee, proposing that the CODA review Standard 2-24n of the Accreditation Standards for Dental Education Programs related to “malocclusion and space management.” Dr. Evans’ request is found in Appendix 1.

**Summary:** The Predoctoral Dental Education Review Committee and Commission are requested to consider the proposed revision to the Accreditation Standards for Dental Education Programs (Appendix 1) submitted by Dr. Carla Evans. If proposed changes are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

**Recommendation:**

Prepared by: Dr. Sherin Tooks
May 30, 2019

Sherin Tooks, Ed.D., M.S.
Director, Commission on Dental Accreditation
211 E. Chicago Ave.
Chicago, IL 60611

Dear Dr. Tooks,

Dental education in the United States is based on a dynamic collaboration between students, faculty, institutions, organizations and the business community, and aims to prepare graduates for the independent, unsupervised practice of general dentistry\(^1\)\(^2\). However, the scope of general dental practice is vague, and blurring of the boundaries between general and specialty practice has increased. A prime example of the lack of consensus is the divergence of opinions about the place of clinical orthodontics within the scope of general dental practice. Legally, a general dentist can practice orthodontics if the results are within the standard of care, but much of dental education is based on the concept of referral of orthodontic problems to a specialist\(^3\).

The word “orthodontics” is not found in the 2020 CODA Accreditation Standards for Dental Education Programs\(^4\). Instead, Standard 2-24n references “malocclusion and space management” with an overall caveat that “the graduate must be competent in providing oral health care within the scope of general dentistry, as defined by the school.” That’s a beginning. However, the ADEA Surveys of Senior Dental Students\(^5\) show that for ALL years from 2006 through 2018, dental graduates feel most unprepared in the area of orthodontics. Appendix A to this letter gives the summary data from the ADEA Surveys of Senior Dental Students and the last column gives the ranking of orthodontics in comparison to other subjects taught in dental school. The total number of subjects varies due to year-to-year changes in groupings in the surveys, but every year orthodontics is ranked last. Other sources of evidence for overall curricular effectiveness include reports of changes in clinical practice, objective measures obtained from national examinations and licensing procedures, as well as reports such as those prepared for predoctoral accreditation and curriculum surveys.

It is difficult for members of accreditation site visit teams to ascertain competence for Standard 2-24n at a general dentist level because: 1. The members are not specialists and vary markedly in their orthodontic knowledge and skills, 2. the ADEA references\(^1\)\(^2\) are not prescriptive, and 3. dental faculty focus on preparing their graduates for licensing examinations based primarily on other topics. So general dentists and non-orthodontist specialists who wish to address malocclusion in their practices learn from short continuing education courses, vendors, published materials or their colleagues – sometimes putting the public at risk. Data exist to show that non-orthodontists are undertaking significant orthodontic treatment in increasing numbers\(^6\)\(^7\) and that even the public is becoming involved in do-it-yourself orthodontic treatment\(^8\).

To address the needs of the public and dental students with respect to orthodontics, an accreditation site visit should evaluate foundation knowledge in the curriculum (e.g. growth and development, physiology of bone and the periodontium, biology of therapeutic tooth movement, orthodontic
materials, biomechanics, facial and dental esthetics and iatrogenic harm). In the clinical realm, at a minimum a dental graduate should be able to document and interpret a patient’s condition, treatment changes, and relapse by using dental models, radiographs, photographs, etc. In addition, a dental graduate should be able to utilize digital technology, communicate potential orthodontic outcomes and risks to patients and evaluate their own abilities before embarking on treatment interventions.

It’s important that dental education be improved to reflect the changes occurring in the world of dental practice and prepare graduates so that they are ready to work and counsel patients. Perhaps the issues discussed in this letter can be addressed by additions to CODA standards or intent statements. Also, it is possible that the annual Survey of Predoctoral Curriculum managed by JACDEI (Joint Advisory Committee on Dental Education Information) and CODA could help identify current shortcomings.

Sincerely,

Carla A. Evans, DDS, DMSc
Clinical Professor of Orthodontics
Henry M. Goldman School of Dental Medicine
Boston University
caevans@bu.edu

APPENDIX:

A. Summary Data (Orthodontics) – ADEA Surveys of Senior Dental Students (2006-2018)

REFERENCES:

6. ADA Health Policy Institute, Dental Fees: Results from the 2018 Survey of Dental Fees.
<table>
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<th>Time devoted to orthodontics</th>
<th>Preparedness for practice (orthodontics)</th>
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<td></td>
<td>Excessive (%)</td>
<td>Appropriate (%)</td>
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<td>2006</td>
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<tr>
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</tr>
<tr>
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<td>47.4</td>
</tr>
<tr>
<td>Year</td>
<td>Count</td>
<td>Not at all confident</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>----------------------</td>
</tr>
<tr>
<td>2012</td>
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</tr>
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</tbody>
</table>

The 2018 survey substituted “malocclusion” for “orthodontics” and rating scales from “preparedness” to “confidence.”
REPORT OF THE JOINT ADVISORY COMMITTEE ON
DENTAL EDUCATION INFORMATION

Background: The Joint Advisory Committee on Dental Education Information (JACDEI) is a liaison committee reporting to the Commission on Dental Accreditation (CODA), Council on Dental Education and Licensure (CDEL) of the American Dental Association (ADA), and the American Dental Education Association (ADEA). The Committee is composed of two representatives each appointed by the CODA, the CDEL/ADA, and the ADEA. The Committee appoints its own chair, which typically rotates among the CODA, the CDEL/ADA, and the ADEA. The primary function of the JACDEI is to review the annual survey instrument and reports for predoctoral dental education programs. Proposed recommended changes for the survey are transmitted to the CODA for approval prior to implementation. The Committee interfaces with the ADA Health Policy Institute (HPI) and oversees the reports resulting from these annual survey activities and data collections.

The Joint Advisory Committee on Dental Education Information (JACDEI) 2018-2019 membership includes: Dr. John Gallo (ADEA); Dr. Uri Hangorsky (CDEL); Dr. Steven Lepowsky (CDEL); Dr. Carol Anne Murdoch-Kinch (ADEA and JACDEI Chair 2017-2018); Dr. Bruce Rotter (CODA); and Dr. Lawrence Wolinsky (CODA, and JACDEI Chair 2018-2019).

Staff support for the JACDEI includes: Dr. Denice Stewart and Mr. Franc Slapar (ADEA); Dr. Anthony Ziebert, Ms. Karen Hart, Mr. Matthew Mikkelsen, and Ms. Cathryn Albrecht (ADA); and Dr. Sherin Tooks (CODA, and staff secretary of JACDEI).

March 15, 2019 Meeting: The JACDEI conducted a meeting during the 2019 American Dental Education Association Annual Session in Chicago, Illinois. The meeting was facilitated by the outgoing chair, Dr. Carol Anne Murdoch-Kinch. As its first order of business, the JACDEI adopted the meeting agenda and subsequently elected Dr. Lawrence Wolinsky as its next chair.

Discussion of the Charge/Purpose of the Joint Advisory Committee: The JACDEI reviewed its charge and discussed the benefit of developing a schedule to document the timing of each agency’s surveys. It was noted that a schedule was previously developed but may not have been inclusive of all education related surveys that may be distributed by the agencies. For example, the JACDEI recently reviewed a survey of the ADA Council on Advocacy for Access and Prevention (CAAP), which was targeted to dental students. The JACDEI learned that ADEA is reviewing the timing of its Faculty Surveys due to the heavy workload needed by programs to complete these surveys. In further discussion, the JACDEI considered whether it should serve as the clearinghouse for all predoctoral dental education surveys noting that, if this were the case, JACDEI should review the predoctoral dental education related surveys (beyond the CODA Annual Survey) of the participant organizations in advance of dissemination. The JACDEI members concluded that it would be beneficial for JACDEI to serve as the clearinghouse for surveys related to predoctoral dental education programs.
**JACDEI Action:** The JACDEI directs the staff of ADEA, ADA, and CODA to establish a schedule that illustrates the surveys distributed by these agencies, for review at its next meeting.

**Discussion Regarding CODA, ADEA, and ADA Surveys:** The JACDEI noted that there may be overlap in the data collected by CODA through the Annual Survey of predoctoral dental education programs and data collected by ADEA. The JACDEI considered whether program data submitted to CODA could be uploaded by the program for the numerous ADEA surveys and other surveys in which similar data is requested. It was suggested that staff investigate the technology tools that are available to all represented organizations to facilitate a program’s ability to upload the same data among multiple surveys that are sponsored by different agencies. In creating such a tool to share data among surveys, the JACDEI believed that an audit of the dental education surveys distributed by ADEA, ADA, and CODA should be conducted to determine the commonality and/or overlap in survey questions. The JACDEI suggested that the staff supporting the committee study this matter with a report to JACDEI in late summer 2019.

In further discussion related to sharing information, it was noted that the ADA Health Policy Institute is interested in other opportunities to use the information collected through the education surveys. The JACDEI primarily discussed the CODA Annual Survey data in which programs are required to complete the survey as an ongoing monitoring mechanism for accreditation; a program may not opt out of the CODA annual survey. The JACDEI agreed that programs are entitled to know how their data is being used, by whom it is being used, and to opt out if the program does not want to share data for the secondary use. A program may submit data to CODA for accreditation purposes but may not want the data applied to other uses for which it is unaware and has not agreed to share its data. Likewise, ADEA would have to inform participants that data might be shared and a data use agreement would be required before data could be shared among agencies. Following lengthy discussion, the JACDEI again emphasized the desire to explore a software solution to enable programs to download their own data (for example, an Excel file) that could be used by the program should it decide to share data within surveys conducted by other agencies.

**JACDEI Actions:** The JACDEI directs staff of ADEA, ADA, and CODA to conduct an audit of the dental education surveys distributed by each agency to determine the commonality and/or overlap in survey questions, for review at its next meeting.

The JACDEI further directs the staff of ADEA, ADA, and CODA to investigate the technology tools that are available to all represented organizations to facilitate a program’s ability to upload the same data among multiple surveys that are sponsored by different agencies, for review at its next meeting.

**Informational Report of CODA Annual Survey Curriculum Data:** The JACDEI reviewed the Annual Survey Curriculum data for predoctoral dental education programs, which was collected in 2018, noting that curriculum data is conducted in alternate years and there will be no curriculum section in 2019. The Committee discussed CODA’s use of the survey data within
CODA’s Data Profile, which is a report of the program’s survey data of the past five (5) years that is used by the program and site visit team during an accreditation site visit. The JACDEI learned that the Data Profile was recently enhanced to include more information from the annual survey that directly relates to the educational standards; further, the Profile’s layout was modified to a contemporary, reader-friendly design. The JACDEI noted that the quantity of clock hour data items was significantly reduced over the years. Clock hours may be used by programs and others to illustrate the amount of curricular time devoted to various topics within the predoctoral dental educational program. Finally, it was noted that fewer predoctoral dental education programs take advantage of the custom survey of their curriculum data compared with cumulative results, with less than one quarter of the predoctoral dental education programs requesting a custom report.

**Summary:** The Joint Advisory Committee on Dental Education Information continues to fulfill its objective to review the annual survey instrument and reports for predoctoral dental education programs. The Committee will meet at least once annually as business arises.

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

Prepared by: Dr. Sherin Tooks