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ADA American Dental Association®

America's leading advocate for oral health

2008

Supplement to
Annual Reports and Resolutions
Volume 2

149th Annual Session

San Antonio, Texas

October 17-21, 2008

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American Dental Association
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Chicago, Illinois 60611

Table of Contents Volume 2

Dental Education and Related Matters

4000 Fifth Trustee District: Re-examination of Mid-Level Providers as Relates to the Academy of General Dentistry White Paper (Res. 35)

4002 Report 15 of the Board of Trustees: Recommendations on the Report of the Task Force on the Commission on Dental Accreditation (Res. 37)

4004a Sixteenth Trustee District: Substitute Resolution (Res. 37S-1)

4037 Report 10 of the Board of Trustees: Update on the Community Dental Health Coordinator (CDHC) Pilot Program (Res. 39)

4042a Twelfth Trustee District: Substitute Resolution (Res. 39S-1)

4042b Sixteenth Trustee District: Substitute Resolution (Res. 39S-2)

4059 Report 5 of the Board of Trustees: International Consultation and Accreditation

4063 Report 8 of the Board of Trustees: Update on the Oral Preventive Assistant Curriculum Project

4072 AAOMP, AAPD, AAP, AAOMS, AAO, AAPHD, ACP: Joint Commission on National Dental Examinations Use of Pass/Fail on National Board Exams (Res. 70)

4074 Fifth, Sixteenth and Seventeenth Trustee Districts: Suspension of International Consultation and Accreditation Advisory Committee (Res. 76)

4076 Third Trustee District: Dentists Education in a Changing Environmental Marketplace (Res. 79)

4077 Fifth Trustee District: Economic Study of Expanded Workforce Models (Res. 82)

Membership and Planning

5000 Council on Membership: Parallel Membership Categories (Res. 10)

5002 Council on Membership: Four-Year Recent Graduate Reduced Dues Program (Res. 11)

5003 Report 11 of the Board of Trustees: Annual Report of the Standing Committee on the New Dentist (Res. 31)

5009 Thirteenth Trustee District: Market Research Project (Res. 36)

5011 Council on Membership Supplemental Report 1: Recent Council Activities

5015 Report 7 of the Board of Trustees: Annual Report of Strategic Planning Activities

5019 Second Trustee District: Student Block Grant Program (Res. 42)

5021 Second Trustee District: Mandate Tripartite Membership for Graduate Student/Resident Members (Res. 43)

5024 Thirteenth Trustee District: Lower Electronic Dues Payment Program Threshold (Res. 50)

5026 Twelfth Trustee District: Allocation of Student Block Grant Program Funds (Res. 54)

5029 Report 20 of the Board of Trustees: ADA Membership Practices and Proposed National Summit on Diversity in Dentistry (Res. 71)

5031 Report of the President

5038 Fourteenth Trustee District: Membership Category for Disabled Dentists (Res. 81)

Dental Education and Related Matters

Resolution No. 35 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 6, 2008

Submitted By: Fifth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $22,650

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

1 **RE-EXAMINATION OF MID-LEVEL PROVIDERS AS RELATES TO**
2 **THE ACADEMY OF GENERAL DENTISTRY WHITE PAPER**

3 The following resolution was submitted by the Fifth Trustee District and transmitted on August 6, 2008,
4 by Dr. Marie Schweinebraten, trustee.

5 **Background:** The ADA has spent considerable time and energy while developing the CDHC mid-level
6 provider model. During this same time period, other entities have begun to develop their own models and
7 definition of the mid-level provider and have defined what it can and cannot do without regard to ADA
8 policy or existing educational parameters.

9 The Academy of General Dentistry (AGD) has adopted policy concerning the definition of a mid-level
10 provider as is found in the AGD *White Paper on Increasing Access To and Utilization of Oral Health*
11 *Care Services*, see (http://www.agd.org/files/newsletter/7025accesstocarewhitepaper7-31-08.pdf), adopted in
12 Orlando in July 2008.

13 **Resolution**

14 **35. Resolved,** that the ADA form a task force composed of equal numbers of four trustees and four
15 general dentists from the House of Delegates to reexamine its policy on the use of the CDHC mid-
16 level provider using the AGD White Paper as its starting point, and be it further

17 **Resolved,** that this task force examine the expansion of the allowable duties of Expanded Function
18 Dental Assistants as a basis for recommendations on the development of a new Expanded Function
19 Dental Assistant II, and be it further

20 **Resolved,** that this task force report its findings and recommendations to the 2009 House of
21 Delegates.

22 **BOARD COMMENT:** While the Board of Trustees opposes this resolution for a number of reasons, we
23 appreciate that there continues to be a misunderstanding of the scope and purpose of the community
24 dental health coordinator (CDHC) model that must be addressed. For example, the resolution mistakenly
25 describes the CDHC model as being a mid-level dental provider. The CDHC is designed to work under
26 the supervision of a dentist and the scope of practice does not in any way reflect that of other models
27 which have been characterized as independent. As is stated in another resolution before this House, the
28 U.S. dental delivery system owes much of its success to the team model, which is supervised by a

licensed dentist. While many underserved communities might benefit from the addition of specially trained, culturally-prepared dental support personnel (like a CDHC), appropriate education, training and dentist supervision is essential to ensuring quality dental care.

In addition, the Board believes that many of the issues raised in this resolution were considered and addressed by the Dental Workforce Task Force Report to the 2006 House of Delegates, including voicing support for the use of expanded function dental assistants as a means of improving access to care in accordance with the dental team model. The Board also noted that it would be premature to re-examine ADA's policy on the use of the CDHC since the implementation of CDHC pilot programs is just beginning, and Resolution 3H-2006 from that report calls for the Workforce Models Task Force to evaluate and document the progress of the pilot projects and other models outlined by the Task Force and to provide progress reports to the House of Delegates. Accordingly, we believe that the creation of another task force is unnecessary.

Finally, the resolution refers to a recently released white paper produced by the Academy of General Dentistry. The Board acknowledges that the White Paper speaks to a number of issues important to grassroots members and is pleased to note that the report details a list of advocacy solutions that are very similar to the ADA's lobbying and public affairs agenda. The ADA and our constituent societies have already pursued many of the solutions through federal and state legislation.

BOARD RECOMMENDATION: Vote No.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
□	■	□	□	CADLE	□	■	□	□	GROVER	□	■	□	□	SMITH C
□	■	□	□	CALNON	□	■	□	□	KELL	■	□	□	□	SYKES
□	■	□	□	FAIELLA	□	■	□	□	KREMPASKY SMITH	□	■	□	□	TANKERSLEY
□	■	□	□	FINDLEY	□	■	□	□	LONG	□	■	□	□	THOMPSON
□	■	□	□	ELLIOTT	□	■	□	□	MANNING	■	□	□	□	VERSMAN
□	■	□	□	GIST	□	■	□	□	NICOLETTE	□	■	□	□	WEBB
□	■	□	□	GLECOS	■	□	□	□	SCHWEINEBRATEN				Res. 35	

Resolution No. 37 New ■ Substitute ☐ Amendment ☐

Report: Board Report 15 Date Submitted: August 2008

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $27,800

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

1 **REPORT 15 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**
2 **RECOMMENDATIONS ON THE REPORT OF THE TASK FORCE ON THE**
3 **COMMISSION ON DENTAL ACCREDITATION**

4 **Introduction:** This report summarizes recent activities of the Board of Trustees' Work Group
5 charged with drafting resolutions in response to the Task Force on the Commission on Dental
6 Accreditation (CODA) Report. The Board accepted the Task Force Report as a comprehensive
7 document and presents a recommendation for the House's consideration at the end of this report.

8 **Background:** At its June 2008 meeting, the Board appointed the following Work Group to
9 develop resolutions for consideration by the Board at its August meeting regarding the Task
10 Force on CODA Report.

11 The members of the Work Group are: Dr. Donald Cadle (chair), Seventeenth District; Dr.
12 William Calnon, Second District; Dr. William Glecos, Third District; Dr. Kathryn Kell, Tenth
13 District and Dr. Russell Webb, Thirteenth District. (Drs. Cadle and Calnon were members of the
14 Task Force on CODA.)

15 The ADA Board of Trustees is firmly committed to the concept that innovative education and
16 broad clinical training are cornerstones of the future advancement of our profession.
17 Accreditation of educational programs, at all possible levels, is fundamental in providing the
18 American public with the most highly qualified dental workforce.

19 Accreditation of dental related educational programs is currently accomplished by the ADA
20 Commission on Dental Accreditation (CODA). Over the past few years, several communities of
21 interest within the profession have voiced concerns related to the perceived functionality and
22 effectiveness of CODA. Following lengthy discussion at its April 2007 meeting, the Board of
23 Trustees adopted Resolution B-21-2007. This resolution called for the appointment, by the ADA
24 President, of a Task Force to examine the structure, governance, policies, operating procedures
25 and functionality of CODA. The composition and scope of the Task Force's work were
26 delineated in the resolution. The Task Force was charged to provide a comprehensive report of
27 its findings and recommendations to the 2008 House of Delegates.

1 At its June 2008 meeting, the Board of Trustees received a report entitled: FINAL REPORT:
2 American Dental Association Task Force on the Commission on Dental Accreditation, May 1,
3 2008.

4 Following extensive discussion, the Board voted unanimously to accept the report of the Task
5 Force. The Board felt it most important to distribute the report to delegates and parties of interest
6 so they would have maximum time to read and digest the contents of the lengthy document prior
7 to the October meeting of the House. At the Board's request, the Task Force Report, complete
8 with its nine attachments, was quickly posted on ADA.org.

9 In accepting the report, the Board had several comments and offers them as follows:

10 The Board wishes to commend the Task Force on the completion of its charge. It is greatly
11 impressed with the completeness of the report and the obvious attention paid to the various
12 directives outlined in the several resolving clauses of B-21-2007. The volume of existing
13 material reviewed is extensive and the research methodology used to gain information and
14 perceptions from a broad array of key stakeholders appears well developed.

15 The benchmarking study that explored best practices in more than 20 accrediting agencies places
16 CODA in perspective within the arena in which it operates. Whereas CODA seems to be
17 conforming to accreditation processes which are considered best practices, the study did elicit
18 some areas in which significant variation exists. These include the size of the Commission, the
19 breadth of the scope of accreditation, communications and the definition and understanding of the
20 ADA/CODA relationship. The Task Force offers recommendations relating to these issues.

21 The Board acknowledges that the ADA is the CODA community of interest which is advancing
22 this report and urging implementation of the recommendations. It is the opinion of the Board,
23 however, that the recommendations of the Task Force will greatly benefit all members, groups
24 and interested parties impacted by CODA. The Board anticipates that other CODA communities
25 will offer comment and hopes that they will envision a greatly enhanced accreditation model for
26 our inclusive profession.

27 The Board strongly feels that CODA and the ADA are partners in dental accreditation as
28 indicated by the title **ADA** Commission on Dental Accreditation, and does not see the difference
29 in mission statements as indicated in the report. In fact the Board sees the overall goal of both the
30 ADA and CODA as to build a better, stronger Commission. The formation of a joint task force
31 certainly speaks to the concern of both to accomplish that goal.

32 The Task Force Report contains 34 recommendations. The Board feels that each of these
33 recommendations is appropriate and the reasoning for each is substantiated in the body of the
34 report. Selected recommendations urge slight alterations while some others suggest more
35 substantial changes in existing structure, governance, policy, operating procedure, and
36 functionality. The Board understands that by urging CODA to accept and implement these
37 recommendations, it is asking the Commission to commit to a tremendous volume of work. In an
38 attempt to underscore its strong belief in both the intent and recommendations of the Task Force
39 Report, the Board wishes to demonstrate to CODA the resolve of the ADA to assist in the
40 extensive undertaking.

1 Further, the Board recognizes the Task Force comments on "culture" of CODA and the need for
2 changes. The Board feels it cannot direct a change in culture and that the way to effect changes
3 in culture is through changes in how CODA goes about its business. The Board also feels that
4 unless these resolutions are passed, there is a lack of accountability to the report on the part of
5 CODA and would like to be assured that the report will be used to improve relationships with all
6 parties of interest. There needs to be a mechanism for CODA to apprise the Board of progress
7 made and reports more often than on an annual basis.

8 The Board agrees with the Task Force recommendation to continue the affiliation with the U.S.
9 Department of Education. There would appear to be more jeopardy to the profession and quality
10 of accreditation if this were changed at this time. It also agreed that the relationship should
11 continue to be monitored and if additional or different accreditation affiliations present benefits
12 they should be investigated. However, the relationship of "arms length relationship" needs to be
13 better defined to determine exactly how long the arm is and how much coordination can occur
14 between CODA and the ADA.

15 The Board of Trustees accepted the Task Force Report as a comprehensive document with all of
16 its recommendations intact. It is the belief of the Board that the intent of the Report is more
17 accurately portrayed in this context and suggests to the House a similar approach. Therefore, be
18 it

19 **Resolution**

20 **37. Resolved**, that the American Dental Association strongly urge the ADA Commission
21 on Dental Accreditation to accept the Report of the Task Force on CODA, and be it
22 further

23 **Resolved,** that the American Dental Association urge CODA to work with all interested
24 parties to implement the recommendations of the Report, and be it further

25 **Resolved,** that the President of the ADA appoint a committee for the express purpose of
26 assisting CODA in implementing the recommendations of the Task Force Report
27 accepted by CODA, and be it further

28 **Resolved,** that this committee consist of a chair, three members of the Board of Trustees
29 and three members of the House of Delegates, and be it further

30 **Resolved,** that this committee provide updates to the Board of Trustees at each of its
31 2008-2009 meetings prior to the 2009 House, and be it further

32 **Resolved,** that CODA provide a comprehensive report to the 2009 House detailing
33 progress on the implementation of the recommendations of the Task Force Report.

34 **BOARD RECOMMENDATION: Vote Yes.**

35 **BOARD VOTE: UNANIMOUS.**

Resolution No. 37S-1 New ☐ Substitute ■ Amendment ☐

Report: Board Report 15 Date Submitted: September 2008

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goals: (Required)

1 **SUBSTITUTE FOR RESOLUTION 37:**
2 **IMPLEMENTATION OF RECOMMENDATIONS IN THE CODA TASK FORCE REPORT**

3 The following substitute for Resolution 37 (Worksheet:4004) was submitted by the Sixteenth Trustee
4 District and transmitted on September 25, 2008, by Mr. Phil Latham, executive director, South Carolina
5 Dental Association.

6 (Deletions are stricken.)

7 **Resolution**

8 **37S-1. Resolved**, that the American Dental Association strongly urge the ADA Commission on
9 Dental Accreditation to accept the Report of the Task Force on CODA, and be it further

10 **Resolved,** that the American Dental Association urge CODA to work with all interested parties to
11 implement the recommendations of the Report, and be it further

12 ~~**Resolved,** that the President of the ADA appoint a committee for the express purpose of assisting~~
13 ~~CODA in implementing the recommendations of the Task Force Report accepted by CODA, and be it~~
14 ~~further~~

15 ~~**Resolved,** that this committee consist of a chair, three members of the Board of Trustees and three~~
16 ~~members of the House of Delegates, and be it further~~

17 ~~**Resolved,** that this committee provide updates to the Board of Trustees at each of its 2008-2009~~
18 ~~meetings prior to the 2009 House, and be it further~~

19 **Resolved,** that CODA provide a comprehensive report to the 2009 House detailing progress on the
20 implementation of the recommendations of the Task Force Report.

21 **BOARD COMMENT:** The Board believes that it is important to provide a mechanism to encourage and
22 support CODA in its review and implementation of recommendations from the Task Force Report. The
23 committee will also provide a mechanism for direct communication on progress back to the ADA.

24 **BOARD RECOMMENDATION: Vote No.**

25

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
□	■	□	□	CADLE	□	■	□	□	GROVER	□	■	□	□	SMITH C
□	■	□	□	CALNON	□	■	□	□	KELL	□	■	□	□	SYKES
□	■	□	□	FAIELLA	□	■	□	□	KREMPASKY SMITH	□	■	□	□	TANKERSLEY
□	■	□	□	FINDLEY	■	□	□	□	LONG	□	■	□	□	THOMPSON
□	■	□	□	ELLIOTT	□	■	□	□	MANNING	□	■	□	□	VERSMAN
□	■	□	□	GIST	□	■	□	□	NICOLETTE	□	■	□	□	WEBB
□	■	□	□	GLECOS	□	■	□	□	SCHWEINEBRATEN				Res.	37S-1

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Final Report:

American Dental Association

Task Force

on the

Commission on Dental Accreditation

May 1, 2008

Table of Contents

Executive Summary……………………………..………...…………………p. 4

I. Introduction..p. 9

II. Summary of research methodology………..…………………….………p. 11

Audiences

a. Internal stakeholders
b. Direct users of the accreditation process
c. External thought leaders and decision makers

Research phases

1. Phase 1 Desk audit
2. Phase 2 Advisory group position papers and presentations
3. Phase 3 Electronic survey
4. Phase 4 Individual interviews
5. Phase 5 Benchmarking
6. Phase 6 Focus groups

Analysis of calibration and consistency of responses

1. Calibration and consistency of responses across type of research methodology employed
2. Calibration and consistency of responses across stakeholder groups

III. Summary of findings…………………………………….………………..p. 14

1. The Structure of CODA
2. The Governance of CODA
3. The Policies of CODA
4. The Operating procedures of CODA
5. The Functionality of CODA
6. CODA's Use of Best Practices in accreditation
7. CODA's continued affiliation with the United States Department of Education (USDE)

IV. Conclusions and recommendations……………….………….………..p. 19

1. The Structure of CODA
2. The Governance of CODA
3. The Policies of CODA
4. The Operating Procedures of CODA
5. The Functionality of CODA
6. CODA's use of best practices in accreditation
7. CODA's continued affiliation with the United States Department of Education (USDE)

Recommendations..P. 30

1. The Structure of CODA
2. The Governance of CODA
3. The Policies of CODA
4. The Operating Procedures of CODA
5. The Functionality of CODA
6. CODA's use of best practices in accreditation
7. CODA's continued affiliation with the United States Department of Education (USDE)

Executive Summary

Introduction

The American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA), from hereon called the “Task Force,” has been charged by the ADA Board of Trustees to study the structure, governance, policies, operating procedures, and functionality of CODA. The scope of the Task Force’s work is delineated in the ADA Board of Trustees’ resolution adopted April 2007:

> **STUDY OF THE COMMISSION ON DENTAL ACCREDITATION**
>
> **B-21-2007. Resolved,** that the president appoint a task force, including the chair, to examine the structure, governance, policies, operating procedures and functionality of the Commission on Dental Accreditation, and be it further
>
> **Resolved,** that the objectives of the task force be to: (1) determine whether the structure, governance, policies, operating procedures and functionality of the CODA adequately meet the accreditation needs of the dental profession and whether CODA is using best practices in accreditation, (2) determine whether it is in the profession’s best interest for CODA to maintain its affiliation with the U.S. Department of Education [USDE], and (3) make recommendations, accordingly, on how the dental accreditation process can be improved to preserve the high standards needed for the future of dental education as a profession, and be it further
>
> **Resolved,** that the task force has as a goal to complete its charge in one year and that if more time is needed that the task force present to the BOT with reasons to extend, and be it further
>
> **Resolved,** that the task force consist of up to 12 members comprised of representatives from CODA, CDEL, ADEA, AADE, and a current or past public member of CODA that has accreditation expertise, as well as members of the ADA BOT and HOD which have no affiliation with ADEA or AADE, and be it further
>
> **Resolved,** that the task force be authorized and requested to retain a consulting firm with specific expertise in the professional education arena to staff and support the task force’s work, and be it further
>
> **Resolved,** that the task force convene an informal group of advisors, made up of at least one person from each of the disciplines represented on CODA, for purposes of consulting with and providing input into the work of the task force, and be it further
>
> **Resolved,** that funding for the task force for 2007 expenses be presented to the Board in June in a supplemental appropriation request and that future funding be added to appropriate budget(s), and be it further

Resolved, that the Board be provided with regular progress reports on the work of the task force, and that similar updates be provided regularly to all communities of interest, including an immediate announcement about the formation of the task force and its objectives, and be it further

Resolved, that the Board provide a progress report to the 2007 House of Delegates and a comprehensive report to the 2008 House.

Summary of Research Methodology

To complete its work, the Task Force contracted with the Plexus Consulting Group LLC of Washington, DC, to conduct a series of research studies to explore the issues outlined above.

The research assessed the perceptions of three groups of key stakeholders:

a) Internal stakeholders such as members of the ADA governance structures, current and past members of CODA, and representatives of 18 dental-related organizations.

b) Direct users of the accreditation process including members of the academic community.

c) External thought leaders and decision makers including individuals who are not members of the dental profession or its academic community but are individuals whose decisions can influence the profession. These included key leaders from the accreditation community.

The research consisted of several sequential phases and was designed to use a variety of methodologies and collect data from a broad spectrum of individuals and organizations. The research consisted of a review of existing documents, an electronic survey that was sent to 5,056 individuals with 1,258 respondents, 31 telephone interviews with individuals selected from each of the audiences identified above, interviews with CODA staff, and two focus groups (one with internal leaders, and the other with members of the academic community). Particularly important to the process was the input from an 18-organization Advisory Group through papers and presentations. Information was analyzed within the context of best practices in accreditation that were identified through an extensive benchmarking study. This study examined more than twenty accrediting agencies as well as relevant federal and international guidance on accreditation policies, practices and outcomes.

Summary of Research Findings

The Task Force determined that there were a variety of opinions regarding CODA. Tensions regarding CODA exist to varying degrees among respondents who participated in the Advisory Group, the written survey, the telephone interviews or the focus groups. Some respondents reported that they had concerns with CODA structure and operating procedures. Others had no concerns regarding CODA and reported that they believe that CODA is functioning satisfactorily and adds value to dental education programs. Still others reported not having sufficient knowledge and/or opinion about CODA practices and policies. Although specific concerns were not expressed by the majority of respondents, the Task Force believes that those concerns that were expressed needed to be explored and addressed.

The benchmarking supports the fact that currently CODA consistently uses accepted accreditation processes that are considered best practices. The benchmarking studies revealed that there were many commonalities among accrediting agencies in the way they evaluated applicants against defined accreditation standards. For example, all agencies benchmarked require a written application, a formal self-study and a site visit conducted by trained evaluators to confirm and validate the content of the self-study. Accreditation agencies all have a council or commission that has the final authority to make accreditation decisions. They all have processes for appeals and complaints as well as processes to share accreditation decisions with the public. Agencies differ in the scope of their accreditation, ranging from accrediting one educational program to accrediting several educational programs. CODA has the broadest scope of those accreditation agencies that were benchmarked.

Significant variation also exists in the size of accreditation commissions, with CODA being among the largest. Additionally, variation exists in the role of the public – CODA actually has more participation of the public on its review committees and on its commission than other agencies. Agencies varied in their relationships to their sponsoring organizations. Some agencies serve as a committee of a sponsoring organization, accrediting against standards that are created or approved by the governing arm of the sponsoring organization. Other accrediting agencies function as totally separate organizations in regard to structure, location, staff and finances. CODA falls within the middle of this range.

Relationships between accreditation agencies and professional associations that house the accreditation agency are often sensitive because of the commonly accepted philosophy that the association and the accreditation agency *de facto* have different and sometimes conflicting missions that normally require accreditation to be at “arm’s length” from the professional interests of the trade or professional association. The following mission statements provide a good example of this.

ADA Mission Statement

The ADA is the professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards.

CODA's Mission Statement

The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflects the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs.

Based on the responses from communities of interest and the benchmarking, the Task Force believes that ADA and CODA need to engage in a process to better define and communicate their relationship and create a transparent and mutually shared set of expectations, rights and responsibilities.

Conclusions

The Task Force had extensive discussions on the structure of CODA. The benchmarking research indicated that CODA accredits a broader scope of educational programs within a single commission compared to most other accreditation agencies. CODA also has a larger number of commissioners compared to most other accreditation agencies. Research indicated expected increases in the number of dental related and advanced practice programs, as well as potential changes in practice scope and increases in the number of international programs applying for international accreditation, which may increase the workload of CODA. The Task Force acknowledges that there are significant differences between predoctoral, entry-level educational programs and programs providing advanced dental and specialty education.

Based on these discussions, the Task Force believes there is merit in restructuring. Consequently, it concludes that CODA should conduct a comprehensive investigation of appropriate structure(s), building on the work of the Task Force, to best meet the current and future needs of the profession and the public.

The Task Force further concludes that CODA should consider potential models and believes that any model should include an oversight body. One model that may have particular merit is a commission whose structure includes an oversight body and two accrediting entities to conduct the following accreditation activities:

A. Predoctoral, allied dental and international predoctoral programs

B. Specialty, advanced general dental and international advanced dental programs

Also, the Task Force recommends a cultural change for CODA. This includes a change in how it perceives its responsibilities to its communities of interest regarding accountability, transparency and responsiveness. For example, there appears to be some disconnect between what CODA does and what some perceive it does. This suggests that CODA needs to do a much better job communicating with its communities of interest and being responsive to their concerns. CODA is not unique in how it is differently perceived among different communities of interest. Every accreditation agency examined continues to struggle to adapt itself in ways that best meet the needs of the profession and the public and the often-conflicting requirements, values and perspectives of its various communities of interest.

The Task Force offers several recommendations for improving communication and responsiveness, including the need for CODA to establish and implement a communications plan, conduct systematic strategic planning and conduct ongoing self-evaluation for the purpose of quality improvement. Additionally, CODA is advised to develop a posture of continuous readiness in regard to monitoring itself and the programs it accredits and make better use of enhanced technology in doing so.

While the Task Force concludes that CODA's policies and practices appear to conform to what are considered best practices in accreditation, there are areas where CODA can improve. The Task Force offers recommendations for improvement in many areas, including recruitment and leadership, the length of terms of commissioners, the training and re-training of site visitors, the ongoing evaluation of site visitors, and the composition of site visit teams and review committees.

The Task Force believes that trends in increasing accountability for higher education accreditors strongly support the need for CODA to continue to be recognized by USDE. CODA should, in addition, explore other opportunities to be formally recognized by other independent agencies that are considered national and international experts regarding best practices in accreditation. These would include the Council for Higher Education Accreditation (CHEA) and the American National Standards Institute (ANSI).

In summary, while the Task Force believes that CODA functions satisfactorily in many respects, the Task Force makes recommendations for actions that should be initiated to improve CODA's structure, policies, and processes. In particular, CODA needs to improve its efforts regarding transparency, openness, responsiveness, and accountability in order to best meet the current and future needs of the dental profession and the public. This will require a significantly increased focus on communication, strategic planning, continuous self-evaluation, and quality improvement.

I. Introduction

The American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA), from hereon called the Task Force, has been charged by the ADA Board of Trustees to study the structure, governance, policies, operating procedures, and functionality of CODA. The scope of the Task Force's work is delineated in the ADA Board of Trustees' resolution adopted April 2007:

STUDY OF THE COMMISSION ON DENTAL ACCREDITATION

B-21-2007. Resolved, that the president appoint a task force, including the chair, to examine the structure, governance, policies, operating procedures and functionality of the Commission on Dental Accreditation, and be it further

Resolved, that the objectives of the task force be to: (1) determine whether the structure, governance, policies, operating procedures and functionality of the CODA adequately meet the accreditation needs of the dental profession and whether CODA is using best practices in accreditation, (2) determine whether it is in the profession's best interest for CODA to maintain its affiliation with the U.S. Department of Education [USDE], and (3) make recommendations, accordingly, on how the dental accreditation process can be improved to preserve the high standards needed for the future of dental education as a profession, and be it further

Resolved, that the task force has as a goal to complete its charge in one year and that if more time is needed that the task force present to the BOT with reasons to extend, and be it further

Resolved, that the task force consist of up to 12 members comprised of representatives from CODA, CDEL, ADEA, AADE, and a current or past public member of CODA that has accreditation expertise, as well as members of the ADA BOT and HOD which have no affiliation with ADEA or AADE, and be it further

Resolved, that the task force be authorized and requested to retain a consulting firm with specific expertise in the professional education arena to staff and support the task force's work, and be it further

Resolved, that the task force convene an informal group of advisors, made up of at least one person from each of the disciplines represented on CODA, for purposes of consulting with and providing input into the work of the task force, and be it further

Resolved, that funding for the task force for 2007 expenses be presented to the Board in June in a supplemental appropriation request and that future funding be added to appropriate budget(s), and be it further

Resolved, that the Board be provided with regular progress reports on the work of the task force, and that similar updates be provided regularly to all communities of interest, including an immediate announcement about the formation of the task force and its objectives, and be it further

Resolved, that the Board provide a progress report to the 2007 House of Delegates and a comprehensive report to the 2008 House.

II. Summary of research methodology

To complete its work, the Task Force contracted with the Plexus Consulting Group of Washington, DC, to conduct a series of research studies to explore the issues outlined above. **Attachment 1** includes the names of the Task Force members and information about the Plexus Consulting Group.

The research was divided into several phases that were perceived as sequential. Task Force members approved all research protocols used in each phase, identified and approved intended audiences, and in the case of telephone interviews and focus groups, identified specific individuals.

The research assessed the perceptions of three groups of key stakeholders:

a) Internal stakeholders such as members of the ADA governance structures, current and past members of CODA, and representatives of 18 dental-related organizations.

b) Direct users of the accreditation process including members of the academic community.

c) External thought leaders and decision makers including individuals who are not members of the dental profession or its academic community but are individuals whose decisions can influence the profession. These included key leaders from the accreditation community.

Each phase of the research was described and analyzed separately. The Task Force was provided with a separate report describing the methodology, participants, and findings for each phase of the research.

Phase 1 - Desk audit

Initial research included a desk audit of CODA documents including policies and procedures, results from previous studies and relevant ADA and CODA correspondence. This material was made available to the Plexus Consulting Group and to all members of the Task Force. **Attachment 2** contains the list of the background documents provided to the Task Force.

Phase 2 - Advisory Group position papers and presentations

The Task Force invited all of its communities of interest to participate in an Advisory Group. This Advisory Group represented organizations from advanced specialty practice areas, general dentistry, dental-related professions or groups, the regulatory community, and the academic community. Members of the Advisory Group were invited to submit written position papers to the Task Force that addressed the areas the Task Force was charged to study. Additionally, all members of the Advisory Group were invited to participate in an all-day forum to provide verbal summaries of their papers and to answer questions from members of the Task Force.

The Plexus Consulting Group assisted the Task Force in conducting an analysis of the themes that emerged from papers and presentations provided to the Task Force by its Advisory Group. **Attachment 3** contains the list of organizations invited to participate in the Advisory Group (and those organizations that submitted papers and/or presentations).

Phase 3 - Electronic survey

An electronic survey was sent to 5,056 individuals with 1,258 respondents, representing a participation rate of 25 percent. The sample was drawn from relevant ADA and CODA databases, and included only people with valid email addresses. Participants in this study included members of the Task Force, the Advisory Group, ADA policy makers (including, but not limited to, the ADA Board of Trustees, the ADA Council on Dental Education and Licensure, delegates and alternate delegates to the ADA House of Delegates), academicians such as deans and faculty of ADA accredited programs, CODA Commissioners, review committee members and site visitors, dental examiners, and CODA staff. New dentists were invited to participate in the survey but were not included in the analyses due to the very low response rate from this segment. **Attachment 4** contains a summary of the electronic survey.

Phase 4 - Individual interviews

Following the analysis of the electronic survey, the Plexus Consulting Group staff completed telephone interviews with 31 participants representing internal stakeholders, direct users of accreditation, and external thought leaders in accreditation. The questions posed to each group were modified to address the different expertise of each group while maintaining survey validity. Additionally, the Plexus Consulting Group liaison to the Task Force and a member of the Task Force conducted an extended face-to-face interview with CODA executive staff. **Attachment 5** contains the findings of the telephone interviews (including a list of participants in the telephone surveys).

Phase 5 - Benchmarking

The Plexus Consulting Group produced a benchmarking study that explored best practices in more than 20 accreditation agencies and offered suggestions based on these practices. The Plexus Consulting Group also conducted an analysis of the impact of USDE recognition criteria on the policies and practices of CODA. **Attachment 6** contains the benchmarking study.

Phase 6 - Focus groups

Additional research included two focus groups. One focus group was held with leaders in the dental practice community that was in conjunction with the Chicago Dental Society Mid-Winter Meeting. Another focus group was held with members of the dental academic community in conjunction with the American Dental Education Association (ADEA) Annual Session in Dallas. **Attachment 7** contains a summary of the focus groups.

Analysis of calibration and consistency of responses

Calibration and consistency of responses across type of research methodology employed

It is important to note that regardless of the research methodology employed (electronic survey, papers and presentations from the Advisory Group, telephone surveys, focus groups) there was a striking similarity in respondents' perceptions regarding CODA.

Calibration and consistency of responses across stakeholder groups

Comparisons of responses among stakeholder groups demonstrate strong consistency regarding similar issues—with a few exceptions. What emerges from this research is that despite certain differences on specifics, most groups hold similar general perceptions of the ADA and CODA. Whether it was in regard to the general value of accreditation, the effectiveness and the variety of CODA's communication methods, the transparency of the accreditation process, the relationships among the ADA, CODA, and USDE, the current structure of the accreditation body, public involvement in the accreditation process, or unannounced visits, comments from each group pointed in the same direction.

The exceptions to the concordance were found in the presentations from the members of the Advisory Group. Analysis of themes from papers and presentations did not show a consistent set of perceptions or recommendations regarding the issues that the Advisory Group was asked to address. Additionally, members of certain groups who participated in the written survey expressed dissenting opinions. Likewise, there were dissenting opinions presented during the telephone interviews and in the focus groups. These appeared to have represented an important but minority perspective. They have been included in the discussion below regarding the summary of findings.

The consistency across most respondents implied that the perceptions, issues, and problems raised during this research were real and significant and did not relate to each community of interest or to each group's bias and specific involvement in the accreditation process. This result should be promising for the ADA and CODA suggesting confidence that addressing these issues and finding solutions will not create political tensions among most communities of interest. During the conduct of this research, some people expressed a certain frustration and discontent with particular aspects of CODA. Overall, participants were satisfied with accreditation and manifested support for the accreditation program. The consensus among groups confirmed the participants' general agreement regarding CODA, and should encourage CODA to move forward in implementing the recommendations outlined in this report.

III. Summary of findings

The Structure of CODA

Regardless of the research methodology employed, many respondents believed that the structure of CODA is appropriate and effective for its current requirements. Exceptions were raised by some representatives of dental specialty areas who would like a structure that provides more autonomy in decision-making relative to defined areas of practice. Specifically, some individuals representing dental specialty organizations objected to public representatives and representatives from areas of dentistry outside their specialty area of practice participating in accreditation reviews and accreditation decisions for educational programs within their specialty area of practice. In light of the number of individuals who participated in the research, these views appeared to represent an important but minority perspective.

The benchmarking research indicated that CODA accredits a broader scope of educational programs within a single commission compared to most other accreditation agencies. CODA also has the largest number of commissioners compared to most other accreditation agencies. Research also indicated expected increases in the number of dental related and advanced practice programs, as well as potential changes in practice scope and increases in the number of international programs applying for international accreditation, which may affect the workload of CODA.

The Governance of CODA

The research suggests that the communities of interest were generally satisfied with the relationship between the ADA and CODA. In the electronic survey, the greatest agreement was shown for the item "The relationship between ADA and CODA is excellent," and the greatest disagreement concerned, "The relationship between ADA and CODA should be more tightly coordinated." The results also showed that there are marked differences of opinion among the segments. For example, policymakers were more likely to believe that, "the relationship between ADA and CODA should be more tightly coordinated" and that, "communication between ADA and CODA needs substantial improvement" than did any other segment.

Individuals who were dissatisfied with the relationship between the ADA and CODA believed that CODA was too autonomous and not responsive enough to the ADA. However, there appeared to be little support, even among those critical of the current relationship, for CODA to become an autonomous and/or financially self-sustaining accreditation body. This is an important finding because benchmarking revealed that a more typical accreditation model is a freestanding, autonomous accreditation agency, particularly in healthcare. In fact, the benchmarking revealed that CODA is less autonomous in regard to the ADA than other agencies are to their sponsoring organizations.

Further, based on CODA's legal status, its location and its staffing structure, it is considerably less autonomous. Where the ADA/CODA relationship fails to conform to the accepted or best practices in accreditation is in the way the ADA and CODA

understand their individual rights and responsibilities, and the way they communicate with each other. (The Benchmarking report provides additional information regarding best practices in this area.)

The Policies of CODA

Most respondents appeared satisfied with the policies of CODA. There seemed to be satisfaction with policies regarding the accreditation and the role of the public (with the exception of concerns regarding public involvement in accreditation decisions). For instance, policymakers tended to believe more strongly than other segments that the public is over-represented in CODA processes, while dental examiners tended to believe more strongly that the public should have a greater role.

Asked about various aspects of CODA quality indicators, respondents expressed the greatest agreement for the statement, “CODA accreditation supports the quality of graduating students.” In terms of segment differences, both academicians and CODA staff tended to share more agreement regarding CODA policies than did most other segments. There was little support for routinely conducting unannounced site visits or developing different levels of accreditation and little support for differential accreditation cycles. Benchmarking showed that CODA’s policies are in line with most accepted practices in accreditation; however, opportunities for improvement were recognized.

Benchmarking also showed that expansion into international accreditation was a growing focus for almost all accreditation agencies. Many agencies are moving internationally in response to requests from non-U.S. institutions and the globalization of the professions with which they are engaged. In this regard, although CODA is starting later than many accrediting agencies, CODA’s interest and activities internationally align with best practices in accreditation.

The Operating Procedures of CODA

Respondents appeared generally satisfied with how CODA members are appointed. However, the concerns expressed were not with the policies themselves but with the lack of transparency in setting polices. Examples include the role of accreditation with respect to programs in non-recognized specialty areas of practice, the lack of understanding of how policies are being applied, and perceived inconsistencies in how some policies were applied.

Respondents also supported the idea of continuous reporting via online methods in order to reduce the amount of paperwork and preparation required for site visits and in order to maintain continuous readiness. Respondents further recommended extensive training programs in an effort to decrease the possibility of personal bias being introduced in the review process and to create a standard across all site visit teams.

Additionally, respondents felt that CODA should extend its meeting format to allow more time for discussion regarding accreditation.

Respondents felt that there was a divide between educators and practitioners. Respondents believed that both groups must communicate better, must understand that members of different communities of interest should not serve with portfolios and must

increase their understanding of the other's work. The benchmarking research confirmed that these are common concerns among accreditation agencies.

The Functionality of CODA

Data gathered through electronic surveys, telephone interviews, Advisory Group position papers and presentations, and the focus groups conducted indicated communication is a serious issue that is impairing the functionality of CODA. In fact, communication problems were the issues most frequently cited by participants in the research studies. Suggestions to improve communication from the electronic survey and the focus groups included: improving the CODA Web site, being more visible at conferences and other ADA related events, improving opportunities for communities of interest to address CODA, being more proactive, being more accountable and being more transparent.

In CODA communications with communities of interest, transparency is being defined as providing more information regarding the rules and processes CODA uses and how it applies those rules and processes and comes to certain conclusions. The goal of increased transparency is to provide all communities of interest, whenever possible, with an understanding of how CODA operates and why CODA does what it does. Increased transparency is not intended to mean that current polices regarding confidentiality should be changed. In fact, all the research indicated that current CODA policies and processes regarding confidentiality of information, especially in regard to accredited programs and applicants for accreditation and re-accreditation, need to continue.

CODA staff also acknowledged the need for improved communications, and CODA has already established its own internal working group to examine this issue. This is significant because the benchmarking study confirmed that CODA did not conform to best practices in communication; the study also provides several suggestions for CODA to consider in this regard.

Additionally, several respondents mentioned that CODA should be using more advanced technologies to communicate with communities of interest and to conduct CODA business more efficiently. The perceptions of communities of interest that the functionality of CODA could be improved by investing in upgraded technology were also supported by the results of the benchmarking study.

CODA's use of best practices in accreditation

Most respondents reported not having sufficient information regarding practices of other accreditation agencies to make comparisons between CODA and other accreditation agencies. There were many suggestions regarding what CODA needs to pay attention to in the future; most commonly stated was the need to adjust to enhanced technology and remain relevant to the profession as it changes. Respondents believed that technology will have an impact on accreditation, and that CODA must be prepared to utilize these emerging technologies.

The benchmarking study showed that CODA conforms to or exceeds currently accepted practices in accreditation in most areas: these included accreditation decision-making processes, the amount of information about accredited

programs that CODA provides to the public, and the level of public participation on review committees and the Commission itself.

Regarding the role of staff, the benchmarking study showed that CODA practices fall within accepted practice. CODA's staffing structure and staff responsibilities also are aligned with accepted practice. Some accreditation agencies use staff as members of site visit teams and review committees; in others, staff only serve to facilitate the accreditation process but offer no content expertise. In no case does staff participate in accreditation decisions. However, examples from other accreditation agencies demonstrated that there are better practices than those employed by CODA in several areas. These included communication with communities of interest and the use of enhanced technology to support accreditation functions. These are addressed in the discussion regarding the functionality of CODA.

Other best practices include strategic planning, self-evaluation, and using a system of continuous quality improvement (CQI). Many accreditation programs are engaging in CQI processes. In fact, such a system is mandatory for accreditation agencies to be recognized against international standards of best practice in accreditation such as ISO17011 (an internationally accepted standard regarding how agencies are to operate, conduct accreditation activities and engage in internal quality management). Many accreditation agencies and other organizations are adopting this system because it serves as a tool for them to be more responsive to the needs of their communities of interest, to identify and correct problems quickly, and to operate more efficiently.

CODA's continued affiliation with the United States Department of Education (USDE)

There is little quantitative data available to demonstrate the exact financial impact of CODA recognition by USDE on educational programs. This lack of quantitative data appears to be the norm for the accreditation community in general and is related to how government agencies track their funding and the relationship of this funding to USDE recognition. However, the research strongly supports the need for CODA to maintain recognition by USDE. Reasons for maintaining USDE recognition are to enhance the credibility of CODA to provide external evaluation of CODA, and to maintain access to all available governmental sources of funding to support dental education programs. Dissenting opinion was expressed by some of the representatives from the advanced general practice and specialty practice community who believed that educational programs in general dentistry, predoctoral and advanced, need to continue to be accredited by a USDE recognized accreditation agency, but that educational programs that prepare individuals for specialty areas of practice would not. However, this perspective was not consistently stated by all of the specialty areas of practice representatives.

While the exact amount of funding cannot be ascertained, USDE recognition clearly provides dental education programs with increased opportunities to access federal funding. Information about USDE and CODA's relationship to the agency, are contained in **Attachment 8.**

IV. Conclusions and recommendations

The Structure

The Task Force had extensive discussions on the structure of CODA. The benchmarking research indicated that CODA accredits a broader scope of educational programs within a single commission compared to most other accreditation agencies. CODA also has a larger number of commissioners compared to most other accreditation agencies. Research also indicates expected increases in the number of dental-related and advanced practice programs, as well as potential changes in the scope of practice and increases in the number of international programs applying for international accreditation, which may increase the workload of CODA. Finally, the Task Force acknowledges that there are significant differences between predoctoral, entry-level educational programs and programs providing advanced dental and specialty education.

For all of these reasons, the Task Force believes there is merit in restructuring CODA to enhance its efficiency and effectiveness. Consequently, it concludes that CODA should conduct a comprehensive investigation of appropriate structure(s), building on the work of the Task Force, to best meet the current and future needs of the profession and the public. The Task Force concludes that CODA should consider a variety of potential models for restructuring but believes strongly that any model should include some type of central bridging/umbrella body to coordinate accreditation activities.

The Task Force believes one model that may have particular merit is a commission whose structure includes an oversight body and two accrediting entities to conduct the following separate accreditation activities for two distinct areas:

A. Predoctoral, allied dental and international predoctoral programs

B. Specialty, advanced general dental and international advanced dental programs

Further, because of expected increases in the number of dental-related and advanced practice programs, as well as potential changes in the scope of practice and increases in the number of international programs applying for international accreditation, the Task Force also recommends that CODA continually examine how its structure can best meet the needs of the profession and the public by incorporating this examination into its comprehensive ongoing strategic planning process.

Structure Recommendations

1. CODA should restructure to better meet the current and future needs of the dental profession and the public.

2. CODA should conduct a comprehensive investigation of appropriate structures. This investigation should build on and extend the work of the Task Force.

3. CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure.

The Governance of CODA

Relationships between accreditation agencies and professional associations that house the accreditation agency are often sensitive because of the commonly accepted philosophy that a trade or professional association and an accreditation agency *de facto* have different and sometimes conflicting missions which require accreditation to be at "arm's length" from the professional interests of its related trade or professional association. The ADA and CODA mission statements provide a good example of this:

> **ADA Mission Statement**
>
> The ADA is the professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards.
>
> **CODA's Mission Statement**
>
> The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflects the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs.

While these missions are not mutually exclusive, the Task Force agrees that this distinction is important for the ADA and CODA to maintain. A document prepared for the ADA Board of Trustees, which is excerpted below, also acknowledges the importance of this distinction:

> "CODA and ADA have distinct missions and stakeholders. The ADA as a member organization is expected to put its members' interests first. CODA's accountability is broader; it must listen to all of its stakeholders and ultimately come to consensus on what is in the best interests of students, the public, educational programs, employers, educators, state boards and the broader

> profession beyond those dentist members who are politically active. Dentistry's ability to set standards and oversee the quality of education through CODA depends on having a credible process that employs best accreditation practices and due process free from the bias of special interests.
>
> ADA's financial support for CODA has been a strategic decision to support quality in dental education so that no education program is deterred from participation in the accreditation process…."

The benchmarking study confirmed that CODA's staffing structure appears to conform to commonly accepted accreditation practice in those instances when an accreditation agency is part of a larger organization.

The Task Force investigated alternative structures for the ADA's governance of CODA but concluded that the current legal and fiscal structure that defines the relationship between the ADA and CODA is in the best interests of the dental community. The research shows that people are generally satisfied with the way things are, with very few exceptions. However, there are problems with communication and with understanding respective roles and responsibilities. For example, while CODA has the authority to accredit educational programs, it does not have the authority to recognize specialty areas of dental practice. That authority rests with the Council on Dental Education and Licensure (CDEL) and the ADA House of Delegates (HOD). After recognition of a specialty area of dental practice is authorized, CODA may then accredit the educational programs within that area.

Recently, CODA has begun accrediting educational programs in non-recognized specialty areas of general dentistry, through the Postdoctoral General Dentistry Education Review Committee, to promote the quality of education within these programs. Some communities of interest have voiced concern that this accreditation has provided *de facto* specialty recognition to these areas, an action that has created confusion both inside and outside of the dental profession. For this reason, the Task Force strongly recommends that CODA openly collaborate with all communities of interest to resolve the perceptions vs. realities surrounding this issue.

The Task Force investigated the advantages and disadvantages of creating a formal memorandum of understanding (MOU) that defines the respective roles and responsibilities of the ADA and CODA. While this option works for several other accreditation agency/professional association models, the Task Force believes that an MOU for the ADA and CODA may become too cumbersome, too inflexible, and too broad and that it may also result in unintended consequences. However, because of the importance of resolving this issue, the Task Force recommends that a mechanism be established for the leadership of the ADA and the leadership of CODA to mutually review their relevant mission and purpose documents, as well as the roles and responsibilities of the ADA and CODA to determine where there are overlapping roles and responsibilities and then to clarify expectations.

Governance Recommendations

4. CODA and the ADA should maintain their current legal and fiscal relationship.

5. CODA and the ADA should clarify their respective roles, responsibilities and expectations and communicate these to their communities of interest.

6. CODA should openly collaborate with its communities of interest to resolve the issue of perceptions versus realities of CODA accrediting educational programs in non-recognized specialty areas of general dentistry and publicize the results of this process.

The Policies of CODA

The Task Force firmly believes that CODA policies are certainly within the range of accepted practice in accreditation. However, the Task Force discussed whether adopting some practices used by other accreditation agencies might improve the functioning of CODA and might also help CODA to evolve into a better organization.

The Task Force believes that the current meeting format for CODA is not sufficient to provide adequate and appropriate time and focus on accreditation decision making. Consequently, the Task Force recommends that the meeting format be changed to allow more time for these discussions.

The Task Force discussed the complex issues being addressed by CODA and the need for ongoing consistency in how decisions are made. In light of this, the Task Force discussed how calibration and training for commissioners could be improved. Additionally, the Task Force discussed the need for greater continuity on the commission and recommends that the term of the commissioners be changed from the current policy of one four-year term to one three-year terms which may be renewed for a second three-year term if desired by the sponsoring agency and by CODA.

The Task Force studied the composition of review committees and supports a new CODA policy that specifies that the number of specialist content experts assigned to a review committee may be flexible based on needs of the programs being reviewed. The current model is for one general dentist, one member of the public, and a minimum of four specialist content experts including the chair. The Task Force also believes that review committee members should be allowed to serve as site visitors, but that they may not serve both functions for the same program.

The Task Force confirmed the continued participation of a representative of the dental licensure community on each predoctoral site visit team, concluding that the licensure perspective is especially important, given the close link between graduation from an accredited program and eligibility for licensure. Additionally, the dental examiner may serve to meet USDE requirements for a practitioner on a site visit team.

Policy Recommendations

7. CODA should extend its meeting format to allow more time for discussion regarding accreditation decisions.

8. CODA should define the composition of the specialty review committees regarding the number of content experts, and should develop procedures for determining that a critical threshold of generalist, specialist and public members is available for each decision at the review committee level. (Note: The Task Force is not recommending any changes in review committee composition for predoctoral, dental hygiene, dental assisting, dental laboratory technicians, and advanced educational general dentistry/graduate programs.)

9. CODA should continue to include a public member on each review committee.

10. CODA should establish a system to permit an academic program to postpone its review if a critical threshold of generalist, specialist and public members is not available at that review committee meeting.

11. CODA should change the term of commissioners from the current policy of one four-year term to the possibility of two three-year terms if desired by the sponsoring agency and by CODA.

12. CODA should consider site visit flexibility including the authority to conduct unannounced site visits when deemed necessary. However, the Task Force does not support the concept of routinely conducting unannounced site visits at this time.

The Operating Procedures of CODA

The Task Force discussed the composition and functioning of CODA, the review committees and the site visit teams. The Task Force discussed and rejected the idea of review committees having more decision-making authority. The Task Force also discussed the advantages and disadvantages of flexible review cycles. Such a system would require the development of strict quantitative criteria to guide commission decision making regarding length of accreditation or review cycle to help the communities of interest distinguish between the messages inherent in differing cycle lengths.

The Task Force also discussed the use of professional, paid full-time site visitors and recommends that CODA explore the feasibility of instituting such a model as part of its strategic planning process.

The Task Force examined several elements in CODA's operating procedures. These included the nominations process, training and evaluation of commissioners, review committee members and site visitors, and CODA's voting procedures.

The Task Force confirmed that the structure for nominations appears to be satisfactory. CODA's Nominating Committee reviews the qualifications of all nominees, however, CODA needs to clarify that nominations are recommendations from the Nominating Committee and that all open seats for CODA should be filled from a slate containing multiple names when possible.

The Task Force also discussed the training and evaluation of commissioners, review committee members, and site visitors. It believes that training needs to be improved, as does the post-visit evaluation of site visitors. Currently, the system requires that the academic program evaluate each site visitor using a standardized format; however, a more comprehensive system for evaluating all members of the site visit team, including the chair, is necessary.

The Task Force believes that, in general, the voting procedure used during CODA meetings is satisfactory. It discussed and rejected recommending a change in voting policies that would have required a two-thirds majority for specified issues. It confirmed the current policy that all votes count equally. However, the Task Force is concerned that there is a perception, as reported through the research, that voting may not be from a profession-wide perspective. It is not clear whether individuals on CODA who are nominated by their respective special interest groups view their role on CODA as representing the interest of the specialty that nominated them or whether they understand that they are expected to leave portfolios behind once elected and view issues from a broad perspective. It is clear from research that the latter model is the most desirable. It is not clear to the Task Force if CODA demands this model and/or offers sufficient education regarding its expectations.

Operating Procedures Recommendations

13. CODA should enhance its pre-nomination education process that provides information regarding expectations and duties of commissioners, review committee members, and site visitors. This information should be made available by CODA to all communities of interest and interested individuals.

14. CODA should continue the nomination process it has initiated. This process calls for multiple nominations from each group with nominations to be evaluated by CODA's Nominating Committee based on criteria developed by CODA. The nomination process should be strongly articulated to all nominating communities.

15. CODA commissioners, review committee members, site visitors and volunteers should serve the interest of CODA without personal or member organization profiles or agendas. This policy should be clearly articulated internally, and strongly articulated externally to all relevant organizations that supply persons for positions on CODA or any of its working committees.

16. CODA should continue to develop and improve an orientation and training process for volunteers after the volunteer is selected but before the volunteer assumes the responsibilities of the position.

17. CODA should require all review committee members to observe at least one site visit.

18. CODA should require that all specialty areas of practice continue to be responsible for funding the formal training of site visitors and should provide content expertise for the training curricula. CODA staff should continue to conduct the training and assure that the training is well organized and consistent across all specialty areas.

19. CODA should require that all site visitors not participating in site visits at least every two years should participate in a training exercise.

20. CODA should establish a system by which all members of site visit teams, including the chair, are evaluated.

The Functionality of CODA

The Task Force focused on critical areas that it believes impact the functionality or the effectiveness of CODA. These areas are communications, continuous quality management, self-evaluation and strategic planning. Recommendations are included for each area.

The Task Force concludes that CODA requires a cultural change in how it sees its role with respect to its communities of interest and how it communicates with them. The Task Force noted that the research and recommendations regarding all areas of CODA functioning confirm the need for better communications from CODA. Concerns focused on the level of information being provided regarding accreditation decisions, CODA operations, and proactive opportunities to get feedback from communities of interest. There appears to be a perception that people do not know what CODA is doing or how it does it. The Task Force believes that CODA should be more transparent in all phases of its operations. Furthermore, CODA needs to seriously address what is perceived by some communities of interest as a tarnished image. These efforts will require a focused approach, led by an individual with specific expertise in communications who can design and oversee the implementation of a communications and public relations plan. The Task Force believes that this individual should not be assigned to CODA from the ADA Communications area. Though equally important, CODA and ADA audiences are different. CODA messages need to be distinct and focused on accreditation. There needs to be an arm's length relationship between the two entities with regards to communications to CODA's communities of interest.

The Task Force confirmed the need for confidentiality with regards to accreditation decision-making discussions and recommends that this be maintained. However, the Task Force recommends that CODA provide opportunities for more involvement in CODA meetings by its communities of interest, to the extent this is possible, given the need for confidentiality in certain matters

Functionality Recommendations

21. CODA should communicate more effectively with its communities of interest by improving the quality and content of its communications. The processes of communication should also be improved.

22. CODA should focus its communications efforts on increasing transparency and accountability as well as communicating the value/outcomes of accreditation.

23. CODA should use outside expertise to assess its current communications efforts and assist in the development and implementation of a detailed communications and public relations plan.

24. CODA should create a dedicated staff position requiring specific expertise in communications to sustain the implementation of its communications plan and to assist in cultural change.

25. CODA should view this effort toward cultural change not just as increasing communication but as a change in its culture regarding transparency, accountability, and responsiveness. This cultural change should be emphasized at the beginning of each CODA meeting.

CODA's use of best practices in accreditation

Based on the benchmarking study, there appear to be technologies used by other accreditation agencies that CODA should be exploring. The Task Force believes that enhanced technology can help foster the concept of "continuous readiness" both to make CODA more responsive to the needs of its communities of interest and to help accredited programs maintain continuous compliance with the standards. This may include the use of enhanced technology to conduct periodic performance reviews for each standard, provide more continuous monitoring of programs, have programs report significant changes to CODA as they occur, create the capacity to respond to program changes more rapidly, utilize alternative methods for site visits including continuous surveillance electronically, and provide opportunities for programs to improve their own continuous readiness and quality systems.

CODA's use of best practices in accreditation Recommendations

26. CODA should establish ongoing evaluation measures to systematically monitor the use of CODA accreditation and its perceived value. This implies the use of an ongoing quality management program tied to strategic planning.

27. CODA should design and implement a quality management system and seek outside assistance in the design as needed from a quality management system expert.

28. CODA should use an outside facilitator to design and support its strategic planning efforts.

CODA's strategic planning efforts should examine (but not be limited to) the following:

- Development and implementation of an ongoing strategic planning process and the establishment of a committee to continue effective strategic planning.
- Reassessment of its meeting format in light of its primary focus of accreditation decisions.
- Consideration of the concept of flexible review cycles.
- Consideration of other models for site visits, such as the use of professional site visitors or the use of fewer site visitors used more frequently to enhance consistency and reliability.
- Consideration of important changes that may affect its operations including expansion of scope and international issues.
- Consideration of its continuing effectiveness and the appropriateness of its structure.

29. CODA should explore alternative methods, including the use of enhanced technology for monitoring programs' continuous compliance with the standards.

30. CODA should evaluate and adopt new technological advances in accreditation for reporting and management of information. This could reduce the burden on CODA as well as the programs it accredits, and thus allow accreditation to move toward the concepts of continuous assessment, data collection, and readiness.

CODA's <u>continued affiliation with the United States Department of Education (USDE)</u>

The Task Force determined that USDE does not require the inclusion of public members on non-decision making bodies, such as review committees. However, the Task Force strongly supports their inclusion on review committees as a best practice of accreditation.

Although CODA accreditation is not required for students to participate in the Federal student financial assistance program administered by USDE under Title IV of the Higher Education Act of 1965, as amended. The Task Force is convinced that USDE recognition provides significant real and potential financial advantages to dental education programs and students in many other ways. There are significant sources of federal funding including funding programs in the Centers for Medicare and Medicaid Services and through the Public Health Services Act that would not be able to be accessed by the dental education community if CODA were no longer recognized by USDE.

In addition to the financial benefits of recognition, the value of being recognized as an accrediting agency by an agency such as USDE is increasing as Congress, the public and the academic community are demanding more value, transparency and accountability from accreditation agencies. The benchmarking study demonstrates that the general perspective in the accreditation community is that USDE recognition is very valuable. USDE recognition adds credibility to the agency and to the processes it uses.

Groups that do not apply for USDE recognition, such as the Accreditation Council for Graduate Medical Education (ACGME), may be recognized by other appropriate U.S. Government agencies so that their accredited educational programs can use relevant federal funding.

The Task Force believes that obtaining accreditation by ACGME, a medically based accreditation agency, could present significant challenges for any dental specialty that sought such accreditation. For example, ACGME requires specialties to be recognized by the American Board of Medical Specialties (ABMS); ABMS currently only recognizes non-degree granting residency programs. Because many dental specialty programs grant degrees, these programs would not be eligible for recognition by ABMS. Additionally, scope of practice issues would be adjudicated among medical specialties that may have limited understanding of the dental profession. The Task Force believes that accreditation of dental specialties by ACGME could negatively impact the profession of dentistry.

Several accrediting agencies that are not eligible for any federal recognition, and some that are, have chosen to become recognized by the Council for Higher Education Accreditation (CHEA). CODA had previously investigated becoming recognized by CHEA, but at the time, it appeared that CODA would not be eligible for CHEA recognition because of the percentage of degree granting programs it accredits. During its research, the Task Force determined that CHEA policies appear to have changed in this regard. The Task Force is not certain that additional recognition by CHEA would provide any advantage to CODA but encourages CODA to explore this possibility. A more relevant possibility for CODA, in light of its international efforts as well as the rapid globalization in the dental practice community through outsourcing of dental services and the growth of dental tourism, may be seeking recognition by the American National Standards Institute (ANSI) if it operationalizes its proposed recognition program for accreditation agencies under an International Organization for Standardization (ISO) standard.

CODA's continued affiliation with the United States Department of Education (USDE) Recommendations

31. CODA should maintain its recognition by USDE.

32. CODA should monitor how USDE recognition influences funding for dental education programs.

33. CODA should explore advantages of recognition by additional agencies such as the Council for Higher Education Accreditation (CHEA). CODA decision(s) regarding recognition by another agency should not be in lieu of USDE recognition.

34. CODA should monitor the progress of the proposed American National Standards Institute (ANSI/ISO) recognition system for accreditation agencies as it develops, and, if appropriate, investigate the advantages and disadvantages of also becoming recognized under this system.

Summary of Recommendations

1. Recommendations regarding the Structure of CODA

1. CODA should restructure to better meet the current and future needs of the dental profession and the public.

2. CODA should conduct a comprehensive investigation of appropriate structures. This investigation should build on and extend the work of the Task Force.

3. CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure.

2. Recommendations regarding the Governance of CODA

4. CODA and the ADA should maintain their current legal and fiscal relationship.

5. CODA and the ADA should clarify their respective roles, responsibilities and expectations and communicate these to their communities of interest.

6. CODA should openly collaborate with its communities of interest to resolve the issue of perceptions versus realities of CODA accrediting educational programs in non-recognized specialty areas of general dentistry and publicize the results of this process.

3. Recommendations regarding the Policies of CODA

7. CODA should extend its meeting format to allow more time for discussion regarding accreditation decisions.

8. CODA should define the composition of the specialty review committees regarding the number of content experts, and should develop procedures for determining that a critical threshold of generalist, specialist and public members is available for each decision at the review committee level. (Note: The Task Force is not recommending any changes in review committee composition for predoctoral, dental hygiene, dental assisting, dental laboratory technicians, and advanced educational general dentistry/graduate programs.)

9. CODA should continue to include a public member on each review committee.

10. CODA should establish a system to permit an academic program to postpone its review if a critical threshold of generalist, specialist and public members is not available at that review committee meeting.

11. CODA should change the term of commissioners from the current policy of one four-year term to the possibility of two three-year terms if desired by the sponsoring agency and by CODA.

12. CODA should consider site visit flexibility including the authority to conduct unannounced site visits when deemed necessary. However, the Task Force does not support the concept of routinely conducting unannounced site visits at this time.

4. Recommendations regarding the Operating Procedures of CODA

13. CODA should enhance its pre-nomination education process that provides information regarding expectations and duties of commissioners, review committee members, and site visitors. This information should be made available by CODA to all communities of interest and interested individuals.

14. CODA should continue the nomination process it has initiated. This process calls for multiple nominations from each group with nominations to be evaluated by CODA's Nominating Committee based on criteria developed by CODA. The nomination process should be strongly articulated to all nominating communities.

15. CODA commissioners, review committee members, site visitors and volunteers should serve the interest of CODA without personal or member organization profiles or agendas. This policy should be clearly articulated internally, and strongly articulated externally to all relevant organizations that supply persons for positions on CODA or any of its working committees.

16. CODA should continue to develop and improve an orientation and training process for volunteers after the volunteer is selected but before the volunteer assumes the responsibilities of the position.

17. CODA should require all review committee members to observe at least one site visit.

18. CODA should require that all specialty areas of practice continue to be responsible for funding the formal training of site visitors and should provide content expertise for the training curricula. CODA staff should continue to conduct the training and assure that the training is well organized and consistent across all specialty areas.

19. CODA should require that all site visitors not participating in site visits at least every two years should participate in a training exercise.

20. CODA should establish a system by which all members of site visit teams, including the chair, are evaluated.

5. Recommendations regarding the Functionality of CODA

21. CODA should communicate more effectively with its communities of interest by improving the quality and content of its communications. The processes of communication should also be improved.

22. CODA should focus its communications efforts on increasing transparency and accountability as well as communicating the value/outcomes of accreditation.

23. CODA should use outside expertise to assess its current communications efforts and assist in the development and implementation of a detailed communications and public relations plan.

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6. Recommendations regarding CODA's use of best practices in accreditation

26. CODA should establish ongoing evaluation measures to systematically monitor the use of CODA accreditation and its perceived value. This implies the use of an ongoing quality management program tied to strategic planning.

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- Development and implementation of an ongoing strategic planning process and the establishment of a committee to continue effective strategic planning.
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- Consideration of the concept of flexible review cycles.

- Consideration of other models for site visits, such as the use of professional site visitors or the use of fewer site visitors used more frequently to enhance consistency and reliability.
- Consideration of important changes that may affect its operations including expansion of scope and international issues.
- Consideration of its continuing effectiveness and the appropriateness of its structure.

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30. CODA should evaluate and adopt new technological advances in accreditation for reporting and management of information. This could reduce the burden on CODA as well as the programs it accredits, and thus allow accreditation to move toward the concepts of continuous assessment, data collection, and readiness.

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31. CODA should maintain its recognition by USDE.

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34. CODA should monitor the progress of the proposed American National Standards Institute (ANSI/ISO) recognition system for accreditation agencies as it develops, and, if appropriate, investigate the advantages and disadvantages of also becoming recognized under this system.

Attachments and References*

Attachment 1. Names of the Task Force members and information about the Plexus Consulting Group

Attachment 2. List of the background documents provided to the Task Force

Attachment 3. List of organizations invited to participate in the Advisory Group (and those organizations that submitted papers and/or presentations)

Attachment 4. Summary of electronic survey

Attachment 5. Summary of findings of the telephone interviews (including list of participants in the telephone surveys)

Attachment 6. Benchmarking study

Attachment 7. Report on focus groups

Attachment 8. CODA and USDE Report

Attachment 9. Bibliography of additional materials reviewed

***NOTE: Due to the number and size of the attachments, these documents can be found on ADA.org, House of Delegates page: www.ada.org/ada/about/governance/hod_2008_resolutions.asp**

Attachment 1: Task Force on the Commission on Dental Accreditation (CODA) Names of the Task Force Members May 2007

Task Force Chair:

David Whiston, D.D.S., past president, ADA; Arlington, Virginia

Task Force Members:

(noting specific position held as it related to the Task Force selection criteria in ADA Board of Trustees Resolution)

Patricia Blanton, D.D.S., member, ADA House of Delegates; Dallas, Texas

Donald Cadle, D.M.D., trustee, ADA, seventeenth district; New Port Richey, Florida

William Calnon, D.D.S., trustee, ADA, second district; Rochester, New York

Mark Christensen, D.D.S., dental examiner; Salt Lake City, Utah

Henry Fields, D.D.S., former dean and former member of the Council on Dental Education and Licensure; Columbus, Ohio

Linda Himmelberger, D.M.D., dental examiner and former member of the Council on Dental Education and Licensure; Berwyn, Pennsylvania

Jeffrey Hutter, D.M.D., MEd., member, Commission on Dental Accreditation; Boston, Massachusetts

Kenneth Kalkwarf, D.D.S., dean, University of Texas, San Antonio; San Antonio, Texas

Karen Kershenstein, Ph.D., public member; Fairfax Station, Virginia

Roger Kiesling, D.D.S., member, Council on Dental Education and Licensure; Helena, Montana

Larry Nissen, D.D.S., member, Commission on Dental Accreditation; Merritt Island, Florida

Ex-Officio

Mark Feldman, D.M.D., president, ADA; Roslyn, New York

Plexus Consulting Group, LLC

Plexus Consulting Group, LLC (Plexus) is a Washington, DC-based management consulting firm specializing in providing accreditation and certification services, market research, and strategic planning facilitation to not-for-profit organizations around the world. Over the past decade, Plexus has worked with approximately 200 associations and not-for-profit agencies and its assignments have included a number of certification and accreditation projects.

Sharon M. Goldsmith, PhD, directs the Certification, Education and Accreditation Practice at Plexus Consulting Group. In this role, she assists associations, primarily in the health care industry, to develop new certification and accreditation programs or improve and expand existing programs based on international best practices and industry needs. Her experience includes directing the national healthcare standards initiative for the U.S. National Skills Standards Board, and serving as Senior Advisor, Standards and Credentialing and Director of Professional Affairs for the American Speech-Language and Hearing Association (ASHA). Dr. Goldsmith is an internationally recognized expert on standards development, certification and accreditation. She currently serves on several national boards addressing standards, accreditation and certification issues including the American National Standards Institute (ANSI) Personnel Certification Accreditation Committee where she implemented a new ISO standard for personnel certification programs. Dr. Goldsmith earned her PhD in psycholinguistics from the Graduate School and University Center of the City University of New York.

Paul Duffy, PhD, a consultant with Plexus, has thirty years experience in various research and consulting assignments. In 1980, Dr. Duffy co-founded Market Dynamics Inc. (MDI), a full-service national marketing research firm, in Tysons Corner, Virginia. MDI provided wide-ranging research services to blue-chip clients in consumer goods, financial services, manufacturing, advertising and communications. Dr. Duffy received his MA and PhD in Industrial-Organizational Psychology from Southern Illinois University. Dr. Duffy is an Adjunct Professor of Marketing at Johns Hopkins University and George Mason University.

Steven Worth, president of Plexus Consulting Group, has extensive experience in assisting businesses, governments and associations with their public affairs, government relations, and strategic planning needs. This includes designing and implementing strategies to create two world federations of not-for-profit organizations, a global educational foundation, a national trade association and numerous trade and political coalitions. He has an advanced degree from the Sorbonne and l'Ecole des Sciences Politiques in Paris and an undergraduate degree from Georgetown University. In addition, he teaches graduate level courses in marketing at Johns Hopkins University.

Attachment 2:
Task Force on the Commission on Dental Accreditation (CODA) List of the Background Documents Provided to the Task Force May 2007

General Reference

- ADA Constitution and Bylaw

Commission on Dental Accreditation (CODA)

- CODA Informational Brochure
- Rules of the Commission on Dental Accreditation
- Commission Operational Policies and Procedures (OPP), revised July 2006
- Commission Evaluation Policies and Procedures (EPP), revised July 2006
- Lists of Accredited Programs ("Dental Education Programs," January 2007)
  - Predoctoral Dental Education Programs
  - Advanced Specialty and Postdoctoral General Dentistry Education Program
  - Dental Assisting, Dental Hygiene and Dental Laboratory Technology Education Programs
- Commission Web Pages (Internet pages on www.ada.org, May 2, 2007)
- CODA Finances Summary
- CODA Outcomes Assessment resource document
- Commission on Dental Accreditation Operational Effectiveness Assessment Plan
- Commission on Dental Accreditation Frequently Asked Questions, September 2006
- Commission on Dental Accreditation Self Assessment in Response to ADA Resolution 119H-2002
- Commission Accreditation Standards for All Disciplines (Available on site or see ADA.org at http://www.ada.org/prof/ed/accred/standards/index.asp.
  - Predoctoral Dental Education Programs
  - Advanced Education Programs in General Practice Residency (GPR)
  - Advanced Education Programs in General Dentistry (AEGD)
  - Advanced General Dentistry Education Programs in Dental Anesthesiology
  - Advanced General Dentistry Education Programs in Oral Medicine
  - Dental Assisting Education
  - Dental Hygiene Education

- Dental Laboratory Technology Education
- Advanced Specialty Education Programs in Dental Public Health
- Advanced Specialty Education Programs in Endodontics
- Advanced Specialty Education Programs in Oral and Maxillofacial Radiology
- Advanced Specialty Education Programs in Oral and Maxillofacial Pathology
- Advanced Specialty Education Programs in Oral and Maxillofacial Surgery
- Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery
- Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics
- Advanced Specialty Education Programs in Pediatric Dentistry
- Advanced Specialty Education Programs in Periodontics
- Advanced Specialty Education Programs in Prosthodontics

Previous Reports and ADA Studies of CODA

- Protocol for Orientation of New American Dental Association Appointees to the Commission on Dental Accreditation

- Report 20 of the Board of Trustees to the House of Delegates: Study of the ADA Relationship with the Commission on Dental Accreditation (B-92 Report)

- B-92 Talking Points (6/15/04)

- Related Reports

  *Report of the Commission on Dental Accreditation Regarding Costs Associated with its Accreditation Program and Proposed Steps to Reduce the Overall Cost

  *Report of the Special Committee to Study the Council on Dental Education and Commission on Dental Accreditation Structure (Report to the 1992 HOD)

  *Report 17 of the Board of Trustees to the House of Delegates: Activities to Address Concerns Related to the Cost of Dental Education and Accreditation (1993)

  *Report 6 of the Board of Trustees to the House of Delegates: Progress Report on Resolution 76-1994 and the Study of the Commission on Dental Accreditation (1995)

  *Report 18 of the Board of Trustees to the House of Delegates: Study of the Commission on Dental Accreditation (1996)

- ADA Resolutions and CODA Actions 1998 – 2006

- Board of Trustees Questions Regarding the Commission on Dental Accreditation, April 2007

- Criteria for Council/Commission Nominees; ADA Appointees

- Protocol for Orientation of New ADA Appointees; Orientation of ADA Appointees

U.S. Department of Education (USDOE)

- USDOE—Final Staff Report of the Petition for Continued Recognition Submitted by the American Dental Association, Commission on Dental Accreditation (6/5-7/2006), includes petition

- Correspondence from Margaret Spellings to Dr. David M. Preble, director, CODA, regarding recognition of ADA as a nationally recognized accrediting agency (12/12/06)

- Federal Funding Program Links to Accredited Education Programs.

CODA Restructure of Review Committees

- Correspondence from Joyce F. Jones, USDOE, Office of Postsecondary Education Accreditation and State Liaison to Karen Hart, director, CODA, requesting procedural changes to CODA's review process (2/5/04)

- CODA—Report of the Ad Hoc Committee on Structure and Function of Review Committees (1/06)

- Correspondence from Dr. Laura M. Neumann, interim director, CODA and AED, Education, to Joyce Jones, addressing implementation of changes (2/6/06)

- Correspondence from Dr. Laura Neumann, interim director, CODA, to Joyce Jones (10/20/05)

- Response from Joyce Jones (11/1/05)

AAOMS / ADA Correspondence

- Correspondence—AAOMS Letter Regarding ACGME Accreditation of Oral and Maxillofacial Surgery Residency Programs (1/22/07)

- Correspondence from President Roth to Dr. Mark Tucker, president, AAOMS (1/10/07)

- Correspondence from Dr. Tucker to Dr. Roth (2/16/07)

- Correspondence from Dr. Roth to Dr. Tucker (2/22/07)

- Memo from Dr. David Preble, director, CODA, CODA Information Requested by Dr. Brandjord re: addition of review committee experts at the request of Oral Surgery (2/21/07), and Summary—Action Items Adopted by CODA in Direct Response to AAOMS Concerns/Requests

- April BOT reports and subsequent correspondence

- Follow-up correspondence between Drs. Roth and Tucker (4/07)

Accreditation Overview

- Definitions
- Accreditation in the United States (includes USDE criteria for recognition)
- U.S. Department of Education—Accreditation in the United States (List of National Institutional and Specialized Accrediting Bodies)
- Liaison Committee on Medical Education
- Accreditation and Program Approval (American Osteopathic Association Commission on Osteopathic College Accreditation)
- Council for Higher Education Accreditation (CHEA)—Informing the Public About Accreditation
- CHEA Talking Points
- CHEA, an overview of U.S. Accreditation
- Association of Specialized and Professional Accreditors (ASPA) Accreditation Overview: Accreditation in the United States
- ASPA Member Code of Good Practice

Accreditation Council for Graduate Medical Education (ACGME)

- ACGME Fact Sheet
- Accreditation Council for Graduate Medical Education (ACGME)

  *The ACGME at a Glance

  *ACGME Mission, Vision and Values

  *The Accreditation Council for Graduate Medical Education (ACGME)—The Role of the ACGME; The Accreditation Process; The Accreditation Site Visit; Resident Duty Hours Standards; ACGME Staff

  *ACGME Board of Directors

  *Member Orgnizations

  *ACGME Policies and Procedures

  *Institutional Requirements

  *Understanding the Difference Between Accreditation, Licensure & Certification

  *History of Medical Education Accreditation

- ACGME Outcome Project
- ACGME Strategic Plan

Miscellaneous

- USDE Staff report to NACIQI on ABA, 1998
- ADHA Correspondence to USDE, July 1999
- ADEA Correspondence to ADA, 1997-98 and Responses (3 letters)

05.07

Attachment 3:
Task Force on the Commission on Dental Accreditation (CODA)
List of Organizations invited to participated in the Advisory Group and Presenters at the Task Force on CODA Meeting
October 31, 2007
Chicago, Illinois

American Association of Hospital Dentists
Presenter: Dr. Harold Livingston, secretary, Madison, MS

American Association of Orthodontists
Presenters: Dr. William Gaylord, president, Flagstaff, AZ, and Mr. Chris Vranas, executive director, St. Louis, MO

National Association of Dental Laboratories
Presenter: Mr. Bennett Napier, co-executive director, Tallahassee, FL

American Dental Education Association
Presenters: Dr. James Swift, president, ADEA, Minneapolis, MN, and Dr. Cyril Meyerowtiz (representing post-graduate education in general dentistry), Rochester, NY, Dr. Richard Valachovic, executive director, and Ms. Gina G. Luke, director of legislative policy development, Washington, DC

American Association of Oral and Maxillofacial Surgeons
Presenter: Dr. Lee Pollan, president, North Chili, NY
Also attending: Dr. W. Mark Tucker, past president, Tampa, FL, and Ms. Randi Andresen, associate executive director, Rosemont, IL

American Academy of Oral Medicine
Presenter: Dr. Craig Miller, treasurer, Lexington, KY

American Association of Public Health Dentistry
Presenters: Dr. Caswell Evans, president, Chicago, IL, and Ms. Pamela Tolson, executive director, Springfield, IL

American Dental Hygienists' Association
Presenter: Ms. Colleen Schmidt, RDH, director of education, Chicago, IL

American Academy of Oral and Maxillofacial Pathology
Presenter: Dr. Valerie Murrah, president-elect

American Academy of Oral and Maxillofacial Radiology
Presenter: Dr. Laurie C. Carter, president-elect, Midlothian, VA

American Association of Endodontists
Presenter: Dr. Shepard Goldstein, president, Framingham, MA and Mr. James Drinan, executive director, Chicago, IL

American Academy of Periodontology
Presenter: Dr. Gerald Bowers, executive director, Pasadena, MD

American Society of Dentist Anesthesiologists
Presenter: Dr. Joel Weaver, president, Westerville, OH

Academy of General Dentistry
Presenters: Dr. Joseph A. Battaglia, AGD Dental Care Council, Wayne, NJ, and Ms. Becky Murray, assistant director of education, Chicago, IL

American Association of Dental Examiners
Presenters: Dr. Guy Shampaine, AADE representative, Annapolis, MD, and Ms. Molly Nadler, executive director, Chicago, IL

American College of Prosthodontists
Presenter: Dr. Arthur Nimmo, past president, Gainesville, FL

American Academy of Pediatric Dentistry
Presenter: Dr. Keith Morley, president, Barrie, Ontario

*__Commission on Dental Accreditation of Canada__ submitted a paper, but elected not to send a representative

**__American Student Dental Association__ was invited to participate, but declined the invitation

04.22.08

Attachment 4:
SUMMARY OF THE ELECTRONIC SURVEY
Summary of the report prepared by
Plexus Consulting Group
March 2008

OBJECTIVE

The purpose of the present study was to conduct a survey among a variety of audiences regarding strategic issues of relevance to the American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA).

This survey is only one element of the overall research project devoted to the objective of CODA strategic planning. Specifically, the other research efforts include a series of personal interviews, focus groups, written papers and oral presentations from invited groups as well as benchmarking of other pertinent organizations confronting similar challenges. In this regard, the present findings represent a complement to those other research efforts, and the present results should be viewed as only one element within this overall context.

APPROACH

The present survey was conducted through an online questionnaire. The sample frame of respondents was drawn from relevant ADA and CODA databases, and included only people with valid email addresses.

The online survey procedure included an announcement email sent to all valid email addresses contained in the sample frames soliciting cooperation and response to the questionnaire. A link to the questionnaire was included in the email to facilitate ease of response. About ten days after the initial email, a reminder email was sent to all non-responders. The total number of outgoing emails was 5,056.

A total of 1,258 respondents provided usable responses to the questionnaire, representing an overall participation rate of 25 percent. For results based on the total sample of respondents, one can say with 95 percent confidence that the maximum margin of sampling error is ±2.4 percent. In addition to sampling error, question wording and practical difficulties in conducting surveys can introduce other types of error or bias into the findings of any survey procedure.

The survey procedure was designed to include several respondent segments (audiences) of interest. In particular, the survey included the following specific segments; including the number in the original sample frame (Outgoing), the actual number completed (Completed) and the associated segmented response rates.

Electronic Survey Results

	Completed	**Outgoing**	**Response Rate**
Advisory Group/Task Force			
TF Advisory Group	17	55	30.9%
Task Force itself	8	15	53.3%
Policy Makers			
ADA Board of Trustees	11	39	28.2%
Council on Dental Education & Licensure	4	29	13.8%
Delegates to the ADA HOD	220	827	26.6%
Academicians			
Deans (of all CODA accredited programs)	50	534	9.4%
Faculty (of all CODA accredited programs	440	949	46.4%
CODA			
CODA Commissioners	28	68	41.2%
CODA Review Committee members	17	41	41.5%
CODA Site Visitors	341	1024	33.3%
Dental Examiners			
Dental Examiners	97	459	21.1%
CODA Staff (ADA)			
CODA Staff (ADA)	8	17	47.1%
(Not included)			
New Dentists (random ADA members)	12	999	1.2%
Total	**1253**	**5056**	**24.8%**

Response rates varied across the segments. In addition, some segments, by their very definition, resulted in relatively small base sizes of respondents. Therefore, the decision was taken to combine selected segments for purposes of this report, as indicated by the color coding in the table above. In this regard, it must be noted that the New Dentists segment is not included in the present report because its small base size cannot reasonably be considered to be at all representative of that segment.

Separate sets of banner tabulations of all of the items in the survey have been delivered. One set of tabulations includes the combined segments as noted above, and the other set contains the results for each individual segment (including New Dentists). Appropriate tests of statistical significance were applied to these results to identify differences among the segments.

FINDINGS

Current Teaching/Practice Area
Respondents were asked to indicate the area in which they currently teach or practice. The largest single category was General Dentistry.

ADA and CODA
The first series of questions concerned respondent opinions about the relationship between ADA and CODA. Overall, the greatest agreement was shown for the item 'The relationship between ADA and CODA is excellent', and the greatest disagreement concerned 'The relationship between ADA and CODA should be more tightly coordinated' (the reference line in the following figure is the overall mean across all items and all segments). The results also showed that there are rather marked and statistically significant differences of opinion among the segments. For example, Policy Makers are more likely to believe that 'the relationship between ADA and CODA should be more tightly coordinated' and that 'communication between ADA and CODA needs substantial improvement' than do nearly all other segments. The table following the chart contains the results showing which of the differences among segments are statistically significant.

Respondents also were asked for their open-ended comments regarding what could/should be done to enhance the relationship between ADA and CODA. These responses were coded to identify similarities among the responses. While the most frequent response was "don't know", a reasonable number of respondents also mentioned minimal or no ADA involvement with CODA, as well as improved communications.

Operations
In terms of CODA operations, most segments tended to give relatively low ratings to these items, particularly the Advisory Group/Task Force and Policy Makers. In contrast, CODA Staff tended to give relatively high ratings. Overall, the greatest agreement was that 'Current CODA operations promote the highest possible quality of education/training for the dental profession', and the greatest disagreement was expressed for 'The dental profession understands the relationship of the various components of CODA'

The three most frequent open-ended comments about CODA operations were "communications, "don't know" and "transparency".

Public Role

Respondents overall tended to disagree with the items concerning the public role in CODA. In other words, the prevailing sentiment tended to be in the direction of slightly downplaying a greater public role in CODA. The most agreement was expressed for 'The public (patients/consumers) is adequately represented in the Commission's accreditation process', while the greatest disagreement was shown for 'The public is sufficiently aware of the issues with which CODA deals'. As with other topic areas, there also were differences of opinion among the segments. For instance, Policy Makers tended to believe more strongly than other segments that the public is overrepresented in the CODA process, while Dental Examiners tended to believe more strongly that the public should have a greater role.

Asked about various aspects of CODA quality indicators, respondents generally agreed with most of the items. Overall, the greatest agreement was expressed for 'CODA accreditation supports the quality of graduating students', while the lowest agreement was shown for 'CODA accreditation supports the quality of research faculty'. In terms of segment differences, both Academicians and CODA Staff tended to show more agreement with the items than did most other segments.

The three most frequent open-ended comments about quality were "don't know," "accreditation does not ensure quality" and "increased education and awareness".

Transparency

Overall, respondents gave fairly average marks to CODA in terms of transparency. The highest agreement was shown for the statement 'CODA has always treated me/us professionally'. The lowest agreement was that 'CODA is transparent in how it sets standards'. In addition, there were consistent differences of opinion between segments. Specifically, CODA Staff, CODA and Academicians expressed considerably more agreement with each statement than did nearly all other segments.

Many respondents reported not understanding how CODA operates. The lowest agreement was that 'CODA is transparent in how it sets standards'. In addition, there were consistent differences of opinion between segments. Specifically, CODA Staff, CODA and Academicians expressed considerably more agreement with each statement than did nearly all other segments. Overall, respondents gave fairly average marks to CODA in terms of transparency. The highest agreement was shown for the statement 'CODA has always treated me/us professionally.'

Experience with Other Accrediting Organizations
About four out of ten respondents had some sort of experience with an accrediting organization(s) other than CODA. And a majority of respondents either perceived no difference in the effectiveness of other accrediting organizations compared to CODA or they simply said they don't know enough to express an opinion.

Asked whether there are any feature(s) of other accrediting organization(s) that CODA might want to incorporate, there was no consistent pattern to the responses for this question. The comment that arose most often is that CODA should make the processes more effective and easy to understand.

CODA Funding and Fee Structure
Overall, most respondents said they do no know whether the current CODA funding and fee structure is appropriate. CODA Staff, CODA and Academicians were more likely than other segments to say that it is appropriate, while Policy Makers and Dental Examiners were more likely to say they don't know.

Negative Experience with CODA
Three quarters of respondents overall said they have not had a negative experience with CODA. Among those who have had a negative experience, they tended to say the resolution of the problem was either unsatisfactory or neither satisfactory nor unsatisfactory.

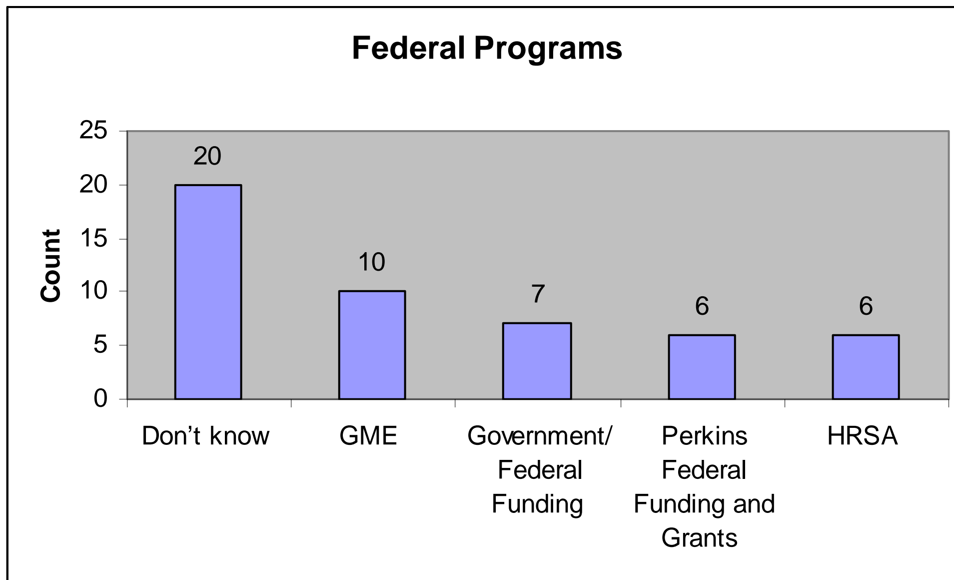
Asked about the nature of that negative experience, the most frequently mentioned was "problems with the site visit", followed by "problems with CODA staff," and "difficulty with accreditation of specialty programs".

Standards
Overall, most respondents tended to disagree with the various items about accreditation standards. For example, the greatest disagreement was shown for 'Dental education program accreditation should be eliminated', while no item gained even a rating or Neither Agree or Disagree. In terms of segments, Dental Examiners tended to be more favorable toward 'Dental education program accreditation should be performed by an industry neutral third party', while Academicians tended to be more favorable toward 'Dental education program accreditation should be eliminated' compared to most other segments.

U.S. Department of Education
Overall, respondents were generally favorable to the items regarding U.S. Department of Education recognition of CODA. For instance, the highest agreement was shown for ‘CODA should continue to be recognized as an accrediting agency by the US Department of Education’; while the lowest agreement was shown for ‘US Department of Education recognition of CODA provides no benefit to our program’. There were some isolated segment differences of opinion among segments, but not in a markedly consistent manner.

In addition, respondents indicated that U.S. Department of Education (USDE) recognition is generally important to their program. However, many of them also indicated that they did not know how much their program’s funding is dependent on such recognition. Academicians and CODA were more likely to say none or very little funding is dependent on USDE recognition.

Among those who said CODA accreditation supports their program’s participation in any federal programs, they also were asked to identify those specific programs. The following chart displays the programs mentioned by more than five respondents.



Withdraw CODA Accreditation
Overall, respondents did not indicate that CODA should discontinue accreditation of any program type.

Types of CODA Accreditation
A clear majority of respondents overall said they don't know whether CODA is equally strong across Pre-doctoral education, Post-graduate/advanced dental education, and Allied professional education.

Among those who said CODA is not equally strong across all areas, they indicated that its strongest area is Pre-Doctoral education, and its weakest area is Allied professional education and Postgraduate education.

A plurality also said they believe CODA should be structured to include separate committees to concentrate on particular areas of accreditation, while almost as many said they don't know.

Those who said there should be separate committees were asked to explain their opinion. The response that was most frequently given was that there should be committees composed of experts knowledgeable in specific areas. The most common response on divisions was that the committees should be divided based on specialty areas. Another response, though much less frequent, was that the current system is adequate and no changes are needed in the committee structure.

Almost half also said it would be an advantage for CODA to have separate accrediting agencies for Pre-Doctoral, Postgraduate and Allied programs.

And a strong majority said all Pre-Doctoral schools should have the same minimum clinical requirements for graduation.

Among those who said there should be identical minimum clinical requirements, they also were asked how that opinion relates to the issue of "innovative curriculums." The most common response is that "innovative curriculums" should have to meet the same minimum requirements as the traditional programs and most curriculums are designed to have more clinical experience than the traditional programs.

Selecting CODA Personnel
Most respondents said they don't know if there is a better way to select CODA Commissioners.

Those who said there is a better method to select commissioners were also asked how that can be accomplished. The most frequent response to this question is to utilize nominations for the commissioners as the best way to develop a pool of potential members who are highly regarded in the dental community.

Those who said there is a better method to select commissioners were also asked how that can be accomplished. The most frequent response to this question is to utilize nominations for the commissioners as the best way to develop a pool of potential members who are highly regarded in the dental community.

Respondents also were similarly unsure if there is a better way to select CODA Review Committee members.

The one comment that was stated several times is that there needs to be a balance in the review committee among the specialties, experts and public member. There were some respondents who felt the public member should not be a part of the review committee.

Respondents were also uncertain if there is a better way to select CODA Site Visitors.

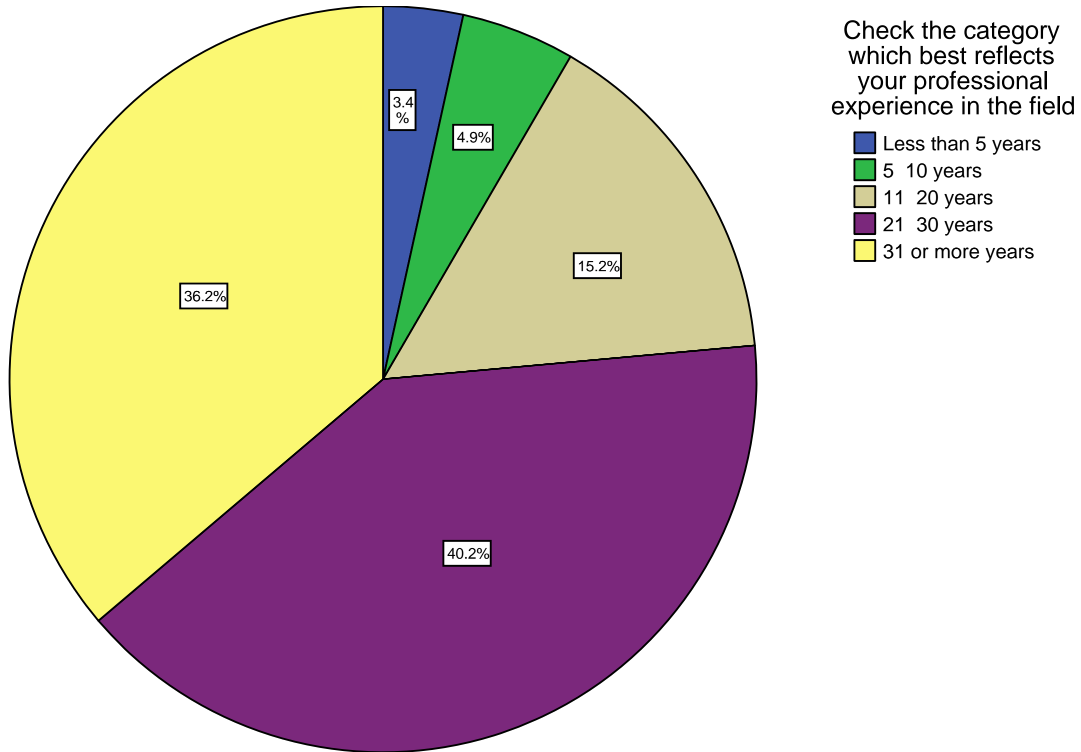
The most common answer to this question was to administer surveys following site visits in order to analyze and select the best team members. Additionally, administering standardized training programs would increase the quality of these individuals.

There were differences among the segments on these personnel selection issues, with Advisory Group/Task Force, CODA and CODA Staff tending to say there were not better methods, while the other segments tended to be more uncertain.

Confidence in CODA

Overall confidence in the CODA accreditation process was reasonably high among all respondents. CODA Staff expressed the highest confidence, while Policy Makers and Advisory Group/Task Force respondents tended to express the least confidence.

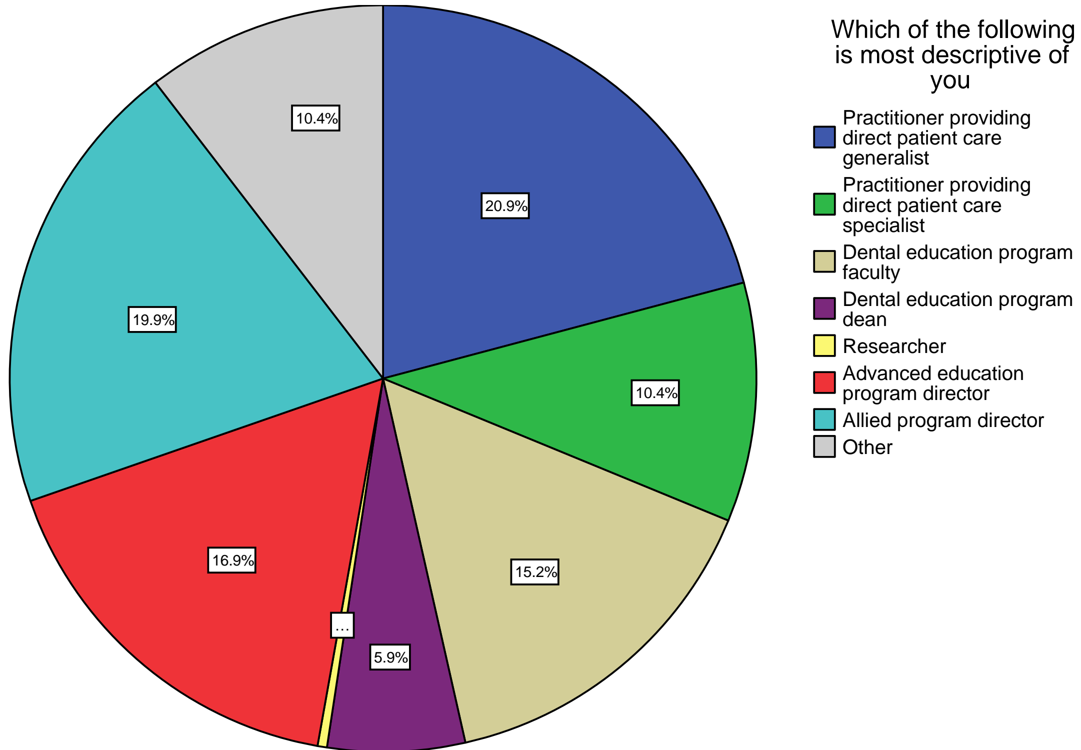
Key Demographics



Key Demographics

Professional experience

Less than 5 years	3.4%
5 to 10 years	4.9%
11 to 20 years	15.2%
21 to 30 years	40.2%
31 or more years	36.2%



Key Demographics

Professional Description

Practitioner providing direct patient care generalist	20.9%
Practitioner providing direct patient care specialist	10.4%
Dental education program faculty	15.2%
Dental education program dean	5.9%
Researcher	.4%
Advanced education program director	16.9%
Allied program director	19.9%
Other	10.4%

Attachment 5: Summary of findings of the telephone interviews (including a list of participants in the telephone surveys)

TASK FORCE ON THE COMMISSION ON DENTAL ACCREDITATION

SUMMARY OF FINDINGS OF THE TELEPHONE INTERVIEWS

QUALITATIVE INTERVIEW RESEARCH REPORT

MARCH 30, 2008

PREPARED BY: PLEXUS CONSULTING GROUP

TABLE OF CONTENTS

I. Executive Summary……………………………..……………P. 3
II. Participants…………………………………………………P. 5
III. Key Findings – Group A……………………………………...P. 6
IV. Key Findings – Group B……………………………………...P. 14
V. Key Findings – Group C……………………………………...P. 22

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I. EXECUTIVE SUMMARY

Plexus Consulting Group, LLC is working with the American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA) on an extensive research project to examine several areas related to accreditation. This project is reviewing the structure, governance policies, operating procedures and functionality of CODA. The findings of this project will be used to determine whether CODA is using best practices in accreditation and make recommendations on areas where improvements could be made to the dental accreditation process.

As a portion of the qualitative research, Plexus conducted 31 interviews with individuals identified as opinion leaders by the ADA Task Force on CODA. The interviewees were classified into three separate groups: Internal Stakeholders; Direct Users of Accreditation; and External Thought Leaders. The questions posed to each group were slightly adjusted to address the different expertise of each specialty group. However, certain themes emerged from the research.

The purpose of maintaining a similar line of questioning for each of the three stakeholder groups was to enable the comparison of responses from one group to another regarding similar issues. What emerges clearly from these interviews is that despite certain differences on specifics, all three groups hold similar general perceptions of the ADA and CODA. Whether it be regarding the general value of accreditation, the effectiveness and the variety of its communication methods, the transparency of the accreditation process, the relationships between the ADA, CODA, and the US Department of Education (USDE), the current structure of the accreditation body, public involvement in the accreditation process, or unannounced site visits, general trends from each group pointed in the same direction.

This tendency implies that the perceptions, issues and problems raised during these interviews are quite real and significant, and do not relate to each stakeholder group's bias and specific involvement in the accreditation process. This result should be promising for CODA, as it can be confident that addressing these issues and finding solutions/improving them will not create political tensions between groups. In many instances, attempting to satisfy groups that hold conflicting perceptions can prove a very complicated and treacherous endeavor. Granted, during these interviews, a few people expressed a certain frustration and discontent with certain aspects of CODA. But overall, participants were satisfied with accreditation and manifested support to the accreditation program. The aforementioned consensus among groups highlights a certain reality about the participants' general perceptions, and should provide confidence to move forward.

The majority of respondents in all three groups identified the general value of accreditation as setting a standard and an assurance of quality to both the students and the public. Regarding CODA's structure, the overall response was that the current model is the most appropriate and effective. In order to function more effectively there are changes that need to be made in communications and the site team reviews.
Respondents feel that there is a divide between the educators and the practitioners and that each is essential to the process. They feel that both groups must communicate better and increase its understanding of the other group's work to create a stronger process.

Numerous respondents in all three groups addressed the review team composition. Respondents also supported the idea of continuous reporting via online methods in order to reduce the amount of paperwork and preparation required for site visits. The majority of respondents felt that unannounced site visits are unnecessary and bring added stress and complications.

Respondents further recommended extensive training programs in an effort to decrease the possibility of personal bias being introduced in the review process and creating a standard across all teams. Additionally, many felt that different levels of accreditation are unnecessary and the goal of accreditation is to create the minimum standard.

There were many suggestions on what to pay attention to in the future; most commonly stated was the need to adjust to technology and remain relevant to the profession and the field. Respondents believe that technology will have a big effect on accreditation and that CODA needs to be prepared for this.

II. PARTICIPANTS

Dr. Eva Ackley
Dr. Leon Assael
Dr. Robert Brandjord
Dr. Thomas Braun
Dr. James Cole
Steven Crow
Dr. Robert Ferris
Dr. Jennifer Fong
Dr. Paul Gaston
Dr. Martin S. Greenberg
Dr. Betsy Hagan
Dr. Jeffery Hicks
Dr. Donald Hoffman
Dr. Jim Koelbl
Dr. Claude Lamarche
Laurie Lipson
Dr. Jerry Long
Sharon McPherron
Dr. Dennis McTigue
Linda Murphy-Knoll
Dr. Robert Pattalochi
Dr. Jacqueline Plemons
Dr. Howard Rosenberg
Dr. Tom Soliday
Dr. Gregory Stoute
Dr. Pat Surdyk
Dr. Todd Thierer
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III. GROUP A: INTERNAL STAKEHOLDERS

Thirteen of the interviews conducted fell into this classification. The following is the question posed to the interviewee and a summary of the responses received. There was a change made to the question regarding unrecognized specialties halfway through the interview process, a comparison of the answers to the two versions of the question determined that there was no difference in the manner in which people responded.

What is the general value of accreditation?

Twelve respondents to this question felt that the general value of accreditation is to provide a standard that all must reach. Respondents believe that this ensures consistency and that each program must reach a minimum level of quality. Respondents saw this as a necessary third party review. Three respondents felt that the ultimate focus of accreditation should be on ethics and patient care. One respondent felt that an ethical vision needs to be established and pursued. This overall vision needs to be the focus, and less emphasis placed on the small details.

What does CODA mean to students/public?

The meaning of CODA to the students and public is the credibility that it gives to a program and the value an accredited program provides for the school. Through accreditation, respondents felt that schools can evaluate where they stand based on the minimum and identify areas where they can make changes and improvements.

Around 50 percent of respondents to this question believe that the public sees CODA as a sign of approval and quality assurance; many of these respondents feel that the general public and some students do not understand what goes into the CODA process.

What could CODA do to increase the value of accreditation?

Six respondents believe that a public information campaign that explains the process and CODA may increase its value. The public sees CODA as a seal of approval and quality assurance, a campaign would increase the public confidence in CODA. Additionally, this would allow students and the public to better understand what goes into accreditation and to appreciate what CODA means. Other suggestions given by respondents to increase the value were to increase the independence of CODA and focus more on what is needed for the profession and less on the outcomes.

Regarding methods for communication – what's worked best for you in your working with CODA? How do you rate CODA communication? What specific suggestions do you have regarding communications?

There were several minor suggestions given to improve CODA communication, but overall respondents seemed satisfied with communications as they are currently. Two respondents expressed the necessity for CODA to better respond to ADA. They feel that CODA acts independently of ADA even though ADA is paying the bills.

Respondents value one-on-one communications and appreciate face-to-face interactions. However, some respondents felt that CODA could better utilize electronic communication to get information out in a timely manner. Respondents felt that there were small changes that could make a big difference.

Suggestions for improvements in communication are as follows:

- Print material available as a complement to electronic communication; for example information about CODA that may be left in a dental office for patients to read.
- A quarterly or semi-annually distributed newsletter.
- Articles about accreditation in the Journal of the American Dental Association.
- Complete a review of best practices in communication and determine areas for improvement.
- Determine the vision and align communications with this vision.
- More communication/updates to those involved outside the inner circle.
- There needs to be a bridge and more two-way communication between the educators and the HOD.

Do you think that stakeholders want more transparency in CODA deliberations/ decisions? What should CODA share, if anything, in addition to what they are currently sharing?

Respondents believe that stakeholders should be treated equally and do want transparency in deliberations and decisions; however, eight respondents to this question feel that CODA currently makes enough of this information available and that people don't know where to look. They feel that this may be a communication issue that could be addressed through better Web site updates or a designated liaison to release information.

Two respondents feel that CODA needs to share more information with the ADA. In particular, respondents felt that more information needs to be shared with reference to policy changes. It is a necessity that CODA listen to issues brought by the HOD.

About 50 percent of respondents feel that it is essential to the process that some information remains confidential. Other respondents feel that there could be more transparency and discussion around how decisions are made and why.

Looking specifically at the CODA/ADA relationship- what are the strengths/weaknesses of the current relationship? What changes can be made?

The most frequent answer for this question is that CODA needs to remain at an "arm's length" from the ADA. Respondents also stressed the necessity that this relationship needs to be clarified and defined so that both outsiders and insiders may better understand the situation. Two respondents felt that CODA treats all specialties and other groups the same and that this not okay; they feel that dental assistants, lab technicians and advanced specialties can not be evaluated the same way. They see that there needs to be a change in the system so that the specialties are treated differently.

Seven respondents felt that it is important that CODA and the ADA remain at the "arm's length." Four respondents feel that there needs to be increased communication and information exchange between the educators and practitioners.

Areas that were identified by respondents as needing improvement, but did not appear in more than one interview are:

- Specialty groups and dental assistants can not be treated the same. There needs to be differentiation.
- The methods and response to complaints needs to be improved.
- Identify other organizations that have a partnership opportunity.
- Those involved in CODA should have a more academic focus.
- There needs to be more transparency as to what the relationship actually is, this is often blurred.
- Policy and rule changes need to go through the ADA.

The strengths and weaknesses of this relationship are outlined below.

Strengths
- ADA Financial support
- Resources
- Facilities
- Good staff
- ADA and CODA are national, strong and respected
- Convenience

- Philanthropy – in the ADA mission
- Knowledge provided by the ADA

Weaknesses
- Lack of independence
- Too much control of process by constituents and organizations
- Financially dependent

The Task Force is interested in your opinion regarding whether there is a better system for the structure of an accreditation body. (This question reviewed four types of structures and asked respondents to give feedback to the structures and suggestions for improvement.)

Eight respondents to this question believe that the current structure is the best. Some stated that there are minor areas for improvement, but the current organization best addresses the needs of accreditation. Two respondents felt that option four was the best – have one commission handle all the specialties, but within that commission there would be separate review committees. Two respondents felt that post-doc programs should be separate from dental school.

One respondent stated it as losing sight of the general umbrella if it is separated out. Some respondents saw the additional structures laid out as impossible or bringing up too many issues that would create "turf wars" or struggles that would do more harm than good.

The additional suggestions for structural changes were discussed:
- Division by dental schools, auxiliary programs, and specialty education.
- Areas for improvement: 1) Lay involvement is not necessary at the site inspection level; 2) The commissioners' term should be increased from four to six years; 3) CODA is too staff driven, there needs to be more of a balance between volunteers and staff.
- Division by pre doctoral, graduate training and advanced training.
- Separate the specialties and have a "mini ACGME" then appoint one or two reps to sit at the CODA table – they have different needs and wants.
- Alternative: change the commission – 1) reduce number of public members if possible to one and have them responsible for oversight and due process only; 2) change specialty review committees back to how they were – five people (the chair, two reps of fostering organization, and two reps of the board).

Should CODA continue to accredit advanced dental education programs in non recognized specialty areas?

The respondents who answered this question were split (six-yes and six-no). As explanations for those respondents that disagreed with the accreditation of non-recognized specialties, they felt that it would dilute accreditation. Those respondents that were in favor of accreditation of non-recognized specialties felt that accreditation raises the bar for programs and gives them something to work for. They saw this as in the best interest of the public.

Some respondents felt that this question can not be answered yes or no and it requires more advanced discussion of the issue before any decisions would be made.

Does it make a difference whether the advanced training leads to specialty accreditation?

The majority of respondents, whether they agreed or disagreed with the accreditation of non-recognized specialties felt that it made a difference whether the training leads to specialty certification.

These questions are focusing on the involvement of the public in accreditation
How can CODA make the best use of the talents and perspectives that representatives of the public can bring to the accreditation process?

Overall, respondents felt that the public member brings value and credibility to the accreditation process. This also increases the validity of accreditation in the eyes of the public. In order to bring the best individuals into this position, a more extensive nomination and training process is essential that utilizes the skills of those who have higher education experience. Respondents also stressed the importance of communicating the public's role in accreditation.

There were three respondents who felt that there should not be a role for the public in accreditation and that the involvement should be limited to the educators and the practitioners. They see the public's role as advisory, not decision-making.

Can public members make accreditation decisions without having content matter expertise?

Seven respondents felt that public members can make content matter decision if they have the proper training and orientation and have been involved at all areas and understand the process. Respondents see this as their role in accreditation, to make decisions and judgments based on the process and to represent the public.

Six respondents feel that the public members do not have the expertise to make content matter decisions and that it is not their place. They see the public

member more as an oversight position and not as an active participant in the accreditation process. The USDE requirement is that there is a public member involved in the process- the extent of their involvement is not defined and these respondents feel that there is no place for the public to make content decisions.

What do you think of CODA's functioning? What's working, what's not?

Overall, the general sense among respondents was that CODA is functioning well. Areas that some felt needed improvement were the site visit process, communication regarding the setting of standards and processes, and reliance on volunteers. Some of the suggestions given for improvement were creating a more consistent site visit process and looking at best practices in order to evaluate the length of time between site visits. There were three respondents who felt that 30 was too many representatives to sit around the "CODA table" and that this number should be lowered to twenty.

What are the impediments that keep CODA from functioning better?

One element that respondents addressed throughout the interview was the amount of paperwork and preparation that is involved in the site visits. They felt that there is a lot of money and resources that are wasted during this process. Three respondents felt that an impediment was the lack of information provided by CODA. They believe that CODA may be able to gain more support if they provided more information to both internal and external entities and work to engage the ADA. The respondents felt that this perception that CODA is not transparent creates unnecessary difficulty. Additionally, a feeling of distrust or that there is an outside agenda being pursued develops from this perception of not being transparent.

There are two respondents that feel there is too much reliance on volunteers and influence from the ADA and other organizations. They feel CODA needs to stand up to the USDE on certain issues.

Do you think there is an issue with conflicts of interest on CODA?

Many respondents did not feel that this was an issue. They believe that CODA has a good system to address conflicts of interest as they may arise. The areas where respondents saw that conflict of interest developing is between CODA and the ADA, the specialty groups, and the educators and practitioners, but believed that as long as CODA addresses these possible conflicts as they arise, there shouldn't be any problems.

Do you have any opinion on the advantages and disadvantages of conducting unannounced site visits?

The seven respondents are not in favor of unannounced site visits. An alternative suggested by several respondents was to establish a process for site visits that would review certain "problem" areas or non-compliant programs. These areas would be reviewed more frequently in a random focused audit and not a complete site visit.

There were a few respondents (around 20%) who were in favor of unannounced visits.

Do you think CODA should have a system for determining levels of accreditation? Why? Why not?

Greater than 75 percent of the respondents don't believe that there should be levels of accreditation. The one suggestion given was a system based on the length of the cycle. Respondents believe that the goal of accreditation is to set a standard – a school either reaches this minimum or they don't. Another suggestion was to provide some sort of ranking system to identify programs that excel, but all who are accredited would have the same level of accreditation.

Are you satisfied with how CODA monitors accredited programs? Any suggestions for improvement?

Many respondents felt they did not know enough to answer this question. Those that did answer, feel that monitoring is adequate, but that some changes need to be made. Mainly, respondents feel that there should be closer monitoring of programs with deficiencies and closer follow-up in between cycles. It was suggested that the monitoring in between cycles could be conducted through interim or detail reports entered online. Three respondents were not aware of monitoring taking place.

Are you satisfied with the training and orientation that CODA provides? Do you have any recommendations for improvement?

Respondents feel that training and orientation are adequate. The following are recommendations given for improvement:

- On-site mock visits as part of the orientation.
- Constantly seek feedback and make changes to the processes.
- Increase the concentration on curriculum and patient care.
- Develop process to better identify volunteers who want to be active.

What do you see as the value and the advantages and disadvantages of CODA having USDE recognition?

Twelve respondents feel that USDE recognition is essential to the credibility of CODA. It provides an outside review and validity to the process.

The disadvantage that was given is the government and political involvement that comes along with this recognition, but respondents feel that it is not an option to go without this recognition.

What do you think would happen if CODA decided not to continue to be recognized by USDE?

Respondents feel that credibility would be lost and that there could be a potential negative financial impact with the loss of funding. There were a small percentage of respondents who felt that if CODA were no longer recognized by the USDE they would have to be recognized by a similar organization.

Three respondents suggested that if the structure was changed all programs may not have to be under USDE recognition.

In planning ahead, from the perspective of the profession, what should CODA be thinking about?

There were a number of different suggestions given for what needs to be considered when looking ahead. The following is a summary of these responses –the first three points were addressed by more than one respondent.

- It is important that accreditation is an ongoing process.
- It is essential that accreditation remains autonomous for credibility.
- International accreditation should be in the back – there needs to be a focus first on improving domestic processes.
- There needs to be an evaluation process – modalities of care.
- Ability to recognize and respond to changes.
- Need to create a bridge between educators and practitioners – they must work together.
- There needs to be more transparency in CODA as well as in the relationship between CODA and the ADA.
- Develop some sort of collaboration with regional testing areas.
- The accreditation, education, and practicing communities need to come together and open communication in order to create a system that is best for all.
- Needs to look to diversity and opportunities with other language programs.
- Be prepared to respond to a split if it would happen.

Is there anything else you want to talk about or mention that we haven't covered yet?

The comments below were made by respondents in addition to the areas covered in the questions.

- Focus needs to be on the profession and the benefit for the public.
- Need to determine and communicate a vision.
- Look at programs and evaluate the accreditation.
- The CODA staff has too much authority. “The Deans are a dominant force on the group, they are interested in saving their own programs above looking at issues from the perspective of what the profession needs and/or the public needs. Need to eliminate uninformed people from making decisions about specialty programs.”
- “If you don’t know where you are going, how do you expect to get there” – vision and means to reach that vision need to be determined.

IV. GROUP B: DIRECT USERS OF ACCREDITATION

Nine of the interviews conducted were direct users of accreditation. This group of questioning focuses on the value to students and the program.

The following questions address the general value of accreditation
How has CODA accreditation helped improve your education program or educational programs in general? How has accreditation helped improve the practice of the profession (professional practices)?

Eight respondents feel that the general value of accreditation is to provide a self study that allows the schools to evaluate themselves and identify places for improvement. The accreditation standards help in establishing curriculum guidelines and identifying where the school stands in relation to other programs. The basic value of accreditation expressed by many respondents was setting the standard for the industry, the minimum value that must be reached.

Respondents believe that accreditation ensures that there are quality programs available with some uniformity from school to school. These quality programs produce quality graduates who in turn become good practitioners. Therefore accreditation leads to good educational programs.

What could make accreditation more valuable to your program?

Respondents feel that the value of accreditation could be improved simply by having more information available. Information available through the Web site on different programs and how to get involved with CODA would be beneficial. More information provided about the accreditation process itself, would be helpful. Additionally, as long as it is adding value, input into the process should be considered. It is important that accreditation is constantly evaluated and updated in order to remain relevant. One respondent felt that moving to a continuous cycle would add to the accreditation process.

One respondent feels that streamlining the process in order to lower the cost and resources required would be beneficial to those being accredited. Recently, two respondents expressed the feeling that there is a reluctance to give recommendations and see this as a bad trend. Recommendations need not be viewed as a bad thing, but as a constructive aspect of the process in order to make necessary improvements. One respondent believes that if this is taken away, so is the value of accreditation. Another respondent felt that closer evaluation and monitoring of programs that performed poorly would increase the value of CODA and place more assurance in the processes. Respondents also believe that CODA should look to the ADA to create a greater depth of information about the various programs.

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Are students relying on CODA to make decisions on what programs they apply to?

About half of the respondents feel that accreditation is one of many factors that students look at when deciding to which programs they wish to apply. The accreditation provides a base of quality. However, a small percentage of respondents feel that students don't consider CODA at all when choosing programs because most are accredited and they don't fully understand CODA's role. Respondents believe that it would be beneficial for CODA to provide extensive resources and be available for communication on a regular basis.

Regarding methods for communication – what's worked best for you in your working with CODA? How do you rate CODA communication? What specific suggestions do you have regarding communications?

Three respondents feel that the necessary information is there, but many people do not know where or how to find the information. Three respondents think that more personal communication such as email and follow-up calls would be highly beneficial. Additionally, they feel that there needs to be more information on the Web site and some sort of quarterly or semi-annual newsletter that provides up-to-date information. They appreciate the value of e-communications. One respondent feels that communication needs to be flexible and should adjust to fit the market as it changes. Another respondent believes that there have been missed opportunities to provide information through enhanced communication programs.

Two respondents believe that CODA staff develop items without advance discussion of the item appearing in an agenda. Four respondents feel that CODA communication needs to be more specifically based and personal.

Do you think that stakeholders want more transparency in CODA deliberations/decisions? What should CODA share, if anything, in addition to what they are currently sharing?

Respondents believe that there is a perception of lack of transparency and that stakeholders would like to see more transparency in CODA. However, they also believe that the necessary information is available and that many don't know how to find it. The respondents see this as a communication, not a transparency issue. They believe that more information about the processes and composition of CODA should be available. They confirmed the belief that it is essential to the process that some information remains confidential. The area where respondents identified the need for CODA to share additional information is internally between the review committees. Each should know why and how certain decisions were made.

One suggestion that was given as a way to decrease the perception of no transparency was to facilitate open forums about the decision making process – why and how decisions are made without releasing confidential information. Two respondents feel that too many political considerations go into CODA processes and would be encouraged if these processes were more transparent. Two respondents feel that CODA acts as if they don't have to pay attention to the ADA. This relationship needs to be defined, but also remain part of the ADA. One respondent also expressed the need for more communication between communities of interest as well as state and regional boards.

Looking specifically at the CODA/ADA relationship- what are the strengths/weaknesses of the current relationship? What changes can be made?

The answers for this question were varied. Three respondents felt that the ADA and CODA should be separate. The response that was given most frequently, by about 40 percent of respondents, was that CODA and the ADA need to maintain an arm's length relationship. One respondent, in particular feels that the ADA must be involved because they represent the dentists, but can't exert too much influence. Respondents also expressed the need to clearly define this relationship so that all involved understand the interactions between the two groups and know what to expect. Several respondents feel that a balance needs to be established between the ADA and CODA as well as the educators and practitioners.

Strengths
- The ADA is the only organization that the resources to bring everyone together
- Majority of work is done by volunteers
- The ADA provided resources and management
- Financial support
- Resource support
- Money savings passed on to institutions
- Greater efficiency

Weaknesses
- Communications
- Difference of opinion- conflict of interest, specialty programs
- Need to be acting in the best interest of CODA, not the ADA
- Perception that the ADA is favored
- Relationship is not clearly defined

The Task Force is interested in your opinion regarding whether there is a better system for the structure of an accreditation body.

Do you have any thoughts about these models? Do you have suggestions for other models? What do you think would be the best system?

The majority of respondents for this question, over 60 percent believe that the current structure works best. They see the other options as increasing the burden of the structure and bringing in an added political element that is unnecessary. They see that improvements may need to be made, but that they should be made within the current structure.

One other suggestion given for structure was to model the structure used by the medical community and have two organizations—one for dental school and one for post-grad. The review committees would function as the board of each accrediting agency. There were two respondents that felt the fourth option is the best model except with separate councils all under the same commission. They did not believe that full authority should be given to the specialty areas.

Should CODA move forward with accrediting non recognized specialties?

Respondents were split on this question as well. There were five respondents who don't believe that CODA should move forward with accrediting non-recognized specialties. They believe that this is going to fragment the profession even more extensively and that there are other methods to provide specialty training without accreditation. They see that most non-recognized specialties fall under other specialties and the way to go is to establish some sort of fellowship or residency training instead of pursuing accreditation.

There were also five respondents who thought that CODA should move forward with accrediting non-recognized specialties. The respondents who believe that CODA should move forward with accrediting non-recognized specialties believe that this would be a valuable step in moving towards recognition.

Two respondents believe that the non recognized specialties do need some oversight, but don't believe that accreditation is the way to provide this oversight.

Does it make a difference whether the specialty training is attached to a recognized specialty certification?

There were four respondents who answered this question who don't see this as having an effect on whether or not the non-recognized specialties are accredited. Two respondents think that it does make a difference whether the specialty training is attached.

How can accreditation entities make the best use of the talents and perspectives that representatives of the public can bring to the accreditation process?

Respondents (around 60 percent) feel that there is a great value added by having the public members be a part of the accreditation process. The overarching goal of these members is to provide a representative for the general rights of the public. These individuals feel that it is important that strong training and orientation be attached in an effort to best utilize the talents of the public members. They feel it is important to identify public members through the nomination process that are discipline specific. Three respondents believe that the respondents should act in an advisory role only.

Can public members make accreditation decisions without having content matter expertise?

The most common response to this question (seven respondents) is that, yes, public members can make accreditation decisions without content matter expertise. Respondents believe that if they are a part of the entire process and have strong training and orientation there is no reason why the public member should not be able to make these decisions. These members can provide valuable input. Several respondents expressed that it would add value to their position if they have a background in education. One respondent expressed the need for CODA to actively seek out stronger leaders in the public members and find individuals that are truly representative of their respective communities.

However, there are three respondents who felt that it is not the place of the public member to make these decisions. They feel that content matter decisions should only be made by those with the specific background and that the public members input should be limited to the process.

What is the appropriate role of students as commission members or review team members? In what other ways should students participate?

The students are the consumers in a sense and in this position several respondents feel that they should be involved at an advisory level. A suggestion given by some respondents was to have students serve as a reviewer of draft copy, but not be involved in the review committee itself. They feel that the students have many things going on and that they are in a position where they cannot actively participate on the level necessary. Respondents feel that their primary focus should be on their education. If students are to participate, respondents feel that it needs to be a selective process that identifies them and they should not have voting authority.

These questions are focusing on the accreditation process
What do you think of CODA's functioning? What's working, what's not?

The majority of respondents feel that CODA is functioning well and don't see much need for improvement. They believe that CODA is a great influence on establishing benchmarks and standards, but feel that there are areas where CODA needs updates in order to remain relevant. Some respondents feel that these updates need to be made within the guidelines and references and any changes made need to be communicated.

Many respondents feel that communications could use some improvement. They would like to see information available in a timelier manner and the method at which internal and external communications are conducted should be revised and updated to incorporate greater utilization of technology. Two respondents said that there needs to be changes made to the cycle length as the current system is not working effectively.

Do you have any comments about conflict of interest, unannounced site visits, stakeholder input, training and orientation?

The majority of respondents who addressed the site visits (around 40 percent of all Group B respondents) don't believe that unannounced site visits would be beneficial. They addressed the idea of shorter time periods – three to five year cycles based on the recommendations a program receives, but don't feel that the unannounced visits would add value. If anything they see these visits as more of a burden. One respondent suggested a semi-unannounced visit to programs that demonstrated problems by informing them two or three months prior to the visit.

Respondents believe that conflicts of interest need to be addressed and defined early. If they are constantly addressed, respondents feel trust will build. Respondents feel that it is important for stakeholders to have input and participate in the process.

Many respondents addressed the importance of strong training and orientation and believe that standard programs should be developed so that there is uniformity among committees and an understanding of the process. The content in the training process must be constantly updated in order to remain relevant. One respondent expressed the need for more scheduling placed in the training process. For example, they completed the training process over one year ago, but have not yet participated in a site visit.

What are the impediments that keep CODA from functioning better?

The main impediment respondents see is the false perception that CODA is not transparent. This detracts from the operations and must be addressed through improved communications.

One respondent felt that the structure with mixed dental and post-doctoral accreditation is creating the commission to act under a number of constraints. Another respondent felt that CODA needs to continuously evaluate the specialty interests so that it is best able to respond to the needs of the different groups and maintain relevancy.

Do you think CODA should have a system for determining levels of accreditation? Why? Why not?

Over half of the respondents do not feel that there should be levels of accreditation. The suggestion of different cycle lengths given to programs based on their number of recommendations was identified as an alternative to levels of accreditation.

Have you used the CODA complaint process? Do you feel comfortable with current complaint procedures?

Four of the respondents are aware of the complaint process, but have not had any experience with the procedures. They feel comfortable with the procedures as they are and believe that if problems were to arise, they would be communication related and could be solved relatively quickly.

Do you have any opinions on the best process to assess educational outcomes?

There were several suggestions given for the assessment of educational outcomes. A few respondents believe that the development of a mechanism, whether its survey or assessment based, that ensures all professionals are up to date would be beneficial. This survey could be conducted yearly, online and track programs in order to ensure that they stay on track.

Respondents maintained the importance that these tools be flexible and continually evolve in order to remain effective. Programs could be evaluated based on the goals and objectives of the programs. Two respondents felt that these outcomes would be best addressed by the educators.

Comment

- Look at ACGME process for comparison– competency list, common program requirements, basic competencies are the same for all programs – assessment tools.

Are you satisfied with how CODA monitors accredited programs? Do you have any suggestions for improvement?

There was not much feedback on this question. Of the respondents who answered, about one-fourth is satisfied with the way CODA currently monitors

programs. A few additional respondents are satisfied and don't believe that there is need for improvement, and a little great than one-fourth of respondents believe that there should be an interim reporting process in order to better monitor the programs. One suggestion given was to submit data and update information online on an ongoing basis.

The length of cycles was addressed as needing to be reviewed. One respondent believes that the cycles should be a maximum of five years.

What do you see as the value and the advantages and disadvantages of CODA having USDE recognition?

Respondents see the main advantage of USDE recognition as giving the consumer a higher confidence level. This provides a validity and credibility to the accreditation process. Some felt that they needed greater clarification on exactly what the relationship is between the two organizations. Respondents see it as essential to be part of an outside oversight body.

One respondent addressed the issue that if the post-doctoral programs were separated from the dental school accreditation, the post-doctoral programs would not need to receive USDE recognition.

What do you think would happen if CODA decided not to continue to be recognized by USDE?

Many respondents don't see this as an option, but if it were to occur they believe that it would result in loss of funding and that it would be necessary for CODA to find another organization to take the place of the USDE. Two respondents suggested a similar format to medicine.

In planning ahead, from the perspective of the profession, what should CODA be thinking about? Below are comments given by the respondents about what needs to be addressed in the future. The first four comments were made by several individuals.

- Adjust to technological change.
- Evolve and makes changes with the profession as they occur.
- Some standards need to be evaluated – it is difficult and unrealistic for schools to demonstrate that they are meeting these standards. This may lead to the need to introduce new standards as a profession in order to move forward.
- CODA should work towards independence from the ADA.
- Increase the sharing of information, workshops, etc.
- Needs to clarify the purpose and engage in debate whether accreditation drives changes or responds to changes.

- Improved communications and switching to a continuous cycle for monitoring.
- Accreditation should drive education.
- This is a good process, it is important that it is seen how it will help and what changes will be made going into the future.

Is there anything else you want to talk about or mention that we haven't covered yet?

Several respondents expressed their belief that CODA is a good process and with a few improvements can be a much better process.

- International relationships shouldn't be ignored – naturally evolves, need to be aware that this is out there.
- Work to streamline processes across all areas of CODA.
- Increase resources on CODA Web site both for internal and external communication. This will facilitate and encourage open communication.
- Currently the review committees come across as a "good ole boy's network"
- There needs to be standardization with the flexibility to be updated without the influence of a political and/or personal agenda. This is important for the credibility of accreditation.

V. GROUP C: EXTERNAL THOUGHT LEADERS

There were three interviews conducted which were classified as external thought leaders. These individuals have a background in accreditation and may not be as familiar with the inner-workings of CODA and the ADA. The following are the key findings summarized by question.

What is the general value of accreditation?

Respondents believe that the largest value of accreditation lies with the institution and the program. Accreditation gives them the opportunity to think more critically about themselves. Accreditation supports the dissemination of best practices and setting of standards. Respondents believe that it is important that procedures are followed and the standards met. It characterizes professionalism and quality that many expect.

How do students and other publics use accreditation? Or do they? What could accreditation bodies do to increase the value of accreditation?

Respondents believe that students look to accreditation to confirm that a program has met some level of quality. The respondents see more value placed in specialized accreditation and less in regional accreditation.

Additionally, respondents feel that the value of accreditation is not fully understood by the public and that more information is needed in order to increase this knowledge among the public. One suggestion given was having pamphlets in the waiting rooms describing the necessity and process of accreditation. The public knows that accreditation is important and it is only when accreditation is lost that the general public pays attention.

Accreditation always seems a balance between customer service that is, helping programs improve their practices, and regulation, or policing programs. Where should the emphasis be and how can it be achieved?

Respondents believe that the emphasis should be placed on the standards, training, and making improvements. The goal of accreditation is overall quality improvement. If the credibility is lost, it doesn't matter if the customer is happy or not. It must be confirmed that the accreditation process is not compromised. Respondents see the necessity that there be a distance between the accreditors and the regulators – the ultimate goal is assisting in the improvement of programs.

Do you think that stakeholders want more transparency in accreditation agency deliberations/decisions?
Do you believe that stakeholders are entitled to more transparency? In other words: How important is the balance between the right of the educational program to confidentiality and the public's "right to know"?
Here's a two part question- What do accreditation entities that you are familiar with, share with the public about specific results? What should they share?
Should suggestions for improvement be made public?
What level of detail should be made available to the public regarding reasons for non-compliances?
Should accreditation entities be developing report cards on the programs that they accredit- listing relative strengths and weaknesses?

Regarding whether stakeholders want more transparency, it depends on which stakeholder you are talking about. Respondents believed that the academic community does not want accreditation agencies to be sharing any more information than they already share. One respondent expressed the importance that every policy document be available. In the case of some accrediting bodies, this is available for everyone on the Web site.

However, from the perspective of the public, one accreditation agency did a study of parents and students who said that the agency was sharing so little information that accreditation had no value to them because it was not helping them make decisions about what college to attend.

Respondents believed that sharing information about the reasons for non-compliances would be difficult because the reasons are often very complicated. For example, some agencies report that there was a non-compliance because a specific standard wasn't met but the public doesn't understand the detail in the standard. It is the responsibility of the accredited program to provide this information if they wish, but the accrediting agencies most often do not provide public information on the opportunities for improvement or recommendations. One respondent doesn't think that providing this information would be to the benefit of the public as they do not understand the process thoroughly enough to understand the decisions reached.

One suggestion was the development of a common report template. This annual report could then be used to compare data from year to year and determine whether there were reoccurring problems.

The amount of information shared by an organization is dependent on the type of organization. Respondents did not think it was in the best interest of CODA to release specific information. It is necessary for certain information to remain confidential in order for the process to maintain validity. These processes should not allow room for subjective opinion. The information that respondents believe

can be released are the decisions that are made and the process that determined that decision. The specific information is not necessary. The respondents believe that the agency has to determine the appropriate information to share, not the stakeholder.

No one believed that the “report card” option was feasible, although a few acknowledged that this is exactly what Congress is wanting to see happen.

Respondents also expressed the importance of communication and teaching those involved the accreditation process. It is an advantage to the academic community especially to understand the process, policies and procedures.

This next group of questions is focusing on relationships
What do you see as the advantages/disadvantages for being part of a related organization versus being a separately incorporated entity?

One respondent stressed how independence has immensely helped the operations and credibility of its accrediting program. The other respondents to this question felt that they didn’t have enough information to make a decision or that it would depend on the structure of the organization. They didn’t feel that there was a best practice that can be applied across all groups.

The example of the ACGME was stated as a positive for independence. While the ACGME was located at the American Medical Association (AMA), the majority of its staff as well as resource support were provided by the AMA. Although they were described as “independent”, the general perception was that the ACGME was under the AMA. When the ACGME became truly independent, the Board members became responsible to the accrediting body instead of the sponsoring organizations.

The Task Force is interested in your opinion regarding the best system for the structure of an accreditation body.
Do you have any thoughts about these models? Do you have suggestions for other models? What do you think would be the best system?

Each respondent to this question had a different answer. One respondent felt that the current model works best for CODA given the profession and industry. They felt that option four would be a “political mess”. The option with three separate commissions would be very expensive and much of this cost would transfer to the customers – creating some problems.

One respondent felt that a single commission with the specialists represented and experts serving as reviewers is the most economical method, but that ultimately this structural decision is based on the culture of the organization. The last respondent to this question believes that one overhead with three divisions is the best structure for accreditation.

The respondents also felt that this depends on the size of the accrediting agency. In the case of the ACGME, there are over 8000 specialty programs across 26 medical specialties. In this case it is impossible for a single commission to handle. The review committees are divided by the 26 medical specialty areas that have "delegated authority" to make accreditation decisions. There are 40 organizations that participate in appointing people to the review committees.

These questions are focusing on specialty recognition and accreditation What do other groups that you are familiar do regarding the accreditation of specialty areas? What are their policies in this regard? Does it make a difference whether the advanced training is attached to a recognized specialty certification?

Specialty areas are not accredited by a regional accrediting agency. Many other accrediting bodies in different industries only accredit the entry into the industry and not the specialty – this didn't seem to make sense to one respondent because if you aren't accrediting the specialties, someone else will and this places added reliance on them. One respondent didn't feel that it made a difference if the advanced training is attached to a recognized specialty because additional education and experience are still necessary.

In another agency, a training program is preparation for certification. Test scores may be used as a quality indicator for each program, but rarely would an accreditation system be developed for a program that isn't associated with a board certification. The respondents do not see one trend within accreditation in other industries.

How can accreditation entities make the best use of the talents and perspectives that representatives of the public can bring to the accreditation process?
How have accreditation entities that you are familiar with addressed the USDE requirements for public involvement, as members of the commission, as members of review teams, as site visitors?

Respondents believe that the standards should ultimately be set by the specialty areas because they know best what is required. Public members are necessary and best utilized if they are policy leaders in other industries. The goal in having a public member in the accreditation process is to have them serve an oversight function. A balance between public interest and special interest must be developed in order for this to be effective. Two respondents felt that there is too much training involved in order to have the public member be active in the decision making process. These respondents don't believe the public members have the content matter expertise to be a part of the review. Another respondent felt that they should be actively involved and that is part of their duty in the accreditation process.

One suggestion given in order to make the public member a more integral part of the accreditation process is to hold focus groups of public members as part of the review process, but not actually have a member on the review team.

If you are familiar with CODA- do you have any opinions about how it is functioning? What's working, what's not? How does it compare to other groups you are familiar with?

Respondents felt that they did not have enough knowledge of CODA to accurately answer this question. One respondent said from their limited knowledge of CODA, it appears CODA is in the same position they were years ago. They were asking the same questions and the process lead to restructuring through strategic planning. This respondent said the best thing that accreditation agencies can do is to continually look at themselves.

What are the impediments that keep accreditation bodies in general from functioning better?

Three out of four respondents to this question believe that the largest impediment to better functioning is the training provided to commission members. They expressed belief that other accreditation bodies are dealing with this same problem. The other impediments described were the need for better technology and the financial constraints placed on the accrediting entities.

Do you have any ideas about best practices in controlling conflict of interest, getting stakeholder input, training and orientation, conducting unannounced site visits, assessing educational outcomes?

The conflict of interest that respondents believe needs to be addressed is people making evaluations based on their own experience and not on the standards and process. One respondent stressed the fact that using volunteers for site visits has great potential to create conflicts of interest as some of the specialties are small communities. The only way they see in eliminating this is to have paid staff conduct the site visits.

It is important that staff provide more training and stronger leadership in order to minimize this bias. Extensive training and orientation is also essential in creating a consistency of reviews. There is often the struggle between the Board and the Staff, and this is something that many accreditation bodies deal with. There is no best practice related, but it is important that the lines of communication are open. Gathering stakeholder input is seen as a critical aspect of the accreditation process.

The respondents have mixed feelings on the unannounced site visits. One respondent feels that unannounced site visits are best practices in accreditation. However, one respondent feels that since accreditation is voluntary – a site visit should be initiated based on a concern. And another feels that unannounced visits are not useful. They believe that this differs from one organization to the next.

One respondent believes that educational outcomes are important to the success of a program and should be taken into consideration during the accreditation process. Another respondent believes that the focus of accreditation standards should be on the educational outcomes; they see the customers as the public and the students, not the programs. They noted that it is very difficult to define and measure the outcomes, but that it is also very important. It requires the input and cooperation of many different parties.

Do you think accreditation bodies should have a system for determining levels of accreditation? Why? Why not?

The respondents do not believe that there should be levels of accreditation. The focus of accreditation is on the compliance level, not what level you can reach.

What do you see as the value and the advantages and disadvantages of CODA or other accreditation bodies having USDE recognition?

Respondents believe that the USDE keeps the accrediting organizations accountable and is a beneficial recognition for degree-granting programs. For non-degree granting programs there are the options of other third party agencies. Without recognition there is no benefit of accreditation seen.

One disadvantage mentioned is the political nature of having a recognition like the USDE often distracts from the benefit and weakens the perceived value of accreditation in the eyes of some.

What advice do you have as CODA begins to move forward internationally?

The advice the respondents had regarding looking to international was to look at best practices and fully prepare before expanding. Respondents feel that the first focus should be on in-house operations, before looking to expand internationally. There are many issues as far as measurement and accountability go that are continuing to be on the forefront. These issues require more attention.

There are changes that would need to be made and overall. Accrediting agencies in Europe, for example, typically release more information than accrediting bodies in the United States.

What do you see as the future trends in accreditation – expected trends/desired trends/undesired trends?

Respondents see technology having a much greater influence on accreditation which will move towards a continuous accreditation process maintained through a Web site. Another trend identified is a move to have national standards and not different standards based on different regions of the country.

Accrediting bodies will feel additional pressure to supply the public with more information. Congress is currently pushing for this and at some point it may become a USDE requirement.

Is there anything else you want to talk about or mention that we haven't covered yet?

One respondent felt that CHEA is not helpful and that despite the problems with the USDE, it is essential that specialized accreditors maintain this recognition.

Attachment 6: Benchmarking study

American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA)

Benchmarking Study

Prepared by: Plexus Consulting Group
February 22, 2008

Table of Contents

Executive Summary……………………………………………………………………....P. 4

I. Introduction……………………………………………………………………..….P. 6

a) Themes for the benchmarking study

II. Methodology……………………………………………………………………………….P. 7

a) Selection of Relevant Accreditation Agencies
b) Approaches utilized to gather the information
c) Terminology

III. Overview of Organizations selected for benchmarking…………………………..P. 9

a) Accreditation Board for Engineering and Technology (ABET)
b) Accreditation Council for Graduate Medical Education (ACGME)
c) Accreditation Council for Pharmacy Education (ACPE)
d) American Health Information Management Association (AHIMA)
e) Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM)
f) American National Standards Institute (ANSI)
g) American Psychological Association (APA), Committee on Accreditation
h) American Speech-Language Hearing Association (ASHA) Council on Academic Accreditation (CAA)
i) American Dietetic Association, Commission on Accreditation for Dietetics Education (CADE)
j) Commission on Accreditation, American Library Association (CoA/ALA)
k) Commission on Accreditation of Healthcare Management Education (CAHME)
l) American Osteopathic Association (AOA), Commission on Osteopathic College Accreditation (COCA)
m) International Association for Quality Assurance in Health Care (ISQA)
n) The Joint Commission (TJC)
o) Land Trust Accreditation Commission
p) Liaison Committee on Medical Education (LCME)
q) National League for Nursing Accreditation Commission (NLNAC)
r) Planning Accreditation Board (PAB)

IV. Issues for ADA Task Force on CODA……………………………………………....P. 19

a) Scope: Accreditation agencies tend to have narrower scopes of accreditation than CODA
b) Structure: Role of Coordinating Councils or Tiered Structures
c) Role of specialties, dental–related disciplines and fractionalization of the professions
d) Models for establishing relationship between accreditation and specialty recognition or certification

V. The ADA/CODA Relationship……………………………………………………....P. 27

a) Options for the ADA /CODA relationship
b) Rights and responsibilities of the ADA and CODA
c) Communication
d) Size of CODA
e) Composition of CODA – achieving balance and participation
f) Recruitment, terms of leadership
g) Serving with portfolios

h) Selecting members
i) Training provided to Review Team members and Commission members
j) Role of the Public in Accreditation
k) Public Members of Commissions and Review Teams
l) Providing information to the Public
m) Role of staff
n) Accreditation process
o) Levels of accreditation
p) Relationship with the United States Department of Education (USDE)
q) Relationship with the Council for Higher Education Accreditation (CHEA) and other Academic Accreditation Agency recognition bodies
r) Impact on CODA when taking on an international component
s) Strategic planning and ongoing evaluation

VI. Trends in Accreditation……………………………………………….……………P. 48
a) Increased use of advanced technology
b) Increased government interest in certification and accreditation programs

VII. Summary of Recommendations…………………………..……………………P. 52

Executive Summary

The American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA) has been charged by the ADA to study the structure, governance, policies, operating procedures and functionality of CODA, to determine whether CODA is using best practices in accreditation, to determine if CODA should remain recognized as an accreditation authority for the United States. Department of Education (USDE) and to make recommendations on how the dental accreditation process can be improved to preserve the high standards needed for the future of dental education.

The benchmarking study conducted by Plexus Consulting Group LLC (Plexus), on behalf of the ADA Task Force on CODA, identifies alternative solutions to issues that the ADA Task Force on CODA has been charged by the ADA to explore based on the experiences of other accrediting groups, and identifies the degree to which CODA's practices and polices conform to best practices in accreditation. Based on the Task Force discussion and research conducted to date, several themes are emerging that warrant additional investigation and are the subject of this benchmarking study. These themes include:

- the best structure for CODA in light of the multiple specialty education programs that CODA accredits;
- the relationships between CODA and the ADA compared to the relationships between other accrediting agencies and their parent organizations;
- communications;
- composition of CODA – achieving balance and participation;
- recruitment and terms of leadership;
- serving with portfolios;
- impact on CODA when taking on an international component;
- benefits of USDE recognition of CODA;
- strategic planning and on-going evaluation;
- use of technology in accreditation to improve Commission functioning;
- accreditation processes;
- role of the public.

Benchmarking revealed that there were many commonalities among accrediting agencies in the way they evaluated applicants against defined accreditation standards. For example, all agencies benchmarked, require a written application, a formal self-study and a site visit conducted by trained assessors that confirm and validate the content of the self-study. Accreditation agencies all had a council or commission that has the final authority to make accreditation decisions. They all have processes for appeals and complaints as well as processes to share accreditation decisions with the public. Where agencies differ is in the scope of their accreditation, ranging from accrediting one educational program to accrediting several educational programs. CODA, in its capacity of accrediting several educational programs that prepare individuals to work in related dental professions through accrediting educational programs in advanced specialty practice areas had the broadest scope of the accreditation agencies that were benchmarked. Wide variation also existed in the size of the Accreditation Commission, with CODA being among the largest. Variation also exists in the role of the public; CODA had more participation of the public on its review teams and on its Commission than other agencies. Agencies also varied in the relationship to sponsoring organizations. Some agencies serve as a committee of a sponsoring organization, accrediting against standards that

are created or approved by the governing arm of the sponsoring organization. Other accrediting agencies function as totally separate organizations in regard to structure, location, staff and finances. CODA falls within the middle of this range.

CODA's policies and practices appear to all conform to what are considered good practices in accreditation. However, there were a few areas in which CODA can improve. These include communication with stakeholders, strategic planning and self-evaluation, and use of technology to support accreditation functions. Additionally, CODA needs to better codify its relationship with the ADA so that there is a mutually shared set of expectations, rights and responsibilities. While not a problem currently, CODA will need to systematically investigate its role and structure in response to the growing number of dental related professions and the growing number of advanced practice specialties.

Accreditation agencies of different and sometimes conflicting shapes and structures are recognized by the Council for Higher Education Accreditation (CHEA) and/or USDE. It has become increasingly apparent, in discussions among members of the accreditation community that USDE and CHEA have not always applied strictly consistent recognition criteria to applicants. However, the value of being recognized as an accrediting agency by an agency such as USDE or CHEA is increasing as Congress, the public and the academic community are demanding more value, more transparency and more accountability from accreditation agencies.

Clearly, the review of these organizations demonstrates that one size does not fit all. Another observation, based on discussions with representatives of several of these accreditation agencies, is that no one feels they have the best or even the better answers. Every accreditation agency examined continues to struggle to adapt itself in ways that best meet the needs of the profession, the public and the often conflicting requirements, values and perspectives of its various stakeholders.

I. Introduction

The American Dental Association (ADA) Task Force on The Commission on Dental Accreditation (CODA) has been charged by the ADA to study the structure, governance, policies, operating procedures and functionality of CODA, to determine whether CODA is using best practices in accreditation, to determine if CODA should remain recognized as an accreditation authority for the U.S. Department of Education (USDE) and to make recommendations on how the dental accreditation process can be improved to preserve the high standards needed for the future of dental education.

The benchmarking study conducted by Plexus Consulting Group LLC (Plexus), on behalf of the ADA Task Force on CODA, identifies alternative solutions to issues that the ADA Task Force on CODA has been charged by the ADA to explore based on the experiences of other accrediting groups, and identifies the degree to which CODA practices and polices conform to best practices in accreditation. Based on the Task Force discussion and research conducted to date, several themes are emerging that warrant additional investigation and are the subject of this study.

Themes for the benchmarking study

Themes investigated in the benchmarking study are as follows:

- the best structure for CODA in light of the distinct programs that CODA accredits;
- the relationships between CODA and the ADA compared to the relationships between other accrediting agencies and their parent organizations;
- communications;
- composition of CODA – achieving balance and participation;
- recruitment and terms of leadership;
- serving with portfolios;
- impact on CODA when taking on an international component;
- benefits of USDE recognition of CODA;
- strategic planning and on-going evaluation;
- use of technology in accreditation to improve Commission functioning;
- accreditation processes;
- role of the public.

II. Methodology

Selection of Relevant Accreditation Agencies

The ADA Task Force on CODA and Plexus selected the accreditation agencies to be included in the benchmarking study. Each of the accreditation agencies were selected because they provide some relevant information for the ADA Task Force on CODA to consider. Agencies were selected to present a variety of examples: because they are in the health care field, and because they are examples of the diverse types of relationships between accreditation agencies and professional organizations. Some are entirely independent organizations while others may be closely linked to sponsoring organizations but have codified Memorandums of Understanding (MoU) that spell out respective roles and responsibilities. Others are embedded within the sponsoring organization and function as a committee. In some cases the sponsoring organization heavily influences accreditation standards and practices. Several are included because their histories provide examples of how accreditation agencies can evolve from one structure or relationship to another, often in response to issues raised by the profession. The benchmarking also illustrates differences in the role of staff.

While attempts were made to be consistent in how the organizations are described, the amount of public information that is available about these organizations differs. Some Web sites are richer than others in the level of detail provided. In some cases staff was quite open about financial matters while others did not want to disclose this kind of information. One lesson learned in this review is that one size does not fit all. Another is that on based on discussions with representatives of several of these accreditation agencies, none believes that they have the best answers. Each accreditation agency reviewed continues to struggle to adapt to best meet the needs of its profession, the public and the often conflicting requirements, values and perspectives of its various stakeholders. One final note: careful reading of the descriptions will show that organizations of different and sometimes conflicting shapes and structures are recognized by CHEA and/or USDE. It has become increasingly apparent, in discussions among members of the accreditation community, that USDE and CHEA do not always apply consistent recognition criteria to applicants. The information provided in the benchmarking study reflects these inconsistencies.

Accreditation agencies selected:

Accreditation Board for Engineering and Technology (ABET)
Accreditation Council for Graduate Medical Education (ACGME)
Accreditation Council for Pharmacy Education (ACPE)
American Health Information Management Association (AHIMA)
Commission on Accreditation for Health Informatics and Information Management Education(CAHIIM)
American National Standards Institute (ANSI)
American Psychological Association (APA), Committee on Accreditation
American Speech-Language Hearing Association (ASHA) Council on Academic Accreditation (CAA)
American Dietetic Association, Commission on Accreditation for Dietetics Education (CADE)
Commission on Accreditation, American Library Association (CoA/ALA)
Commission on Accreditation of Healthcare Management Education (CAHME)
American Osteopathic Association (AOA), Commission on Osteopathic College Accreditation (COCA)

International Association for Quality Assurance in Health Care (ISQA)
The Joint Commission (TJC)
Land Trust Accreditation Commission
Liaison Committee on Medical Education (LCME)
National League for Nursing Accreditation Commission (NLNAC)
Planning Accreditation Board (PAB)

Approaches utilized to gather the information

Approaches utilized to gather the information included:

a. internet searches specific to each organization;
b. telephone interviews with members of the accreditation unit of identified agencies;
c. U.S. government and other publications that cover best practices and issues in accreditation;
d. summaries of meetings of accreditation agencies that addressed issues of interest to the Task Force;
e. familiarity, experiences and insights of Plexus Consulting Group consultants based on their work with accreditation entities.

Terminology

This report provides information about best practices in accreditation for comparison purposes. The focus is on general trends that may be helpful in shaping recommendations. The report has not been reviewed by experts in dental education and/or accreditation. Therefore, the document may include some terminology, references and wordings that are not technically correct. However, the general concepts should be apparent and precise wording will, of course, be a priority when formal recommendations are crafted.

III. Overview of Organizations selected for benchmarking

1. Accreditation Board for Engineering and Technology (ABET)

ABET is a federation of 28 professional and technical societies. Established in 1932, ABET assesses 28 areas such as applied science, computer science, engineering, and technology. There are 2700 programs at more than 550 colleges and universities assessed utilizing 1500 volunteers for on-site peer reviews. Individual members of these societies—practicing professionals from industry and academia—form the body of ABET through its program evaluators (PEVs), Board of Directors, and four accreditation commissions: the Applied Science Accreditation Commission (ASAC), Computing Accreditation Commission (CAC), Engineering Accreditation Commission (EAC), and Technology Accreditation Commission (TAC).

An international component of ABET includes many countries preparing engineers and technology specialists. The association responds to Institutions of Higher Education (IHEs) if they graduate even a single student. Approximately one-and-one-half years are required for the cycle of preparing a self-study, team formation, on-site visit, report to the commission members and report to the institution. Multiple areas of specialization are assessed individually or at one time. Four sub-boards act as accrediting boards. Practitioners are members of the on-site team. Public members are included in the commission.

The primary responsibilities of the Board of Directors are to set policy and approve accreditation criteria. The commissions implement accreditation procedures and decisions. Program evaluators, along with commissioners, make up ABET's accreditation teams. There are several active councils and committees within ABET. Councils include the Industry Advisory Council, whose members represent the major industries ABET serves; the Accreditation Council, whose members are the leaders of ABET's four commissions; and the International Activities Council, whose members are current and former Board and commission members. CHEA recognition was awarded in 1997.

2. Accreditation Council for Graduate Medical Education (ACGME)

ACGME is a private, nonprofit council that evaluates and accredits medical residency programs in the United States. The ACGME was established in 1981 from a consensus in the academic medical community for an independent accrediting organization. Its forerunner was the Liaison Committee for Graduate Medical Education, established in 1972.

ACGME has 28 review committees (one for each of the 26 specialties, one for a special one-year transitional-year general clinical program, and one for institutional review). Each residency committee is composed of about six to 15 volunteer physicians. Members of the residency review committees are appointed by the AMA Council on Medical Education and the appropriate medical specialty boards and organizations. Members of the Institutional Review Committee and Transitional Year Committee are appointed by the ACGME Executive Committee and confirmed by the Board of Directors. ACGME's member organizations are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies. Member organizations each appoint four members to the Board of Directors, which also includes two resident members, three public directors, the chair of the Council of Review Committee Chairs and a non-voting federal representative. Each review committee is responsible for preparation of the program requirements for the area(s) of its competency, and for periodic revisions to reflect *current education and clinical best practice.* Graduate medical

education programs are accredited when they are judged to be in substantial compliance with the Essentials of Accredited Residencies in Graduate Medical Education. The Essentials consist of (a) an Introductory Preface, (b) the Institutional Requirements which are prepared by the ACGME, approved by its sponsoring organizations, and apply to all programs, and (c) the Program Requirements which are prepared by a review committee for its area(s) of competence and approved by the ACGME. Review committees hold regularly scheduled meetings to review programs to determine whether accredited programs continue to be in substantial compliance with the Essentials of Accredited Residencies in Graduate Medical Education.

As noted in the ACGME Web site[1], the current ACGME was created in response to Congressional approval of the Medicare bill in 1965. "*With the creation of public (Medicare) support, graduate medical education (GME) was raised to the level of public policy. The medical education community realized that the multiple RRCs in existence at the time, each with its own standards and policies, did not give the appearance of coordinated standards or a coordinated effort that could assure quality of residency programs across the board. The need for focused oversight was seen as compelling by both governmental and medical groups other than the AMA"*. The ACGME continued to evolve and in 1972 Five organizations in medicine and medical education came together, under the direction of the AMA, to create the Coordinating Council on Medical Education (CCME). These five organizations were the American Medical Association, the American Board of Medical Specialties, the American Hospital Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. Its charge was to approve and coordinate all areas of medical education. The structure in place to coordinate GME ultimately failed to achieve its goals due to the cumbersome reporting and approval processes in place to accomplish tasks and establish policy. There were three layers of bureaucracy. The unhappy RRCs, who were slowly losing their independence, were at the bottom. The new LCGME was over the RRCs. Over the LCGME were five eminent member organizations. Sitting atop this whole construct was the CCME composed of the same five member organizations as the LCGME. In 1981, the need for streamlining led to reorganization. The Coordinating Council was abolished. The LCGME was restructured under new bylaws and renamed the Accreditation Council for Graduate Medical Education (ACGME), a name that would more clearly reflect its responsibility for accreditation of GME. In 2000 The ACGME became a separately incorporated organization with new bylaws.

In academic year 2005-06, there were 8,186 ACGME-accredited residency programs in 120 specialties and subspecialties. The number of active full-time and part-time residents for academic year 2005-06 was 103,367. ACGME is not eligible to be recognized by either CHEA or the USDE because its accredited programs are not degree granting programs.

3. Accreditation Council for Pharmacy Education (ACPE)

The Accreditation Council for Pharmacy Education (ACPE) is the national agency for the accreditation of professional degree programs in pharmacy and providers of continuing pharmacy education. ACPE was established in 1932 for the accreditation of pre-service education, and in 1975 its scope of activity was broadened to include accreditation of providers of continuing pharmacy education. It most recently began to accredit programs that provide a Doctor of Pharmacy (Pharm.D.) degree. The Pharm.D. is now considered the entry level degree for the profession of pharmacy. All states require pharmacists to be graduates of an accredited school of pharmacy. Currently 90 IHEs have attained full accreditation, ten have attained

[1] ACGME. History of Medical Education Accreditation, p. 3. Retrieved from http//www.acgme.org/acWebsite/GME.info/historyGEM.pdf

conditional accreditation, three are in pre-conditional status and 416 provide approved Continuing Education programs. There is currently no accrediting process for educational programs that train pharmacy technicians.

ACPE is an autonomous and independent agency but with strong ties to three related organizations. It has a ten member Board of Directors appointed by the American Association of Colleges of Pharmacy (AACP), the American Pharmacists Association (APhA), the National Association of Boards of Pharmacy (NABP) (three appointments each), and the American Council on Education (ACE) (one appointment). ACPE members serve six-year terms. Each of these organizations provides $60,000 yearly to ACPE. Because of perceptions of conflict of interest and its relationship to the National Boards of Pharmacy (NABP), ACPE severed its ties with NABP in very symbolic ways which included moving out of NABP headquarters and relocating to another city. Commission members also participate in site visits. In order to be a member of the Commission and a site visitor, individuals must first complete a year of training as an observer. One-third of ACPE members are from education; two-thirds are from practice.

ACPE is recognized by USDE and CHEA. ACPE is a Title VII, but not a Title IV, gatekeeper.

4. American Health Information Management Association (AHIMA)
Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM)

AHIMA began in 1928 as part of a library process that would assist hospitals and clinics with record keeping regarding health services. Over the decades, the organization reviewed best practices and standards from health information management groups and by 1991 the name change indicated the change in orientation of the program from individual medical records to health information along the entire continuum of care. Future programs will focus on electronic health records, maintaining national health information statistics and a network to coordinate information for use by state, communities and programs.

CAHIIM was established in March 2005 as an independent accreditation agency sponsored by the American Health Information Management Association (AHIMA). This structure gives CAHIIM the final authority to make accreditation decisions but CAHIIM accreditation standards are currently approved by the AHIMA House of Delegates. CAHIIM is attempting to change its governance structure and relationship to AHIMA to give CAHIIM the final authority to approve the accreditation standards. Prior to 2005, CAHIIM was under the umbrella accreditation of CAAHEP, and has origins back to the AMA/CAHEA. Since 2005 CAHIIM has conducted full cycle accreditation of more than 30 specialized health information management programs and introduced a web-based annual program assessment report (APAR) process. CAHIIM expects to expand from the currently accredited 240 associate and baccalaureate degree programs to include master's degree program accreditation in 2008. It is also exploring the feasibility of expanding internationally and offering accreditation to non-U.S, programs. The CAHIIM process includes site visits by a two-member team. CAHIIM is applying for CHEA recognition.

5. American National Standards Institute (ANSI)

ANSI, founded in 1911, is an independent membership association representing academia, individuals, government, manufacturing, trade and professional associations, service organizations, standards developers, consumer and labor interests to promote the development of higher quality standards across all industries, facilitate dialogue to create new

ideas/innovation, promote public/consumer protection and recognize organizations that can demonstrate adherence to recognized standards of quality.

ANSI does not develop standards but provides a neutral venue for U.S. organizations to collaborate in the creation of common agreements. ANSI-accredited standards developers are required to adhere to a set of requirements or procedures known as the *"ANSI Procedures for the Development and Coordination of American National Standards*" that govern the consensus development process. The Institute currently serves as facilitator for more than 270 organizations that work cooperatively to develop both voluntary consensus standards and American National Standards (ANS). These developers represent approximately 200 distinct organizations across numerous industries in the private and public sectors.

Originally focused on accrediting standards developers, ANSI now has accreditation programs in the products and services sector. ANSI service sector accreditation programs include an accreditation system to accredit certification agencies that conform to an international standard created for personnel certification bodies, ANSI/ISO/IEC 17024. ANSI is also investigating developing a program to recognize higher education accreditation agencies. The ANSI accreditation process adheres to international requirements for accreditation agencies (ISO 17011). These requirements include a detailed application in which the applicant documents how it meets each of the requirements in the standard and an audit (on-site visit) by trained assessors to validate and confirm information provided by the certification body. ANSI applies certain defined principles in designing and implementing the accreditation process. These provide assurance of openness, balance, due process, transparency, and consensus throughout the process. The assessors then work with a three-person review team selected from the membership of the relevant Accreditation Committee. ANSI accreditation committees vary in size depending on the scope of the accreditation program. For example one accreditation committee is made up of six individuals while the ANSI Personnel Certification Accreditation Committee (PCAC) is composed of 17 individuals representing a broad range of stakeholders including representatives from accredited certification agencies, government and industry. There is one public member on the PCAC. The PCAC has its own nomination process. A PCAC nominating committee solicits nominations and prepares a slate which is then presented to PCAC for a vote. The role of the ANSI staff is to facilitate the process and staff do not participate in any accreditation decisions.

ANSI is recognized by the U.S. Government, specifically the National Institute of Standards and Technology (NIST) to represent U.S. government interests on international standards development initiatives. ANSI is the U.S. representative to the International Organization on Standardization (ISO) and is the U.S. representative to the International Accreditation Forum (IAF).

6. <u>American Psychological Association (APA), Committee on Accreditation</u>

APA includes 53 sub-groups and professional divisions that function under the umbrella of the large professional association with almost 150,000 members. Accreditation involves only doctoral (primarily Ph.D. but some Ed.D.) programs in clinical psychology, counseling, school psychology and similar areas of study. APA's Committee on Accreditation involves graduate level educators and practitioners as well as members of the general public and students and is composed of 32 members that evaluate the self-study materials and on-site review reports. Some 880 programs are accredited. Other than institutions in Canada and Puerto Rico, no institutions outside the US are approved. In order to attain APA accreditation, the institution must have regional accreditation as an educational institution, USDE approval, and Veteran's

Association approval to provide stipends for students in the program. The standards for accreditation were accepted by the APA managing board in 1996 and have had only minor "tweaks" since then. All practitioners serving on the on-site team have a doctoral degree. At least two students are included on the review committee. The APA is recognized by CHEA and USDE.

7. American Speech-Language Hearing Association (ASHA) Council on Academic Accreditation (CAA)

The American Speech-Language Hearing Association (ASHA) Council on Academic Accreditation accredits more than 300 educational programs that are considered to offer entry to the profession, which for speech-language pathologists is the master's level and for audiologists is the doctoral level. ASHA bylaws specify the number (eleven) and type of members on the council. Seven are from accredited academic programs, three are practitioners from non-academic settings, one is a public member, and ASHA staff serves as *ex officio* non-voting members. Because the Council accredits programs in two professional specialties, the bylaws further specify that five of the voting members represent hearing pathology, four of whom must hold ASHA certification in audiology, and five of the voting members represent speech-language pathology, four of whom must hold ASHA certification in speech-language pathology. Directors of undergraduate programs may sit on the Council on Academic Accreditation even though these programs are *de facto* not eligible for accreditation. Appointment of CAA members is a combination of appointments made by the by the Executive Board of the American Speech-Language Hearing Association and votes of the accredited programs. There is no formal MoU between the CAA and ASHA. All revenues from the accreditation program go back into the central budget. The CAA, like all other programs in ASHA, prepares and then negotiates a budget which is approved by the Executive Board and subsequently the Legislative Council. Reviews are done by a site visitor review team comprised of two academic representatives and a practitioner representative from the profession. Public members do not serve as members of review teams. The CAA is recognized as an accreditation entity by both the USDE and CHEA.

8. American Dietetic Association, Commission on Accreditation for Dietetics Education (CADE)

CADE accredits programs at the associate, baccalaureate, master's and post-baccalaureate internships. CADE was established as an administratively autonomous organization in 1992. CADE sets its own accreditation standards with input from communities of interest. Standard-setting, financing and administration are all handled by CADE. The Commission convenes a nominating committee of its own and elects its own members. However, the CADE Chair is elected on a national ballot with very specific criteria. CADE members (14 members + past chair) are selected from site visitors and include two public members and a student member. The Chair serves one year as Chair-elect, two years as Chair, and one year as past-Chair.

CADE has an MoU with its related professional organization which specifies amount of shared space, chargeback for space, and staff salaries and benefits. Accreditation revenues and workshop fees go strictly into the CADE budget and it is considered a separate entity within the Association annual report. CADE receives 20 percent of its budget from its sponsoring organization—a minimum of $150,000 is designated each year.

CADE is recognized by both CHEA and USDE. CADE is recognized by the USDE as a Title IV gatekeeper for its post-baccalaureate dietetic internship programs. Out of the more than 600 accredited programs, five receive Title IV funding as a result of CADE accreditation.

9. Commission on Accreditation, American Library Association (CoA/ALA)

CoA/ALA accredits master's programs in library and information studies in the United States, Canada, and Puerto Rico. ALA policy recognizes the ALA-accredited master's degree as the appropriate entry level professional degree for librarians and information professionals. ALA accreditation requires that the program has undergone a self-evaluation process, has been reviewed by peers, and meets the Standards for Accreditation of Master's Programs in Library and Information Studies that were established by the Commission on Accreditation and adopted by the ALA Council in 1992. The Commission on Accreditation evaluates each program for conformity to the Standards, which address mission, goals and objectives, curriculum, faculty, students, administration and financial support, and physical resources and facilities.

CoA/ALA is embedded in the ALA under the Programs and Services Division; it earns its own fees. The level and type of ALA support is clearly delineated. CoA/ALA members are appointed by the president-elect of ALA through a Standing Committee. A 1,700 member structure (similar to a house of delegates) within ALA approves the CoA/ALA accreditation standards. Although ALA approves the standards, CoA/ALA has full and final authority for accreditation decisions.

CoA/ALA is recognized by the CHEA.

10. Commission on Accreditation of Healthcare Management Education (CAHME)

The Commission on Accreditation of Healthcare Management Education (CAHME) was formed in 2004 following a forty-year tradition of accrediting graduate healthcare management education by ACEHSA (Accrediting Commission on Education for Health Services Administration). Funding is provided by more than two dozen health systems, healthcare professional and trade associations, payers, and other related organizations. The evolution of ACEHSA into CAHME was driven by the Association of University Programs in Health Administration (AUPHA) in response to its communities of interest wanting change and increased credibility in accreditation. CAHME accredits only master's level programs. AUPHA certifies (but does not accredit) undergraduate programs. There are many different types of degrees offered through CAHME programs including MBA, MHA, MS in health administration.

The new organization has new standards and more practitioner representation on the Board. There are 19+ sponsors but major funders currently are the American Hospital Association, American College of Healthcare Executives, AUPHA, and Blue Cross/Blue Shield. In the new structure there are three councils vetted through the Commission. Each council is composed of 50 percent practitioners and 50 percent educators; each council is chaired by a board member. Board and council members are nominated by the sponsoring organizations. Council members serve three-year terms. Commissioners serve four-year non-renewable terms; 50 percent are educators, 50 percent are practitioners. In addition, there are two public members that serve two-year terms, renewable for one additional term.

CAHME is recognized by USDE and CHEA.

11. American Osteopathic Association (AOA),Commission on Osteopathic College Accreditation (COCA)

The COCA is the accrediting body for colleges of osteopathic medicine (COM) that reviews, evaluates and establishes the accreditation status of a COM. The COCA is a single 17-member

body with accreditation of COMs as its sole function. Accredited schools have met or exceeded the standards for educational quality with respect to organization, administration and finance, faculty and instruction, curriculum, student admissions, performance and evaluation, research and scholarly activity and facilities. The process of accreditation is a cooperative activity calling for continual self-assessment on the part of each COM, periodic peer evaluation through site visits and review. The COCA is closely aligned with its sponsoring organization, the American Osteopathic Association (AOA). To satisfy public perceptions of too much influence on COCA from the AOA a formal MoU was negotiated between the president of the parent organization and the Commission. This was an important factor in demonstrating what the conditions of the relationship were and clarified that COCA made independent accreditation decisions. The MoU stipulates, for example, that the Governing Board of AOA will only receive information that would be available to the general public. The Executive Director of the COA is a full-time employee of AOA. All funding comes from AOA with COCA funds in a separate budget. COCA strives to be budget neutral. AOA has a house of delegates which does comment on the direction of education and accreditation, and provides governance through four reference committees that review resolutions and report out to the House. AOA created a separate education committee that deals with these issues and reports back to the House.

COCA members are selected against specified requirements created by AOA with three-year terms plus one renewable term. Requirements specify expertise and also require a 50:50 balance of representation by educators and practitioners. A chair-elect is appointed by the AOA president.

COCA is recognized by the USDE under a waiver of the separate and independent provision. It has been recognized by USDE as an institutional accreditor since 1952 to accredit free standing COMs. COCA is also recognized as a programmatic accreditor since some programs are parts of schools and not stand-alone COMs. Currently there are only two schools for which they are the institutional gatekeeper (Title IV).

COCA applied but was denied CHEA recognition in 2002 although it had been recognized by the two agencies that preceded CHEA (COPA and CORPA). COCA decided not to pursue CHEA recognition because COCA considers itself very much a part of the AOA through its financial relationship, and did not want to change its practices to satisfy CHEA requirements.

12. International Association for Quality Assurance in Health Care (ISQA)

More than 70 countries are members of ISQA which functions as a multidisciplinary forum for monitoring health care programs across national boundaries. A Secretariat is headquartered in Melbourne, Australia. ISQA is recognized by the World Health Organization and was formed in 1985 by a group gathered in Italy. It is managed by an Executive Board that is elected every two years. In the United States, Quality Assurance Programs are monitored by ISQA. Accreditation involves an external evaluation utilizing a formal process based on established standards on a four year cycle. Best practices are identified. In the United States The Joint Commission is ISQA accredited.

13. The Joint Commission (TJC)

In 1910 the need for standardization in hospital services led to the first organization of Health Care service programs. By 1918, on site reviews of hospitals were undertaken. In 1950, 3,200 hospitals achieved approval from TJC. The Social Security Administration required that hospitals be approved by the Commission in 1965. By 1982, the first public members were

appointed to the commission. Today, more than 15,000 health care organizations function under the umbrella of The Joint Commission on Health Care. These organizations represent ambulatory care, home health care, behavioral health care facilities, hospitals, long-term care facilities, laboratory services and many others. TJC is led by a 29 member Board of Commissioners comprised of MDs, administrators, nurses, labor representatives, health care planners, consumer advocates, quality experts and health plan leaders. It is the organization that coordinates issues relevant to physicians and surgeons, dentists, hospital administrators and other stakeholders. More than 1,000 employees coordinate the functions of the myriad of sub-groups.

All Joint Commissioner surveyors are employed by The Joint Commission and surveys are unannounced. TJC is not eligible for USDE recognition because it does not accredit degree-granting higher education institutions or programs residing in degree-granting institutions, but is recognized by CMS (Center for Medicare and Medicaid Services).

14. <u>Land Trust Accreditation Commission</u>

The Land Trust Accreditation Commission was created in 2006 as an independent program of the Land Trust Alliance (LTA). The LTA is a trade association of land trusts across the country. Its members range from large national organizations to small, community centered organizations that are run only though volunteers that protect natural spaces and working lands. The charge of the Land Trust Accreditation Commission is to operate a land trust accreditation program to build and recognize strong land trusts, foster public confidence in land conservation and help ensure the long-term protection of land.

The Commission has twelve members that represent a broad cross-section of the land conservation community, plus one public member. The Land Trust Accreditation Commission is required to accredit against standards and performance indicators created by its sponsoring organization, the Land Trust Alliance. Accreditation decisions are made solely by the Commission. The Commission does not routinely conduct site visits. All reviewers are also members of the Commission. The Commission is not formally recognized by any governmental agency but has been responsive to issues raised by the IRS which is examining operations in the land trust community and whose concerns to some degree motivated the LTA to create this accreditation program.

15. <u>Liaison Committee on Medical Education (LCME)</u>

The Liaison Committee on Medical Education (LCME) was established in 1942 and is the nationally recognized accrediting authority for medical education programs leading to the MD degree in U.S. and Canada. The LCME is an independent accrediting agency. It has final authority for determining the accreditation standards for medical education as well as making accreditation decisions. The LCME is sponsored by the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC). Currently, the LCME accredits 125 programs in the United States and, together with the Committee on the Accreditation of Canadian Medical Schools (CACMS), accredits 17 MD programs in Canada. The 17 members of LCME are medical educators and administrators, practicing physicians, public members, and medical students. The AAMC and the Council on Medical Education of the AMA each appoint six professional members. The AAMC and AMA each appoint one student member. The LCME itself appoints two public members, and a member is appointed to represent the CACMS. There are a total of two public members and two student members on the LCME. LCME does not charge any fees for accreditation services except for schools requesting initial provisional

accreditation. Operating funds come equally from AMA and AAMC. LCME maintains two headquarters offices (one in Chicago at AMA and one in Washington at AAMC). Leadership of LCME alternates between the two offices annually.

The accreditation process includes completion of a survey by the institution and site visits by LCME. The LCME evaluators who conduct on-site visits of medical schools are a mix of basic science and clinical educators, medical researchers and medical practitioners. Survey team members are selected from a pool of almost 200 volunteers. The standard term of accreditation is eight years. The LCME will disclose to the public only the accreditation status of the school. The LCME does not rank programs. Most state boards of licensure require that U.S. medical schools be accredited by the LCME, as a condition for licensure of their graduates. Graduates of LCME-accredited medical schools are eligible to enter residences approved by the Accreditation Council for Graduate Medical Education (ACGME) that is described earlier in this report. It is important to note that LCME and ACGME are separate accreditation agencies, with LCME accrediting medical schools, and ACGME accrediting post graduate residency programs. Accreditation by LCME is required for schools and colleges to receive grants from USDE for their education programs. LCME is recognized by USDE as a Title IV (federal loan program) gatekeeper.

16. National League for Nursing Accreditation Commission (NLNAC)

The League provides accreditation services for a full range of nursing education and preparation from nurse's aide to Ph.D. level programs. It is responsible for voluntary, self-regulatory "gatekeeper" functions and is recognized by USDE and Title IV of the Health and Human Services Acts. The League has an extensive history beginning in 1893 when the association was formed to set standards for training nurses. By 1938, accreditation programs for nurses were instituted. By 1997, the last year of data reports, fifteen commissioners composed of the review panel (nine nurse educators, three nursing service executives and three public members). More than 200 nursing education programs per year are evaluated by the League which oversees more than 1,300 nursing education programs nationwide. In addition to NLNAC, there are over twenty independent advance practice specialty accreditation agencies. NLNAC has been recognized by USDE since 1952.

17. Planning Accreditation Board (PAB)

This independent accreditation agency accredits bachelors and master's level programs. It has three sponsoring organizations: Association of Collegiate Schools of Planning (ACSP); American Planning Association (APA); American Institute of Certified Planners (AICP). PAB is a 501(c) 3 organization, has its own independent auditor and provides copies of its audit to each of the three parent organizations. PAB is funded 50:50 by programs and APA/AICP; if the number of participating programs decreases resulting in lower revenues from programs, APA/AICP percent dollar support also decreases; if the number of programs increases, APA/AICP funding must increase. PAB maintains independence with co-location with APA via three MoUs that address (1) sublease; (2) staffing agreement for PAB staff salary and benefits; and (3) shared services agreement. PAB is charged for administrative overhead. There are 83 accredited programs in 71 colleges or universities, fifteen are baccalaureate programs.

The PAB Board is composed of eight members appointed by the three organizations – three educators and one public member from ACSP; three practitioners from AICP and one citizen planner from APA. All are appointed for three years with one possible reappointment (totaling six years). Bylaws require a rotation in the chair position between an educator and a

practitioner. The qualifications of board members will be codified through a forthcoming bylaw revision and articles of incorporation.

Site visit review teams are comprised of two educators and one practitioner (the practitioner must be AICP credentialed).

IV. Issues for the ADA Task Force on CODA

Scope: Accreditation agencies tend to have narrower scopes of accreditation than CODA

It appears that CODA's scope of accreditation is among the broadest compared to other accreditation agencies. CODA is accrediting the full range of levels of instruction, from pre-professional dental-related programs through entry-level professional programs (in general dentistry) through several advanced practice specialty programs. No other accreditation agency was identified that had such a broad scope. Many accreditation agencies such as ASHA or APA accredit programs that are considered entry-level programs into the profession (for example, master's level programs for speech-language pathologists by ASHA, doctoral level programs for psychologists by APA). An interesting example is ASHA where the CAA accredits master's level programs in speech-language pathology and doctoral level programs in audiology. The common link however is that both levels represent the level for entry into their respective professions as recognized by certification and licensing authorities. For example, ASHA will not accredit doctoral level programs in speech language pathology since for that profession, doctoral education exceeds entry-level educational requirements. The commonality among these accreditation agencies is not the level of the program being accredited but that the program prepares people for entry into the profession. Some accrediting agencies, such as the American Physical Therapy Association, Commission on Accreditation accredit both assistant level and professional level preparation programs. In many professions, there are separate accreditation authorities for the different levels of education. An example is the Council on Medical Education that accredits entry level programs in medicine while the Accreditation Council for Graduate Medical Education (ACGME) accredits educational programs in advanced practice specialty areas. Similarly, The Commission on Accreditation of Healthcare Management Education (CAHME) accredits master's level programs, while the Association of University Programs in Health Administration (AUPHA) certifies, but does not accredit, undergraduate level programs.

A Coordinating Commission would coordinate the work of the two Accreditation Commissions (what two commissions?). The role of this Coordinating Commission would be to foster communication between the two separate accreditation commissions, and address issues that would be of interest to both Commissions including monitoring what is happening in the regulatory and industry arenas that is likely to affect accreditation and the professions, helping design and implement marketing initiatives, serving as a resource in strategic planning. However the Coordinating Commission should not be seen as having an oversight function, especially in regard to the development or implementation of standards. A conceptual model therefore would look like three parallel commissions, rather than having a central commission that would be "above" the other two.

Plexus recommends that CODA be split into two commissions, one for educational programs leading to entry into practice (including dental related professions) and the other for advanced practice specialties.

Structure: Role of Coordinating Councils or Tiered Structures

There is trend for a smaller accreditation agency with specialties to have more authority and autonomy. Several models are used in educational accreditation agencies. The ADA Task Force on CODA will need to address whether the profession, the public and the education system would best be served by:

1. an "umbrella group that recognizes multiple specialties" (e.g., ACGME);

2. having each specialty or nexus of specialties develop its own accreditation program (e.g., NLN);
3. separating the accreditation structure along some other lines, for example-undergraduate/graduate/postgraduate (e.g., LCME);
4. separating allied dentistry education systems (dental hygienists, laboratory technicians) into a separate structure (e.g., ACPE); or
5. another solution.

Some organizations do not utilize a single all purpose Accreditation Council structure but rather will separate functions into various councils. For example, the American Speech-Language Hearing Association had a Council on Professional Standards that set policy and created and approved standards. A separate Academic Accreditation Board focused on creating applicant evaluation criteria and making decisions regarding individual applicants. The advantage of this system was that it permitted a single group to be the big picture thinkers and focus on program development issues without needing to take the time to consider individual applications, etc. However, the disadvantages, which ultimately lead to the structure's collapse into a new model that combined standards and decision making into a single entity, included continual problems in communication between the entities and disagreements regarding whether standards were being interpreted as intended. Similar examples exist in other accreditation agencies.

Plexus recommends that the ADA retain standards-setting and implementation within a single structure.

<u>Role of specialties, dental–related disciplines and fractionalization of the professions</u>

The core of any profession is its educational systems. Licensing boards, in defining scopes of practice, will look at the education system—and will shift toward broadening the number and complexity of tasks in a specific occupational scope of practice if the petitioning group can demonstrate that the practitioner has been adequately trained in this area. For example, when the APA wanted to expand the scope of psychologists to include prescribing psychotropic drugs it had to begin by including pharmacology in its training programs. Only after this was accomplished could examinations be offered so psychologists could demonstrate that they possessed the requisite knowledge and skills necessary to prescribe these types of drugs. Similarly, when pharmacists wanted to increase the scope of their profession to include additional initial consultation and team work with members of the medical profession regarding appropriate drug regimens, the first step was a shift in the accreditation standards and the contents of the training and the degree tag that would be recognized by the accreditation entity. In summary, the organization that controls the accreditation of the academic programs controls their content.

There is a lot of value in CODA maintaining a single body for specialties at this time. A single body encourages coordination and communication as specialties evolve and as new specialties are created. It is very detrimental for a profession when specialties fight with each other in a public forum over scope issues. Specialty accreditation bodies that are independent of each other can contribute to "public airing of dirty laundry" because there is no central authority to coordinate the accreditation standards for the specialty groups. The interest in creating new accreditations and certifications appears to be attributable to several sources:

- increased pressure on trade and professional organizations to provide a competitive advantage for their members;
- improve public recognition of the industry;

- provide a mechanism for self-regulation as an alternative to increased government regulation or oversight;
- provide additional income-producing programs;
- increase demand by employers and members for credentials that will have meaning across international boundaries and in a global business environment.

Similar trends are being observed in dentistry and related dental professions. A recent report from the American Dental Education Association, published in the *Journal of Dental Education*, but reported by the AMA[2] states "To help ensure access to oral health care for all Americans, several new dental workforce models are emerging, including:

- advanced dental hygiene practitioner,
- community dental health coordinator,
- oral preventive assistant,
- dental health aide therapist."

The ADA and CODA are advised to look at the experiences of other agencies in developing strategies in response to these new workforce models. The development of additional related disciplines in health professions has had significant impact on other accreditation agencies for reasons that deal with critical mass, percentage of representation, shifts in focus as new systems are being created, and new paradigms for professional versus pre-professional training programs. The role of CODA in accrediting these new training programs will need careful examination. On one hand, CODA accreditation adds credibility for these professions, which may then compete with currently accredited CODA training programs. On the other, the result of CODA not accrediting these programs may range from poorly constructed programs which will not be in the public interest to the development of an alternative accreditation agency that may eventually compete with CODA as an accreditation authority for the profession of dentistry and dental related professions. The concept of break away and competing accreditation agencies exist in many professions including nursing. In the behavioral health field there are two entirely separate accreditations agencies, one in psychology that is structurally a part of the APA. The other organization is entirely separate from any professional association and accredits counselor education programs at the master's level. The accredited educational programs have very large overlaps in educational content and in scope of practice for graduate individuals.

Similar scenarios occur throughout the health care community as related occupations, historically perceived as "support" or "related" personnel, grow in number and gain stature through the development of formal accreditation and certification structures. Nursing specialties were codified with increased scopes of practice to begin to compete with tasks traditionally performed by MDs. An example is the administration of anesthesia. Accreditation of nurse anesthetists programs requires advanced graduate level training. However anesthesia assistants that complete a two-year undergraduate training program are now beginning to gain credibility and are, in turn, beginning to intrude on the scope of practice of nurse anesthetists.

The American Physical Therapy Association (APTA) formally recognized the Physical Therapy Assistant (PTA) and developed a certification and educational program accreditation system for this occupation. The APTA Commission on Accreditation in Physical Therapy Education scope of recognition from the USDE includes physical therapist education programs leading to the first

[2] retrieved from AMA Health careers news letter 1-16-08 http://enews.ama-assn.org/t/181722/175574/137/0/

professional degree at the master's or doctoral level and physical therapist assistant education programs at the associate degree level.

The credibility of the physical therapist assistant grew as did the scope of practice and the numbers of individuals entering the occupation. Increased credibility, credentials and scope of practice, fueled by lower salaries encouraged employers to hire PTAs in lieu of physical therapists to perform many of the functions historically provided by physical therapists.

Plexus recommends that CODA prepare for the possibility of competing accreditation systems especially for related dental professions.

Models for establishing relationship between accreditation and specialty recognition or certification

Accreditation and certification programs generally begin as associations create certification standards and accreditation standards that are designed to work across the industry. Then as the profession develops and the industry becomes more differentiated, specialty certifications and specialty accreditations develop. This generally occurs using one of four models of program development. The four models are briefly described below.

A. Executive-Driven Model: In this model, the professional association takes the initiative to identify the areas requiring specialty recognition. The professional association specifies the criteria for education, experience and qualifications. It is the association's responsibility to monitor the evolving needs of the public and the emerging specializations within the professions and to predict those areas in which the public and the professions would be best served by implementation of specialty recognition programs. This model puts maximum control and maximum responsibility within the administrative structure of the professional association.

B. Practitioner-Driven Model: This model requires that the professional association develop general standards for a program of specialty recognition and that it develops a governing board charged with administering the program. In this model, the professional association takes no responsibility for determining which areas of specialization should be recognized. Rather, it provides the structure within which practitioners (and consumer representatives) can determine whether a particular area of specialization meets the general standards (established by the professional association) required of a specialty area.

When a petitioning group (such as special interest group or related credentialing association) satisfies the general standards for qualification as a specialty area and the general standards for recognition of specialists, the specific requirements for education, experience, continuing education and credentialing examinations (if any) are established by the specialty area itself. The task of the governing board would not be to impose specific education requirements but to verify that the petitioning group had determined what their particular specialty area would require.

The advantages of this model are:

- Quality assurance across specialty areas is maintained at a high level.
- Primary responsibility for the establishment of area-specific requirements lies with the practitioners.
- Professional associations representing practitioners within a specialty area of practice can interact with a broader based professional association in the establishment of quality care delivery of services to the public.

The disadvantages of this model are:

- Creation of an additional administrative board or other administrative structure within the professional association.
- Attendant costs of implementation and maintenance of the program.

C. Accreditation Model: Under this model, the professional association does not create a program of specialty recognition, but rather a mechanism for accreditation of educational programs for specialists. This model does not provide a centralized structure for credentialing individuals in specific specializations; rather it provides a centralized structure for accrediting programs that educate specialists.

The advantages of this model are:

- Quality assurance across specialty areas is maintained at a high level.
- Primary responsibility for the establishment of area-specific requirements lies with the practitioners.

The disadvantages of this model are:

- Creation of an additional administrative board or other administrative structure within the professional association.
- Attendant costs of implementation and maintenance of the program.

D. Arm's-length Model: In this model, the professional association plays only an indirect role in the establishment of a specialty-credentialing program. The professional association operates with the concept that the association exists primarily to protect and advocate for the interests of its members while the primary purpose of credentialing is to protect the interest of the public. Therefore, the primary role of a credentialing agency (whether for certification and/or accreditation) and a professional association may not be compatible. In many cases, the by-laws of the professional association do not permit or allow for any credentialing activities, viewing such activities as outside the mission of the association or the scope of allowable activities.

Furthermore, the professional association may not wish to assume the costs of managing a credentialing program or assume the legal exposure inherent in making decisions about whether an individual (or program) qualifies for a credential. In this model, associations will not have any accreditation program. In such cases, there may be separate agencies within the profession that either certify individuals or accredit educational programs. Most health related professions utilize this latter model of complete separation between the professional group and the credentialing functions.

There are many variants as to how the relationship between a professional association and its various credentialing arms actually works. It is impossible within the scope of this report to provide an analysis of all of the credentialing bodies, their standards and their administrative structure. However, a few professions that are included in this benchmarking study are presented to provide examples of the models that are used to create and manage programs of specialty recognition and the various kinds of relationships that exist between professional associations, accreditation agencies, certification bodies and specialty certification bodies.

Example 1: Pharmacy

The Board of Pharmaceutical Specialties is the agency within the profession of pharmacy through which specialty boards are formally recognized and through which specialists are

certified. The American Pharmaceutical Association established the Board of Pharmaceutical Specialties in 1976 after five years of study. The Board of Pharmaceutical Specialties currently recognizes three specialties: Nuclear Pharmacy, Nutrition Support Pharmacy Practice and Pharmacotherapy.

The Board of Pharmaceutical Specialties has established a petition process by which groups may apply for specialty recognition. To ensure that specialty recognition and the certification of qualified persons result in tangible benefits to the association, seven criteria were developed and implemented for designating specialty areas in pharmacy practice:

- Demand—is there a significant and clear health demand for the specialty?
- Need—are specially trained pharmacists needed to fulfill the responsibilities of the specialty?
- Number and Time—do a sufficient number of practitioners exist to justify development and administration of the certification and recertification program?
- Specialized Knowledge—is there a unique pharmaceutical-sciences knowledge base associated with the proposed specialty practice?
- Specialized Functions—is there an identifiable and distinct field of practice that requires the unique knowledge and skills beyond those required for licensure?
- Education and Training—do schools of pharmacy and/or other associations offer recognized postgraduate programs in the area of specialty practice?
- Transmission of Knowledge—is there a body of professional, scientific, and technical literature immediately related to the specialty?

Example 2: Speech-Language Pathology

The American Speech-Language Hearing Association (ASHA) does not have a system to accredit education programs that prepare people for specialty practice. Stand alone specialty training programs do not exist, specialty preparation is provided as concentrations within more general programs. ASHA does provide guidance to the content of the educational curriculum in specialty training through its program of Specialty Recognition. ASHA adopted a program of Specialty Recognition in 1994. ASHA systematically investigated the various models used for specialty recognition and chose to use the one adopted by the Board of Pharmaceutical Specialties. ASHA created a Board for Specialty Recognition that adopted standards for how the specialty boards were to create and apply standards and for how specialties were to be recognized. The specialty board must petition ASHA for recognition as a specialty area of practice, demonstrating that it has a distinct area of knowledge and skills and that there are sufficient numbers of individuals who agree that it is a distinct area of practice. Additionally, once recognized as a specialty area of practice, the board must demonstrate how it developed standards in the following areas: education, specialty practice experience and objective measure of demonstrable proficiency. Additionally, as ASHA certification is linked to licensure in many states, ASHA needed to clarify:

- How would a specialty certificate relate to the right to practice?
- Would the certificate be required for practice, with non-holders prohibited from practice?
- Alternatively, would the specialty certificate simply provide recognition that the practitioner has acquired additional expertise in a specific practice area, with no implication that non-holders are unqualified?

ASHA resolved these concerns by differentiating between "certification," with an implied right to practice, and "recognition," which recognizes individuals who have chosen to identify through qualification as having a specialized body of knowledge and skills. ASHA currently offers credentials in three specialty areas: fluency, neurological speech disorders and dysphasia.

Example 3: Nursing
There is probably more competition, confusion and fragmentation in specialty credentialing in nursing than in any other profession. According to a recent study by the Institute of Medicine twenty different associations offer certification with nearly one hundred specialty exams that focus on particular areas of practice. Accreditation is provided by more than twenty specialty accreditation agencies, all of which are free standing and not linked through any sort of coordinating council. The American Board of Nursing Specialties (ABNS) accredits some, but not all, of the nursing certification programs. However, there is no equivalent coordinating function for academic accreditation agencies in nursing. Both ABNS members and non-members are eligible for accreditation. ABNS is an approved accrediting agency for the National Council of State Boards of Nursing's Advanced Practice Registered Nurses (APRN) Certification Review Program. Nursing certification agencies may attain accreditation by demonstrating compliance with standards established by ABNS. These standards address:

- Definition and scope of nursing specialty
- Research
- Based on a body of knowledge
- Association and structure of the certification board
- Eligibility criteria for test candidates
- Test development, and administration and scoring
- Continued competency
- Communications
- Confidentiality
- Appeals
- Misrepresentation and non-compliance
- Quality Improvement

Example 4: Medicine
The American Medical Association (AMA) sponsored an independent board to develop and manage a program of specialty credentialing and accreditation of training programs within the profession of medicine in 1954. This has now evolved into more segmented and administratively independent structures. In medicine, multiple bodies comprise the medical specialty program. There are specialty residency review committees (RRC) that accredit the residency programs in each specialty. Such RRCs communicate and cooperate through the Accreditation Council for Graduate Medical Education (ACGME) that coordinates the activities of each of the 26 independent RCCs. The AMA is now one of five groups that hold a seat on the Accreditation Council for Graduate Medical Education (ACGME). The American Medical Association supports the role of medical specialization by conducting research studies and providing information on residency openings to students.

The American Board of Medical Specialties (ABMS) is an independent association that operates autonomously from the American Medical Association and recognizes and coordinates the work of the various medical specialty certification boards. Board certified physicians must complete a specialty residency training program approved by one of the 26 specialty residency review committees (RRC) in order to qualify to sit for an exam in a particular specialty. The specialty exams are created by one of the specialty boards recognized by the ABMS. The AMA plays no role in recognizing the medical specialty boards. The specialty board confers the specialty credential to those individuals who meet the specialty certification requirements by completing both the required specialty residency program and passing the specialty certification exam. The ABMS is a very powerful influence in the profession of medicine. According to a recent Institute of Medicine Report, 90 percent of MDs are certified by one or more of the specialty boards recognized by the ABMS. Additionally, most employers will only provide hospital privileges to

ABMS certified MDs. However, according to ABMS literature there are over 180 non-ABMS self designated medical boards. Such Boards have either not met the criteria for ABMS approval or have chosen not to apply for approval. In addition to the medical specialty education function and practitioner certification function that operates independently of the AMA, an AMA Section on Medical Specialties determines which emerging specialties can be constituted and recognized as a specialty association. Such societies may subsequently develop a certification and/or residency accreditation board.

Plexus suggests that while the current model is working, the ADA and CODA may want to explore alternative models that might better serve the evolving needs of the profession in the future. The current model might be improved by establishing a structure in which each specialty has the authority to set its own standards and evaluation criteria and maintain control over its own accreditation decisions but also benefit from the perspectives of others.

V. The ADA/CODA Relationship

Relationships between accreditation agencies and professional associations that house the accreditation agency are often contentious. Professional associations that sponsor accreditation agencies often complain that even though they financially support accreditation, they have less control over that program than they do over any of their other programs, except professional certification. This perception is true. It is also true that this is the way it has to be. Accreditation has to be "arm's length" removed from the professional interests of the trade or professional association. The mission of the association is to protect the interests of its members, the professionals. The mission of accreditation is not to protect the interests of the professionals but the interests of the public.

For example, the mission of The Joint Commission is:

> *"To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care."*[3]

The mission of the Accreditation Council for Graduate Medical Education (ACGME) is:

> *"To improve the quality of health care in the United States by assessing and advancing the quality of resident physicians' education through accreditation."*[4]

Best practices in accreditation demand focus on public interests and avoidance of any conflict of interest when the interest of the public and the interest of the members of the profession are not co-joined. This primary focus on the public interest is needed for any accreditation program to be credible. Whether CODA continues to choose to be recognized by the USDE or chooses not to be recognized by the USDE, there are other federal programs to which the academic and professional community are accountable that will demand the separation of professional versus public interests.

The challenge for CODA and for the ADA in the future, will not be how to give the ADA more authority over CODA decision making and authority (as some stakeholders are requesting) but how to give it less. A trend identified in the benchmarking research is for accreditation agencies to begin as part of sponsoring "parent" organizations and then become legally separate entities. This shift generally occurs because new accreditation agencies are initially dependent on the finances, resources and good will of the sponsoring "parent" organization. As accreditation agencies mature, rifts often develop over financing, autonomy of decision making and perceptions that the accreditation agency is not being responsive enough to the sponsoring "parent" organization from which it evolved (and that is still "paying the bills"). Conversely, this developing rift is often exacerbated by public or regulatory interests that criticize the accreditation function as being too responsive to the special interests of its sponsoring "parent" organization.

This issue also needs to be examined from the perspective of the academic community and particularly the specialty organizations that appear to believe that the current system is too ADA controlled. They may embrace a structure that provides them legal independence from the ADA but then they, and the programs they accredit, will have to contribute to underwrite the expense. The issue of the need for independence, whether it is independence from the ADA or independence from a membership organization within a single specialty, will still need to be

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[3] Retrieved from www.jointcommiccion.org/AboutUs/mission-committments.htm, February 10, 2008
[4] Retrieved from www.acgme.org/acwebsite/newsroom/ataglance.asp, February 10, 2008

addressed. The future for accreditation will be more independence, not less, and USDE will not be the main driver here. The Spellings Report on the Future of Higher Education[5] concludes that it will be the Congress (with authority over multiple federal agencies) that will be demanding increased separation of accreditation from what Congress perceives to be self-serving professional and commercial interests. The federal government is also concerned over the proliferation of accreditation authorities. There is new and increased federal interest in examining accreditation and looking at good practice in accreditation. Essentially, best practice in accreditation, as well as requirements of regulatory agencies that recognize accreditation agencies, uniformly speak to the importance of the administrative independence of these programs.

The term "administrative independence" is generally interpreted to mean independence in the following areas:

- Setting and implementing standards: This includes developing the standards, approving the standards, developing criteria to use to determine how applicants demonstrate conformance to policies and procedures to decide which applicants meet or don't meet the standards, and finally, grant or deny accreditation.

- Developing and monitoring budgets: While it is common for accreditation bodies to receive funding from sponsoring associations or other interests, once the money is received–unless specifically earmarked for exam development or a special conference, etc.–the accreditation body has full responsibility and authority for determining how the money is spent.

An existing ISO standard (ISO 17011) includes requirements for accreditation bodies regarding organizational structure, capacity and accreditation processes. While the standard does not apply only to academic accreditors, several of the requirements in the standard are related to best practices in accreditation, which are very relevant to academic accreditation. ISO 17011 requirements[6] regarding independence state:

> *"The structure and operation of an accreditation body shall be such as to give confidence in its accreditations.*
>
> *The accreditation body shall have authority and shall be responsible for its decisions relating to accreditation, including the granting, maintaining, extending, reducing, suspending and withdrawing of accreditation."*

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Some organizations may be understandably frustrated that it "pays the bills but doesn't get the final say." But the only option for the credibility and integrity of the accreditation system and therefore the educational system is not for the ADA to have more of a say, but for the ADA to stop "paying the bills" and work out an alternative system as some of the other accreditation

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[5] USDE, A TEST OF LEADERSHIP: Charting the Future of U.S. Higher Education
A Report of the Commission Appointed by Secretary of Education Margaret Spellings, 2006

[6] ISO: **Conformity assessment — General requirements for accreditation bodies accrediting conformity assessment bodies 17011** ***ISO/IEC FDIS 17011:2004(E)***

agencies featured in the benchmarking study have done. Options for alternative systems are summarized in the following section.

Options for the ADA/CODA relationship

Achieving administrative independence as defined above can be achieved in three ways:

1. Set up a separately incorporated legal entity separate from the ADA for accreditation. The advantages of this model are that it protects the sponsoring association from the legal exposure created when making accreditation and certification decisions. It also tends to encourage programs to become more financially independent more quickly. It presents to the public a clear separation of functions and addresses what is often seen as a conflict of interest between the sponsoring membership organization's focus on protection of – and service to – members, and the role of certification and accreditation which should have as its primary purposes the improvement of the profession and the protection of the public.

   However such separation is costly to maintain due to redundancy in the use of resources. Most importantly though, in many instances it can cause rifts within the industry due to differences in opinion regarding how programs are operating. While these differences can certainly exist in the other models outlined below, they tend to become more difficult to resolve when organizations are entirely separate. In one example, the membership organization for Occupational Therapists actually sued the certification organization for that profession over a disagreement regarding the authority of the certification body and related concerns regarding policy decisions the certification body was making.

2. Form a subsidiary of ADA with independent decision making authority. Such a subsidiary would function much like an Association's Foundation and might have a separate tax status and Board but would be connected to ADA along multiple measures generally creating a memorandum of understanding (MoU) that specifies how the organizations will relate to each other and utilize resources. Several certification and accreditation programs are grounded in this model, including the National Restaurant Association Foundation which runs a certification program for food protection managers, as well as the National Franchise Association Educational Foundation which runs the certification program for Certified Franchise Managers.

   A very new accreditation program that accredits land trusts was created using this model. The sponsoring organization, the Land Trust Alliance, chose to maintain some level of control over the new accreditation system yet be responsive to expressed federal government agency (the IRS) concerns regarding the separation of agency member interests and public protection interests. These few examples appear to work quite well once careful MoUs outlining respective roles and responsibilities between the entities are negotiated. Plexus will be happy to provide some sample MoUs should the ADA wish to explore this option further.

3. Maintain accreditation as part of the ADA as it currently exists. This is the model that many accreditation agencies operate under. They include the accreditation entities affiliated with the psychology, speech pathology and audiology, and health information management.
   This is the model that Plexus recommends for CODA based on our understanding of the current environment and the issues that CODA faces. Demonstration of "separate" and "independent" must be reflected in the organization's bylaws. But this definition is actually quite narrow. For example, ASHA bylaws state:

> *"The Association by action of the legislative Council shall establish and maintain programs for certification…according to standards specified by the Council on professional standards and a program of academic accreditation according to standards specified by the Council on Academic accreditation... and shall maintain a registry of holders of such certification and accreditation."*

The ASHA bylaws further go on to specify the organization and authority of the certification and accreditation programs. For example, ASHA bylaws specific to the Council on Academic Accreditation in Audiology and Speech-Language Pathology state:

> *"The Association shall establish the Council on Academic Accreditation in Audiology and Speech-Language Pathology which shall define the standards for the accreditation of...and apply these standards in the accreditation of such programs. (…) The Council on Academic Accreditation in Audiology and Speech-Language Pathology shall have final authority to establish the standards and processes for academic accreditation and subject to the application of established appeal procedures the decision of the Council on Academic Accreditation in Audiology and Speech-Language Pathology shall be final."*

It will be of interest to the Task Force to know that these bylaws reflecting the language above had to be modified to satisfy USDE and subsequently CHEA requirements. While from an operational perspective the Standards programs always had the authority to set and apply standards, the bylaws didn't sufficiently clarify that authority, hence the need for the change. It might also be of interest to know that the Legislative Council of the Association, as well as the Executive Board, does have formal agenda items and discussion relating to the standards of certification and accreditation and has multiple opportunities for input – both as a Legislative Council and Executive Board – and of course as individual members of the Association. Some discussions at the Council and Board level were very extensive – particularly where there was the possibility of raising the degree tag for certification and eligibility for academic accreditation from a master's to a doctoral degree. However, the actual vote was conducted by members of the certification or accreditation bodies.

Plexus believes that CODA is not more autonomous from the ADA than other agencies are from their sponsoring organization. In fact, based on CODA's legal status, its location and its staffing structure, it is considerably less autonomous. The ADA/CODA relationship fails to conform to the accepted or best practice in accreditation in the way the ADA and CODA understand what their individual rights and responsibilities are and the way they communicate with each other.

Rights and responsibilities of the ADA and CODA

Based on the data collected in the benchmarking, all the accreditation agencies that had created a formal MoU reported that it was extremely helpful. What appears to be missing in the ADA/CODA relationship is a detailed memo of understanding (MoU) that spells out what the responsibilities of each of the organizations is to each other. This MoU is not typically created when the accreditation entity is part of the legal organization. It is more commonly done when the accreditation entity has its own legal status but relies on the sponsoring organization for resources (and often pays the sponsoring organization for supplying these resources). However, given the concerns that have been expressed through the research regarding the ADA/CODA relationship, the negotiation of an MoU can help better define the ADA/CODA relationship and provide each with a clearly negotiated list of expectations and behaviors. The

MoU can address issues from levels of funding, reporting processes, and other issues that appear to be problematic between the ADA and CODA.

This information is not likely to satisfy some interests who believe that the current relationship, while satisfying regulatory requirements is not satisfying perceived professional needs for more oversight and control. However it is also believed, based on the issue research conducted to date, that concerns regarding control are actually founded in what appears to be ongoing problems in communication between the ADA and CODA. Communication is addressed in a separate section of the benchmarking report.

Plexus recommends that the ADA and CODA establish a MoU to better define the ADA/CODA relationship and provide each with a clearly negotiated list of expectations and behaviors.

Communication

Information from several participants in the Advisory Panel meeting of the Task Force on CODA on October 31, the experiences that CODA staff reported and data from the electronic survey and phone interview surveys, all strongly suggest that CODA will need to do a better job communicating with its stakeholders. Concerns focused on the level of information being provided about how accreditation decisions are made, data regarding accredited programs and CODA operations and proactive opportunities to get stakeholder feedback. Based on the communication vehicles and processes that other accreditation agencies use, there are many alternatives for CODA to consider. CODA already recognizes that it needs to improve in this area and has established a communications committee. It will begin its work in January 2008 and it is not clear when it expects to conclude its work.

In discussions[7] with other accreditation agency executive directors, communication was mentioned as a challenge by virtually all the executive directors. Comments included:

- *"In accreditation, perception is reality."*
- *"Historical problems in communication tend to remain alive, often they are linked to individuals but are seen as indicative of the behavior of the Commission as a whole."*
- *"Leadership must include good communication skills and strategies."*
- *"We must be respectful of all entities involved including the public, students and the profession."*
- *"It is important to be good friends of our programs – educators want to think we are one of them."*

Communication is as much about marketing and making friends, as noted in the quote above, as it is anything else. One model that derived from the benchmarking that has worked very successfully and that CODA may want to emulate would be to create formal advisory bodies of employers, education leaders and the ADA leadership that can work with CODA on an ongoing basis and respond to CODA and vice versa in a systematic way. This might include responding to standards, policy changes and supporting communications to reach a broader group of internal and external stakeholders. As examples:

[7] Summary of conversations at AHIMA meeting on ACCREDITATION ORGANIZATION GOVERNANCE AND STRUCTURE , Chicago, Illinois, August 2, 2007

Internal stakeholder communication

- The American Health Information Management Association (AHIMA) designates a Board Liaison to its accrediting body, CAHIIM. The liaison attends all CAHIIM meetings as an observer. The liaison's responsibilities include sharing information about AHIMA activities that may impact on CAHIIM's activities. Likewise, the liaison is expected to go back to the Board of Directors and provide a report on CAHIIM issues and initiatives. A similar model has been successfully used for many years by the American Speech-Language Hearing Association (ASHA) with its Council on Academic Accreditation (CAA). The liaison, a member of the ASHA Executive Board, is not considered a member of the CAA. The liaison does not participate in accreditation discussions or decisions but has proven helpful in encouraging and often smoothing communications and relations between the CAA and ASHA.
- In yet another model, used by the Land Trust Accreditation Commission, two members of the Accreditation Commission are also on the sponsoring "parent" association Board of Directors. This model does not appear to work as well as the liaison model, because this model often creates conflicts of interests for the individuals holding dual allegiance as policies and budgets are formulated.

External stakeholder communication

- The National Institute for Certification in Engineering Technologies (NICET) has created an Industry Partner Initiatives program as stated in the NICET Web site: "*The goal of the new Industry Partner Initiatives program is to galvanize the support of these organizations for NICET's mission and to recognize them for their support for quality in the technical workplace. NICET maintains connections with corporations, associations, foundations, and government agencies across the spectrum of engineering technologies in order to keep its certification requirements accurate and current and its programs valuable.*" Partners include corporations that hire NICET certificate holders, associations whose members hire or hold NICET certificates, foundations with a focus on technology and government agencies that oversee workforce development units.
- The Certified Franchise Executive Certification Board has representation from major organizations such as Yum brands and other "fast food" chain owners that operate the largest franchises and the Conference for Food Protection Certification and Training Committee has designated seats for organizations that represent the major employers of certified food protection managers. In both instances, the designated organizations independently appoint their representatives to the certification group.
- Conversely, the chief staff officer for the American Association for Clinical Pathology – Board of Registry holds a seat on an independent Industry Council composed of chief executives of the major medical laboratories.

Plexus recommends that CODA communicate more effectively with its stakeholders.

Size of CODA

The benchmarking revealed that there is no optimal size for a Commission of an accreditation agency. Size ranged from six members in the ANSI-Conference for Food Protection Accreditation Committee to thirty members in CODA. Size of commission was largely dependent on the number of organizations supporting the accreditation entity that had to be represented at the table, and the level of work that the Commission needed to do. In some instances, commissions increase in size because of work load concerns, particularly in agencies where commission members also serve on review teams. For example, the American National

Standards Institute recently expanded the size of its Personnel Certification Accreditation Committee from sixteen to twenty members to provide broader representation and also to address Committee member work load concerns. The Land Trust Accreditation Commission has petitioned its sponsoring organization to add two additional members, expanding its numbers from thirteen to fifteen to address Commission member work load concerns.

Plexus believes that CODA falls within the upper range relative to size which is appropriate for the large scope of CODA's activities.

Composition of CODA – achieving balance and participation

Preliminary research indicated that there were concerns from some stakeholders regarding the composition of CODA both in terms of size and the respective representation on CODA and on the review teams of specialty area representatives. Specific concerns were voiced regarding the balance among representatives of specialty groups, and also the balance between educators, practitioners and public members.

Best practices in accreditation (and also personnel certification) require that these bodies be representative of all stakeholders. The USDE requirements for recognition of accrediting agencies stipulate that there be one public member for every six members of the profession. ISO 17011 includes requirements for accreditation bodies regarding organizational structure, capacity and accreditation processes. While the standard does not apply only to academic accreditors, several of the requirements in the standard are related to best practices in accreditation, which are very relevant to academic accreditation.

ISO 17011 requirements[8] regarding the composition of accreditation agencies are as follows:

> ***4.3.1*** *The accreditation body shall be organized and operated so as to safeguard the objectivity and impartiality of its activities.*
> ***4.3.2*** *For safeguarding impartiality and for developing and maintaining the principles and major policies of operation of its accreditation system, the accreditation body shall have documented and implemented a structure to provide opportunity for effective involvement by interested parties. The accreditation body shall ensure a balanced representation of interested parties with no single party predominating.*
> ***4.3.4*** *All accreditation body personnel and committees that could influence the accreditation process shall act objectively and shall be free from any undue commercial, financial and other pressures that could compromise impartiality.*
> ***4.3.5*** *The accreditation body shall ensure that each decision on accreditation is taken by competent person(s) or committee(s) different from those who carried out the assessment.*

CODA's broad representation appears very consistent with practices in accreditation. Most groups do not formally require that all Board members come from accredited programs. Such a requirement would violate best practices since accreditation systems require participation of all interested parties. These would include employers, consumers, regulators, and students. As a practical matter, practitioners sitting on certification boards do hold that agencies certification(s)

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[8] ISO: **Conformity assessment — General requirements for accreditation bodies accrediting conformity assessment bodies 17011** ***ISO/IEC FDIS 17011:2004(E)***

and representatives of the education community sitting on accreditation Boards come from accredited programs—if the program they come from is eligible for accreditation. For example, the American Speech-Language Hearing Association (ASHA) accredits educational programs that are considered to offer entry to the profession, which for speech-language pathologists is the master's level. There are undergraduate program directors that might sit on the Council on Academic Accreditation but these programs are *de facto* not eligible for accreditation. All agencies examined specify, as does CODA, the number and type of members on Commissions and other working groups. CODA has among the largest number of members. ASHA has among the smallest number of members, particularly taking into consideration that the CAA is responsible for accrediting programs in two independent professions. ASHA bylaws stipulate that there are eleven members. Seven are from accredited academic programs, three are practitioners from non academic settings, one is a public member, and staff members are designated as *ex officio* non-voting members. Because the Council is accrediting programs in two professions, the bylaws further specify that five of the voting members represent hearing pathology, four of whom must hold ASHA certification in audiology, and five of the voting members represent speech-language pathology, four of whom must hold ASHA certification in speech-language pathology.

One element that appears to be missing from CODA is the formal representation of the major decision leaders outside the dental community. While CODA has four public members, these individuals are designated to represent the public at large, not a specific industry or agency. CODA may want to broaden its reach to include representatives from organizations that employ dentists or develop regulations that affect the practice of dentistry. This can help accreditors market themselves but can also help accreditors understand the changing market forces that are likely to affect educational content. Many programs across all industry sectors include employers (especially employers that are recognized industry leaders) on accreditation bodies. For example:

- The Certified Franchise Executive Certification Board has representation from major businesses in the franchise industry. The Conference for Food Protection Certification and Training Committee has designated seats for organizations that represent the major employers of certified food protection managers. In both examples, the designated organizations independently appoint their representatives to the certification group.
- The Personnel Accreditation Committee of the American National Standards Institute has representatives from government agencies, including the Department of Defense and Department of Labor that care about accreditation issues.

Plexus believes that CODA's broad representation appears very consistent with practices in accreditation. One element that appears to be missing is the formal representation of the major decision leaders outside the dental community.

Recruitment, terms of leadership

Ability to recruit a sufficient number and diversity of individuals to participate in CODA as commission members, review team members and site visitors appears to be an issue. In addition, the limited terms of office and/or inability to serve multiple terms present challenges for orienting and calibrating participants.

A typical term of office is three years with eligibility for a successive term. This provides the opportunity for volunteer leaders to gain knowledge and provide leadership. Six years is not a long time to commit to learning and leading. Some organizations permit more successive terms

to promote leadership development. This keeps well-experienced leaders in the picture, but can also lead to burnout and stagnation.

Organizations are divided on the election of officers, but the trend seems to be for Commissions and boards to elect their leadership.

- It is the body most knowledgeable about the persons among them and within the organization who have the needed leadership skills.
- It knows what kind of leadership the board needs.
- Members must work under the leadership and should select the persons they most respect and follow.

Commissions and boards regularly perform a board profile, identifying the skills and expertise needed to meet the strategic priorities of the organization and to identify the leadership skills that will be lost in upcoming years through term limits.

Plexus recommends that CODA regularly perform a board profile.

Serving with portfolios

It is not clear whether individuals on CODA that are nominated by their respective special interest groups view their role on CODA as representing the interest of the specialty that nominated them or whether they are expected or willing to leave portfolios behind once elected and view issues from a broad perspective. It is clear from research on effective governing boards[9] that the latter model is the most desirable. It is not clear if CODA demands this model and/or offers sufficient education to entities conducting the nominations or to individuals once elected, what the expectations are in this regard. Benchmarking revealed that there was wide variance among accreditation agencies regarding expectation of the roles of their members regarding serving with portfolios. Some agencies expected members to bring their portfolios to the table while others did not. What was expressed as being most problematic were instances in which expectations were not clear, with commission members having varying perspectives about their roles. To paraphrase a participant in a focus group that another accreditation agency held on the issue of portfolios: "*When I vote on an issue, am I voting for what I think is the best decision, should I be polling the members of the group that appointed me to the Commission or at least voting based on what I think would be in their best self interest. I am not clear what is expected of me.*"

Plexus recommends that CODA should clarify with members that they do not serve with portfolios.

Selecting members

There are four general ways to chose members of certification or accreditation bodies. All of these methods are considered acceptable by USDE, CHEA, and also comply with international standards for accreditation entities.

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[9] Carver, John. *Boards That Make a Difference*, 3rd Edition, New York: Jossey-Bass, 2006.

a) Each stakeholder group (for example educational associations, employment sectors, and funders) independently appoints a predefined number of people. Stakeholder groups are given the autonomy to define the qualifications and the appointment process.
b) The Board of Directors of the sponsoring association solicits nominations and then holds an election from among its membership of the membership and/or from among the direct users of accreditation (for example, accredited programs).
c) The Board of Directors of the sponsoring organization appoints members to the certification or accreditation body trying to keep in mind some degree of balance between the types of participant.
d) The Accreditation Commission holds its own nomination process, soliciting nominations from broad categories of stakeholders. A nominating committee of the Commission then culls through the nominees and presents a slate to the Commission. The Commission then votes its new members. An alternative that is commonly used in accreditation is for the nominees to be voted on by the accredited programs in the academic community.

Plexus believes that CODA's member selection process is consistent with accepted practices.

Training Provided to Review Team members and Commission members

Working in the areas of certification and accreditation requires special technical expertise. Many organizations, such as the Land Trust Alliance Accreditation Commission, have detailed job descriptions for their volunteers. They also invest considerable time matching volunteer interests and skills to organizational needs. The Smithsonian Institution requires that all volunteers go through a rigorous training period and periodic re-training. Only those who successfully pass training requirements and demonstrate skills and attributes needed are then assigned to volunteer positions within the organization.

The American National Standards Institute (ANSI) requires a mandatory one-week course for assessors (site visitors). Assessors must pass an examination. The assessors then often progress to become members of Accreditation Committees.

The Baldrige program recognizes organizations that have demonstrated quality practices and systems. This award program is not described as an accreditation process, but it does involve demonstrated compliance with quality standards, a rigorous peer review and judgments process, and awards for applicants that demonstrate a high level of performance and achievement in the required areas. Assessors who make these judgments, called Baldrige Examiners, have to complete between 117 and 142 hours of supervised work and training.

Many of the benchmarked accreditation programs require site visors to serve as observers for a prescribed number of visits before they can actually be assigned site visitor responsibilities. None of the accreditation agencies believed they had a really good system of training. In fact, due to the expressed needs of its members for better training models, the Association of Specialized and Professional Accreditors will be conducting a full-day workshop on training models at an upcoming meeting. Meeting organizers have reported that it has been very difficult to identify accreditation agencies whose training programs represent best practices.

Plexus recommends that CODA maintain its process to train assessors and review team members prior to sending them on assignments. What about re-training?

Role of the Public in Accreditation

One clear shift in accreditation is the increasing importance of accreditation as serving a public function and the need for more public involvement in the accreditation process. All of the accreditation agencies studied reported much more outreach to the public in terms of the amount of information being shared and the methods being used to get feedback from the general public on accreditation value and processes. Many accreditation agencies including TJC and North Central survey their public constituents to assess the public's perceptions of the value of accreditation.

Plexus recommends that CODA consider public outreach programs, as described above and below, both for gathering public concerns and opinions and to create awareness of the benefits of its accreditation programs for the public.

Public Members of Commissions and Review Teams

There is a wide variance in accreditation agencies in how public members are used—some do participate in review teams, as is the CODA model, while other accreditation agencies limit public participation to only the level of the Commission. However, none of the accreditation entities studied reported that the public had an unseemly or too influential role in the accreditation operations. Based on the survey conducted on behalf of the Task Force, there appears to be no evidence that public members of CODA or CODA review teams have shifted accreditation decisions in a direction that is different from those recommended by content matter experts. To the contrary, people interviewed believed that the public members add a fresh eye and can help reduce turf protection and other conflicts of interest that are sometimes observed. CODA can reexamine the job descriptions and qualifications for public members of CODA and adjust these to populate CODA with public members whose skill sets will specifically enhance CODA operations.

Plexus believes that the role of public members in CODA is consistent with accepted practices.

Providing information to the Public

CHEA recently published a study entitled *Current Accreditation Practice With Regard to Information to the Public.*[10] The study results summarized below have relevance for CODA.

- *Information about the accrediting process.*
  All accrediting organizations provide information to the public about how the accreditation process works. This is done either in print (90 percent) or on organizational Web sites (95 percent) or both. Ten percent of accreditors distribute this information upon request.
- *Information about current accredited status of institutions and programs.*
  All accrediting organizations provide information to the public about the current accredited status of the institutions and programs they review. This is done either in print (80 percent) or on an organizational Web site (95 percent) or both. Ninety-five

[10] Council for Higher Education Accreditation, CHEA Survey of Recognized Accrediting Organizations: Providing Information to the Public *May-June 2005,*CHEA Occasional Paper, March 2006. Retrieved from www.chea.org. Feb 1, 2008

percent of accreditors distribute this information upon request. Twenty-seven percent of accreditors provide an accreditation history.

- *Information about accreditation operations and activities.*
  Two-thirds of accrediting organizations prepare an annual report or similar document that describes their activities for a given year. Fifty percent place this report on their Web sites, and 50 percent provide this in print form. These reports include information on the types of actions that are taken.
- *Summary information about institutions and programs that are accredited.*
  One-third of accrediting organizations provide descriptive information about the institutions and programs they accredit. Data in these reports include enrollments, faculty size, degrees earned and descriptions of degrees or program offerings. Eighty percent of those providing the information make it available on Web sites and include contact information or Web links to the institutions or programs.
- *Information on the results of individual accreditation reviews beyond accredited status.*
  Eighteen percent of the accrediting organizations provide information to the public about the results of individual reviews beyond reporting on formal actions. The information may include descriptions of the results of a review with reference to specific accreditation standards, summaries of strengths or good practices, summaries of weaknesses and deficiencies, extracts of team reports or action letters, full team reports or action letters and institutional or program responses.

Specifically out of 66 accreditation agencies that participated in the survey:

- 44 accreditors provide an annual report or other operations summary.
- 31 accreditors provide descriptive summaries of institutions or programs.
- twelve accreditors provide information on results of individual reviews beyond accredited status.
- eleven accreditors provide information about institution or program performance or student academic achievement.
- fifteen accreditors require institutions or programs to make public the information they compile about the institutional and program performance or student academic achievement.

Many state regulatory agencies that accredit higher education programs have expanded their Web sites to make it easier for the public to participate in accreditation.

Plexus believes that the amount of information that CODA provides to the public conforms to accepted practices, but recommends that CODA consider providing this information in more easily accessible formats for the public.

Role of staff

Benchmarking research indicated a wide range of staff roles in accreditation. For example, ACPE staff participates in each site visit. ACPE staff also provides recommendations and fully participates in the accreditation decision discussion at the Council meetings, but only the Council members have a vote. In some regional accrediting agencies, staff routinely participates on site visits, in others they do not. Based on the benchmarking research it appears that senior staffs are often members of the profession and/or the academic community. But this is not the case in all accreditation agencies. For example, ASHA made a deliberate decision about fifteen years ago not to hire senior staff with a background in the professions but to hire staff with specific expertise in accreditation. The decision was made due to concerns about staff members

overstepping their roles and becoming more like accreditation reviewers rather than process facilitators. In general, staff should have skill sets that complement those of the members of the accreditation agency volunteer leaders, not compete with them.

CODA staff provides important content matter expertise in accreditation and also contribute important historical perspectives which are critical to calibrate decision making and provide fair and equitable treatment to accreditation applicants. It is suggested that CODA obtain staff support in two additional key areas: public relations/communications and CQI. While these skills are generally expected of all senior staff what is suggested here is that an individual with specific expertise in PR/Communications be retained to design and oversee the implementation of a communications and public relations plan. This need for an expert in CQI is further explained in the section in this benchmarking report that addressees strategic planning and evaluation.

Plexus believes that CODA's functioning could be improved with the addition of experts in public relation/communications and in Quality Management Systems.

<u>Accreditation process</u>

CODA is responsible for assessment of some 1,300 educational programs. There is commonality among the organization's approaches to accreditation which includes:

1. A set of self-study materials are designed and presented by the Institution of Higher Education (IHE) or other training program that address a set of standards which had been designed by the accrediting body. The standards of each organization have typically been prepared by a transparent sub-group and revised frequently.
2. A group of trained on-site examiners visit the organization to confirm and validate the self-study materials.
3. A council or commission comprised of organization members serves as the legal decision-maker awarding accreditation or a pre-accreditation status.
4. A timeline cycle of re-accreditation, including updated statistics regarding graduates of the program is provided.
5. A procedure to deal with disputed outcomes, conflict of interest and/or requests for re-evaluation is in place.

A more detailed review of the procedures used by the accreditation agencies used for this benchmarking study provides CODA with many supportive positions. Almost all the similar accreditation agencies utilize:

1. Self-study documents reviewed by a professional (unpaid) group which then prepares for an on-site visit.
2. The on-site team validates materials in the self-study documents.
3. The on-site team makes a report to an established, multidisciplinary commission of professionals that almost always includes professional educators, professional practitioners, public members, community liaison members, and community representatives.
4. The professional commission reports to the governing body of the association and rarely differs from the report of the on-site team. When the commission does differ, documentation is extensive, reliable and valid, so that members of the association are able to assess and weigh conclusions effectively. Issues of conflict of interest, errors of reporting, lack of adequate responses can be addressed by a separate sub-committee.
5. Public reporting—a listing of approved programs is maintained and distributed.

Plexus believes that procedures utilized by CODA (as described in materials detailing the Commission on Dental Accreditation) are in agreement with best practices of similar organizations.

Levels of accreditation

Accreditation is seen as a bar representing minimal standards of compliance. Those programs that fall below the bar are sometimes acknowledged through categories similar to those that CODA uses, typically accreditation with recommendations and probation. In this regard, CODA provides more information than many other higher education accreditation groups whose only public designation is accredited. Some accreditation entities do not even publish probationary status, since the USDE considers probation to mean that the program is still accredited. A common practice is not to publish probation but to only respond to direct inquiries regarding whether a specific program is on probation. CODA's policies then, in regards to public information about levels of accreditation, exceed what typically occurs.

Most accreditation bodies do not use any system that publicly distinguishes exemplary programs. However, there are some that do provide information on programs that exceed the bar of acceptability. For example, The Joint Commission awards high performing health care organizations with the Ernest Codman Award. This award is the only health care award that recognizes excellence in performance measurement that contributes to organization improvement. The Council on Law Enforcement Agency Accreditation (CALEA) identifies "Exemplary Programs" that have demonstrated best practices that others may want to emulate on their Web site. The U.S. Chamber of Commerce Accreditation program publishes a rating system of one to five stars. The American National Standards Institute (ANSI) provides commendations to applicants in its accreditation report and is developing a system to publicly disseminate information about commended organizations and for what they have been commended. However the ANSI system will retain a single level of formal accreditation. The advantage of such levels is it encourages programs to strive for higher levels of performance and supports the concept of accreditation as fostering, and in these cases rewarding, continuous quality improvement. The disadvantage is that it requires an objective, valid and reliable system for making these kinds of judgments. Furthermore, many accreditation agencies believe that such a system exceeds their authority and is not consistent with their core mission.

CODA provides more information than many other higher education accreditation groups.

Relationship with USDE

Just as accreditation of an academic program fosters program improvement and confers a level of credibility to that program, recognition of an accreditation entity by an external third party encourages continual improvement and confers additional credibility to organizations—promoting their recognition in national and international arenas. Because external recognition is generally perceived as a mark of quality, it can provide a competitive advantage for recognized programs in an environment where multiple programs compete for the same or similar occupational titles and where individuals have multiple educational programs to choose from.
Another major benefit is that recognition can increase access to international markets. Other advantages of accreditation include: a) increased recognition among key stakeholders such as relevant government agencies, employers and consumer groups; b) increased competitive advantage; and c) membership in a network of "Best Practices."

There appears to be a strong trend for state and federal agencies to begin to rely on external third-party measures of quality in order to make distinctions among organizations. Many state and federal agencies are increasingly demanding accreditation of personnel certifications and accreditation of educational institutions.

For example, California adopted legislation that permitted physicians to advertise a specialty certification only if the certification was from an American Board of Medical Specialties (ABMS) recognized board or equivalent, or if the physician had some specific specialty graduate residency training. The U.S. Court of Appeals has more recently upheld this finding for the Ninth Circuit. Additionally, legislation was proposed in California that would have permitted licensing boards to recognize only those phlebotomy certifications accredited by the National Commission for Certifying Agencies (NCCA) or an equivalent accreditation group. Massachusetts recently passed regulations that require individuals offering financial services or financial advice to individuals over the age of 65 to hold a certification accredited by NCCA or ANSI.

After considerable review of current program's affiliations with specific departments of the United States government agencies; specifically, Department of Education and Department of Health and Human Services (DHHS), it is clear that at this time most organizations maintain their approval status in order to facilitate grants, contracts, research awards, stipends for students, and loan programs for students. The requirements for USDE or DHHS recognition appear less intrusive than the benefits of recognition for members.

One finding from the research the Task Force conducted to date is that it may not be possible to quantify the financial value of CODA recognition by the USDE to educational programs in dentistry. CODA staff and ADA legislative personnel do not have the data to determine exactly what level of financial assistance is being used by, or even potentially available to, CODA accredited programs that directly results from USDE recognition of CODA.

CODA staff indicated that they tried to collect this information before and that program directors themselves did not have this information. Additionally, CODA staff reported that even the federal agencies that reference CODA accreditation as a condition of participation in certain federal programs did not have this information when CODA staff attempted to secure it.

It appears that this situation is not unique to the ADA. Other accreditation agencies that are USDE recognized did not believe that they or the programs they accredit have "good data." Despite the lack of data on financial impact, other programs that participate in USDE programs as a result of accreditation believe that the potential of utilizing these federal funds, being referenced in federal regulation and the prestige of recognition by an external oversight agency are sufficient reasons to maintain recognition.

Other reasons for maintaining recognition that have been reported by other agencies include improving the credibility of the program to stakeholders and the fact the federal oversight promotes best practice in accreditation and ensures that the quality of the accreditation structure and process is not influenced or obstructed by political or special interests.

At a meeting of specialized accreditors held in Chicago[11] in the spring of 2007, all of the Executive Directors attending said that they valued USDE recognition because it gave their

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[11] Summary of conversations at AHIMA meeting on ACCREDITATION ORGANIZATION GOVERNANCE AND STRUCTURE , Chicago, Illinois, August 2 (is this spring? See above), 2007

programs increased credibility. Those that didn't have this recognition wanted it. In a recent survey conducted by the ASHA, "The number one value of the {ASHA} CAA accreditation program, that gives the most benefit, as identified by 64 percent of respondents, is the national recognition of {ASHA} CAA accreditation." [12]

None of the organizations studied for this benchmarking appear to have voluntarily chosen to withdraw from USDE recognition. Several organizations that were formally recognized by USDE lost recognition when USDE reframed it eligibility requirements. Some papers presented to the ADA Task Force on CODA by its Advisory Group noted that ACGME chose not to be recognized by USDE. ACGME is not eligible to seek USDE recognition as an accreditation agency. USDE recognition is only available to accrediting agencies that accredit programs housed in degree granting academic institutions. ACGME accredits medical specialty residency programs that are housed in hospitals, not in institutions of higher education. These residency programs do not confer a degree. ACGME is not eligible to apply for recognition under USDE. ACGME is however recognized as an accreditor by other federal agencies, such as the CMS section of HHS. Such recognition carries with it its own very stringent requirements and oversight mechanisms. The suggestion provided to the ADA Task Force on CODA that accreditation systems that fall under the umbrella of ACGME have less federal interest and involvement is not substantiated by the benchmarking research.

Plexus strongly recommends that CODA maintain its USDE recognition.

Relationship with the Council for Higher Education Accreditation (CHEA) and other Academic Accreditation Agency recognition bodies

CHEA is a membership organization of colleges and universities that recognizes Academic Accreditation programs. Located in Washington, DC, CHEA functions as conduit for members to review their accreditation issues. It feels it is a bulwark against "degree mills" and other types of unregulated post secondary and higher education programs that do not serve students in positive ways. Recent additions to CHEA monitoring include distance learning and community college transfer articulation agreements. Some 16,000 volunteers are engaged in the program reviews that include 81 recognized organizations and a $70 million dollar budget in the 2004-2005 academic year. Some 3,000 degree granting IHEs interact with CHEA via their regional accreditation or specialized accreditation programs. CHEA offers strong networking and educational opportunities for accreditation agencies including national conferences and a myriad of guidance documents on key issues and trends in accreditation. These networking and educational opportunities are already available to CODA and to the public.

CODA is very familiar with the standards and operating polices of the Council on Higher Education Accreditation (CHEA) and has already explored with CHEA the possibility of seeking CHEA recognition. Since CODA already satisfies USDE recognition requirements, Plexus believes that CODA will have little difficulty in satisfying CHEA requirements for recognition should it chose to apply. However, it is not clear at this time what additional benefits CHEA recognition will provide to ADA or to CODA.

There may be other recognition programs for academic accreditors to consider. The International Organization for Standardization (ISO) is becoming increasingly interested in

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[12] Retrieved from http://www.asha.org/accreditation . February 1, 2008

education programs. There are three new ISO standards being developed that will address how academic programs should operate. Additionally, ANSI is developing an accreditation program to accredit certificate programs. This new accreditation system is expected to have some relevance for accreditation bodies that accredit certificates offered in the higher education programs they are currently accrediting.

In addition, there is an existing ISO standard (ISO 17011) that includes requirements for accreditation bodies regarding organizational structure, capacity and accreditation processes. While the standard does not specifically apply only to academic accreditors, several of the requirements in the standard relate to best practices in accreditation, which are very relevant to academic accreditation. ANSI is exploring the feasibility of developing a system to recognize academic accreditors against this standard or some variant of the standard. This program is not likely to be operational for at least two years. However, it is recommended that CODA look at ISO 17011 and cross-walk within the relevant requirements to determine where it complies, and where it does not. Such an exercise will help CODA identify where it is in compliance with best international practices in accreditation. It would be perfectly legitimate, if it sees an advantage to doing so, to publicly declare its perceived level of compliance with this standard and its interest in following its relevant requirements. Several relevant sections of this standard have already been referenced in this benchmarking report.

Plexus believes that CODA should investigate the benefits of CHEA recognition and should monitor the development of potential new recognition opportunities.

Impact on CODA when taking on an international component

CODA is beginning to explore how it will accredit non-U.S. dental education programs. There are several models that accreditation bodies use to do this. These will be reviewed in the benchmarking. Additionally, the impact of this on the Commission structure will need to be considered. For example CODA may be enlarged to accommodate leaders from international affiliates. It appears that the expectation is that CODA would remain a unified body governing the entire process; however the issue of whether review teams will be created or modified to address specific countries will need to be explored. An alternative used by other organizations is to create Advisory Councils. Based on the experiences of others the most effective structure is a unified Commission not divided by national boundaries.

It appears that the ADA, HOD interest in having CODA move toward international accreditation is very limited in scope. That is, CODA is not being asked to develop an international accreditation system, as many other accreditation agencies are doing but to rather focus on developing a system in response to requests from the licensing community to assess whether foreign educated dentists applying for licensure have an education that would be comparable to that offered in the U.S. This scope of CODA's international expansion is quite narrow. To complete this aspect of its work, CODA can look at how other agencies evaluate educational programs in other countries for the purpose of facilitating cross frontier mobility of personnel. For example, the International Commission on Healthcare Professions (ICHP), a division of CGFNS International, has been authorized by the Department of Homeland Security (DHS) to evaluate the education of certain foreign healthcare workers who want to obtain visas to work in the U.S. Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) requires that certain foreign health care workers have their credentials evaluated and certified before they will be allowed to work in their profession in the United States.

The regulations cover workers in nine major health care occupations. They include: nurses, registered nurses and licensed practical (vocational) nurses; physical therapists; occupational therapists; medical laboratory technicians; medical technologist (scientists); speech language pathologists and audiologists; and physician assistants.

To obtain the required certification, called the CGFNS *VisaScreen*™ Certificate, CGFNS must verify that:

- The foreign health care worker's education, training, license, and experience is comparable with that required for a U.S. worker of the same type;
- The foreign health care worker's education, training, license, and experience is authentic and, in the case of the health care worker's license, unencumbered. The rule requires that the verification of the education and license come directly from the issuing source.;
- The foreign health care worker's education, training, license, and experience meets all applicable statutory and regulatory requirements for admission to the U.S.;
- If the health care worker is a registered nurse he or she must have passed either the CGFNS Qualifying Exam or the NCLEX-RN; and
- The health care worker must have passed an approved English language proficiency examination.

CODA can look at the systems that ICHP uses to evaluate educational equivalency which are created by profession specific standards committees for each for the health care profession covered in the regulation. The Educational Commission for Foreign Medical School Graduates assesses the readiness of international medical graduates to enter ACGME accredited medical residency programs. The Foundation of Advancement of International Medical Education and Research (FAIMER) maintain a directory of international programs that are recognized by the appropriate recognition agency in their country. However, it does not appear that FAIMER has any system to assess the actual equivalency of the medical education to U.S. requirements. Several accreditation agencies in the U.S. are already offering accreditation to educational programs in other countries. These include programs in laboratory medicine. ASHA helped design a Mutual Recognition Agreement (MRA) for recognition of credentials of speech pathologists that will soon include six countries. A condition for participating in this MRA is demonstrating that the professional educational programs in the petitioning country are substantially equivalent to that offered in the other countries that participate in the MRA. The procedures for doing this are quite codified and include examination of course content, level of instruction, level of clinical training, qualification of instructors, materials used, evaluation methods, etc.

Plexus recommends that ADA explore opportunities to expand accreditation internationally.

<u>Strategic planning and ongoing evaluation</u>

It is curious that while accreditation agencies foster continuous quality improvement and that self-study is a requirement for accreditation enforced by all the accreditation agencies examined (including CODA), accreditation agencies themselves are far behind their accredited programs in establishing systems of quality management and review within their own accreditation agencies. CODA does what other agencies do, including systems whereby applicants can evaluate the accreditation experience and the site visitors. CODA also has some semblance of a strategic planning process whereby strategic objectives are defined and examined annually.

However, CODA's system is not state of the art in this regard. CODA's system for periodically evaluating itself and making changes in response to stakeholder input, priorities and environmental shifts should be examined. It appears that there may be alternative and better ways to accomplish this than the methodology CODA currently employs.

International Guidance on how Accreditation agencies are to conduct quality improvement through management systems is found in ISO 17011[13].

Requirement 5.1.1 states*: "The accreditation body shall establish, implement and maintain a management system and continually improve its effectiveness in accordance with the requirements of this International Standard.*"
The standard further goes on to address how internal audits are to be conducted:

> ***5.7.1*** *The accreditation body shall establish procedures for internal audits to verify that they conform to the requirements of this International Standard and that the management system is implemented and maintained. NOTE: As an indication, ISO 19011 provides guidelines for conducting internal audits.*
> ***5.7.2*** *Internal audits shall be performed normally at least once a year. The frequency of internal audits may be reduced if the accreditation body can demonstrate that its management system has been effectively implemented according to this International Standard and has proven stability. An audit programme shall be planned, taking into consideration the importance of the processes and areas to be audited, as well as the results of previous audits.*
> ***5.7.3*** *The accreditation body shall ensure that:*
> *a) internal audits are conducted by qualified personnel knowledgeable in accreditation, auditing and the requirements of this International Standard;*
> *b) internal audits are conducted by personnel different from those who perform the activity to be audited;*
> *c) personnel responsible for the area audited are informed of the outcome of the audit;*
> *d) actions are taken in a timely and appropriate manner;*
> *e) any opportunities for improvement are identified.*

The standard also defines requirements for management reviews as follows:

> ***5.8.1*** *The accreditation body's top management shall establish procedures to review its management system at planned intervals to ensure its continuing adequacy and effectiveness in satisfying the relevant requirements, including this International Standard and the stated policies and objectives. These reviews should be conducted normally at least once a year.*
> ***5.8.2*** *Inputs to management reviews shall include, where available, current performance and improvement opportunities related to the following:*
> *a) results of audits;*
> *b) results of peer evaluation where relevant;*
> *c) participation in international activities, where relevant;*
> *d) feedback from interested parties;*
> *e) new areas of accreditation;*
> *f) trends in nonconformities;*
> *g) status of preventive and corrective actions;*

[13] ISO: **Conformity assessment — General requirements for accreditation bodies accrediting conformity assessment bodies 17011** ***ISO/IEC FDIS 17011:2004(E)***

h) follow-up actions from earlier management reviews;
i) fulfillment of objectives;
j) changes that could affect the management system;
k) appeals;
l) analysis of complaints.

5.8.3 *The outputs from the management review shall include actions related to*
a) improvement of the management system and its processes,
b) improvement of services and accreditation process in conformity with the relevant standards and expectations of interested parties,
c) need for resources, and
d) defining or redefining of policies, goals and objectives.

Many accreditation programs are engaging in CQI processes. For example, in 2005 the ASHA CAA has instituted a CQI management system that attempts to be compliant with ISO standard 17011. They learned about this system because they are trying to have their personnel accreditation system recognized by ANSI. Accreditation by ANSI requires evidence of a CQI system. While ANSI does not at this time recognize accreditation agencies, ASHA determined to put this system in place in response to concerns expressed by some members of the academic community about how the CAA operates. It is believed that having such a management system can allow the CAA to systematically collect information about stakeholder perceptions, address stakeholder concerns and identify and address other aspects of the accreditation program, including its internal operations that can be improved.

As an example of how this system works, one aspect of the system was to collect feedback from key stakeholders. The ASHA Web site[14] reports that an online survey was conducted in April 2007 to collect feedback from accredited academic program directors, faculty, CAA site visitors, and accreditation program staff. Of those surveyed, 166 individuals (51 percent response rate) provided input. Results indicated that 60 percent of respondents from academic programs are very or somewhat satisfied with the academic accreditation program offered by the CAA. Further, 55 percent of accredited clinical doctoral programs in audiology indicated that they were very or somewhat satisfied.

Based on these findings the CAA published its 2007-2008 goals, they include:

- complete revision of the candidacy application and process;
- easier access by programs to expected timelines and greater adherence by CAA to those published timelines;
- training of new site visitors and re-training/calibration sessions for current site visitors;
- more/clearer guidance to programs as to what the CAA is seeking in order to demonstrate standards compliance (as offered through upcoming CAA webinars);
- streamlining of the Application and Annual Report form;
- implementation of an online application and annual report process through the Higher Education Data System (HES), that will eliminate many of the previous problems with faculty data collection and table formatting, redundancy of information collected, and re-entering of same data from year to year (e.g., through use of pre-population).

Often, agencies use an external auditor to collect and review this information. For example, the National Association of State Boards of Accountancy (NASBA), that coordinates administration

[14] Retrieved from http://www.asha.org/accreditation . February 1, 2008

of the national CPA exam and licensure of certified public accountants, undergoes a comprehensive review of its strategic plan every three years using an outside consultant. The mission is reviewed for relevancy, current member needs are identified, and NASBA discusses how to address these needs. The strategic plan is then updated.

It is highly recommended that CODA seek outside assistance from a quality management system expert to help them design and implement a quality management system. Further guidance on suggested components of such as system that have specific relevance for accreditation can be found in an guidance document published by ANSI entitled Guidance for Confrmance withISO/IEC 17024 Requirements for Management Systems. This document can be retrieved at no cost from the ANSI Web site, http://publicaa.ansi.org/sites/apdl/documents/conformity assessment/personnel.

CODA should establish on-going evaluation measures to systematically monitor the use of CODA accreditation and certifications and their perceived value.

V. Trends in Accreditation

Increased use of advanced technology

Several respondents in the phone interviews indicated that new technologies will radically change the way accreditation is conducted.

A helpful example of how an organization has used new technologies is ANSI. Until 2004, ANSI maintained records and documentation related to the accreditation activity in a variety of media including shared drives, hard copy archives, staff emails, elements of third-party software, etc. Due to the beginning of rapid growth of accreditation activity in several programs, ANSI needed to improve its capacity for data collection, storage and retrieval. Additionally, process tracking capabilities were need to ensure timely execution of all the different tasks related to the accreditation activity by the responsible staff. ANSI's director of accreditation services reported:

> "*ANSI first looked at third party off-the-shelf as well as customized solutions and faced the following problems: the first category, although affordable, did not present much value since it did not sufficiently match the accreditation workflow and specifics of our complex processes and therefore did not present significant improvement over the existing methods we used; the second option proved to be extremely pricey as well as time consuming with quotes ranging from $250-$500k and turnaround close to a year. The problem is that third party developers are not familiar with ANSI process and countless staff hours would be needed to guide them to create the system that works right. ANSI decided to develop a proprietary application in-house, utilizing the strong combination of knowledge of the process as well as technical skills that staff offered. The resulting product was called ANSICA which we began to use in mid 2004. It houses all the organizations that we had in our previous legacy dataset, as well as information on assessors, contacts, accreditation committees and their members, various scopes of accreditation offered and generally all the other elements that are related to accreditation activity. Another strength of the system lies in its process-tracking capabilities. It allows for a customizable assessment tracking mechanism where each step of the process follows a pre-determined sequence and provides not only the ability for staff to store records of assessment in that specific step, but also offers visual workflow / workload and reminder mechanism ensuring that each task is completed and checked off. Finally, the biggest advantage of the system which allowed us to actively and successfully use it without virtually unchanging anything for the past four years is its unique design which allows for user definition of assessment process, step by step, making it as detailed or as broad as needed for the specific process (surveillance, information visit, reassessment). In fact, ANSICA simultaneously maintains several unrelated accreditation programs at ANSI and it takes minutes to add a new process.* "[15]

Most accreditation entities are looking at using technology to makes assessments easier, faster and cheaper. As an example: ANSI is currently piloting remote assessment practices with several accredited programs. The assessment still includes limited onsite visits by at least one of the two or more assessors that compose the team, but the rest of the assessment is performed using conference calling and remote desktop access technology. Similar practices are also being investigated by some accreditation agencies that are hoping to cut down on the

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[15] E-mail correspondence from Sandro Shelia, Director, ANSI Accreditation Services to Sharon Goldsmith, Plexus Consulting Group February 10, 2007

time and cost of conducting site visits by being able to examine documents virtually and conduct virtual site visits.[16]

Plexus recommends that CODA evaluate and adopt new technological advances in accreditation.

Increased government interest in certification and accreditation programs

There has been increasing government interest in accreditation programs. CODA has a long history with the USDE as discussed earlier in this paper. However several other government agencies are developing oversight programs for existing accreditation programs. Some are encouraging professional and trade associations to create new accreditation programs for their industries as a way of protecting the public and helping consumers distinguish between qualified and unqualified personnel. Other government agencies are concerned with the increase in bogus or less-than-rigorous educational programs which has been accompanied by a parallel increase in bogus or less-than-rigorous accreditation programs. Government agencies are finding it increasingly difficult to understand which systems are legitimate and which personnel are appropriately educated to work in certain government jobs or in agencies that compete for government contracts. Both of these issues are motivating increased government interest and oversight to help define certification and control the quality of the certifications being offered. This interest is particularly strong within government agencies, such as the FDA and DHS, which are concerned with public safety and homeland security. Examples of the actions of a few government agencies that may have relevance for the ADA Task Force on CODA are outlined below.

General Accounting Office (GAO): In Congress also, there has been increased interest in relying on third-party accreditation to recognize certification programs. Two recent GAO reports address the issue of bogus credentials. In *Certification Requirements: New Guidance Should Encourage Transparency in Decision Making* (GAO/GGD-99-170) the authors expressed concern for the lack of information on the number of certification programs, the lack of definition as to what constitutes a certification program, the lack of uniformity in the processes, and the lack of transparency in the way many certification programs make their decisions. In a related and more recent report (GAO/GGD-03-269), the authors demonstrated how easy it was to get a master's degree from a diploma mill. The GAO reports that there are "more than 200 federal government procurement programs in which agencies provide or require certification, accreditation, listing or registration."[17] OMB Circular A-119 says that all federal agencies must use voluntary consensus standards in lieu of government-unique standards in their procurement and regulatory activities, except where inconsistent with the law or otherwise impractical.[18] If an agency uses government-unique standards, it must explain why it does so in a report to OMB through the National Institute for Standards and Technology (NIST). The circular also says that agencies must consult with voluntary consensus standards bodies, both domestic and international, and must participate with such bodies in the development of voluntary consensus standards "when consultation and participation is in the public interest and is compatible with their missions, authorities, priorities, and budget resources."[19]

[16] Conversation with Steve Crow, Director, North Central Accreditation Commission, Feb. 7, 2008
[17] GAO/GGD- 99-170 p. 17
[18] GAO/GGD- 99-170 p. 12
[19] GAO/GGD- 99-170 p. 9

The Interagency Committee on Standards Policy (ICSP) is comprised of several federal agencies. ICSP advises the Secretary of Commerce and other executive branch agencies on standards policy matters. The committee reports to the Secretary through the Director of NIST. Most standards used in the government focus on products or services, only a few focus on personnel. However, the GAO report does provide a few examples of government use of personnel standards.[20] These are summarized as follows:

The Department of Labor (DOL): DOL is investigating establishing an Office of Certification within DOL. Negotiations are proceeding informally and no legislation has yet been introduced. From its perspective, DOL increasingly recognizes the important role that certification can play in guiding job training efforts, helping individuals secure and retain jobs, assisting employers to make informed and more objective decisions about job applicants and candidates for promotion and assisting the public in being "informed consumers."

Department of Veterans Affairs (DVA): In a related initiative, DVA is placing increased emphasis on helping ex-military personnel and their spouse's transition from military to civilian careers by negotiating with licensing boards and certification bodies to create seamless transitions between military and civilian licenses and certifications. DVA is experiencing challenges in advising veterans as to which certifications will provide value in the workplace due to the proliferation of certification programs and the proliferation of multiple certifications for the same occupation title. One aspect of this has been measures to assess the comparability of educational systems. DVA has requested that DOL actively begin to address this problem. It has been strongly recommended that DOL attempt to define and/or utilize standards for determining which credentials are legitimate and which are bogus.

Department of Defense (DOD): DOD is concerned about the number of certifications that have been developed in the IT community, particularly in light of increased homeland security concerns. DOD has recently issued a directive that stipulates that only individuals who have certifications that have been accredited against the new ANSI/ISO standards for personnel certification agencies will be permitted to work on computer hardware and software installations used within DOD or being utilized by DOD. This represents a significant step in federal oversight of private certifications as it requires that all manufacturers, software developers and other certification programs have their certifications formally accredited by an independent third party.

Food and Drug Administration (FDA): The increased importance of the role of the certified food protection manager for public health and safety has prompted FDA to require that all facilities serving food have a food protection manager that is certified by an approved agency. The food service community, including restaurants, hotels, prisons, hospitals, food retailers and regulators have created the Conference for Food Protection and has partnered with ANSI to implement a system using specific industry developed accreditation standards to accredit the various agencies that certify food protection managers. The FDA has released a statement officially endorsing this accreditation program.

Department of Homeland Security (DHS): DHS appears to be focusing on standards for equipment, not personnel. However in a recent article, Burt Coursey, Director of Standards for DHS, indicated that DHS is not focusing on standards for training *per se* but are focusing instead on "common curriculum elements that can be used by all the groups that now carry out

[20] GAO/GGD- 99-170 p. Appendix 1 Examples pp. 30-37

training within DHS"[21]. He further indicated that DHS is not a regulatory agency but will be working with voluntary consensus standards group.

Center for Medicare and Medicaid Services (CMS): CMS also has requirements that address the credentials of providers and suppliers of health care services to Medicare and Medicaid beneficiaries. In some instances, credentials of personnel are referenced. There are extensive requirements that address reimbursement of services provided in medical residency programs. Medical residency programs also have to meet certain accreditation requirements in order to be eligible to apply for certain training and research grants. Several private agencies are, or have tried to be, specifically referenced in these requirements. For example, hospitals accredited by TJC, residency programs accredited by ACGME and individuals certified through the American Osteopathic Association or the American Speech-Language Hearing Association are deemed to participate in the program and meet federal requirements.

Plexus recommends that ADA continue to monitor federal activity that may impact accreditation.

[21] Interview: Burt Coursey Talks about Homeland Security Standards, retrieved from http://www.homelandresponse.org/500/Issue/Article/False/12429/Issue 6/24/2006, p.3

VI. Summary of Recommendations

The American Dental Association (ADA) Task Force on the Commission on Dental Accreditation (CODA) has been charged by the ADA to study the structure, governance, policies, operating procedures and functionality of CODA, to determine whether CODA is using best practices in accreditation, to determine if CODA should remain recognized as an accreditation authority for the U.S. Department of Education (USDE) and to make recommendations on how the dental accreditation process can be improved to preserve the high standards needed for the future of dental education. After completing extensive quantitative, qualitative, and benchmarking research, Plexus Consulting Group provides the following recommendations to the ADA Task Force on CODA.

Issues for the ADA Task Force on CODA

1. Scope: Accreditation agencies tend to have narrower scopes of accreditation than CODA
   Recommendation: Plexus recommends that CODA be split into two commissions, one for educational programs leading to entry into practice (including dental related professions) and the other for advanced practice specialties.

2. Structure: Role of Coordinating Councils or Tiered Structures
   Recommendation: Plexus recommends that the ADA retain standards-setting and implementation within a single structure.

3. Role of specialties, dental–related disciplines and fractionalization of the professions
   Recommendation: Plexus recommends that CODA needs to prepare for the possibility of competing accreditation systems especially for related dental professions.

4. Models for establishing relationship between accreditation and specialty recognition or certification
   Recommendation: Plexus suggests that while the current model is working, the ADA and CODA may want to explore alternative models that might better serve the evolving needs of the profession in the future. The current model might be improved by establishing a structure in which each specialty has the authority to set its own standards and evaluation criteria and maintain control over its own accreditation decisions but also benefit from the perspectives of others.

The ADA/CODA Relationship

1. Options for the ADA/CODA relationship
   Recommendation: Plexus believes that CODA is not more autonomous from the ADA than other agencies are from their sponsoring organization. In fact, based on CODA's legal status, its location and its staffing structure, it is considerably less autonomous. The ADA/CODA relationship fails to conform to the accepted or best practice in accreditation in the way the ADA and CODA understand what their individual rights and responsibilities are and the way they communicate with each other.

2. Rights and responsibilities of the ADA and CODA
   Recommendation: Plexus recommends that the ADA and CODA establish a MoU to better define the ADA/CODA relationship and provide each with a clearly negotiated list of expectations and behaviors.

3. Communication
Recommendation: Plexus recommends that CODA communicate more effectively with its stakeholders.

4. Size of CODA
Recommendation: Plexus believes that CODA falls within the upper range relative to size which is appropriate for the large scope of CODA's activities.

5. Composition of CODA – achieving balance and participation
Recommendation: Plexus believes that CODA's broad representation appears very consistent with practices in accreditation. One element that appears to be missing is the representation in a formal way of the major decision leaders outside the dental community.

6. Recruitment, terms of leadership
Recommendation: Plexus recommends that CODA regularly perform a board profile.

7. Serving with portfolios
Recommendation: Plexus recommends that CODA should clarify with members that they do not serve with portfolios.

8. Selecting members
Recommendation: Plexus believes that CODA's member selection process is consistent with accepted practices.

9. Training Provided to Review Team members and Commission members
Recommendation: Plexus recommends that CODA maintain its process to train assessors and review team members prior to sending them on assignments.

10. Role of the Public in Accreditation
Recommendation: Plexus recommends that CODA consider public outreach programs, as described above and below, both for gathering of public concerns and opinions and to create awareness of the benefits of its accreditation programs for the public benefit.

11. Public Members of Commissions and Review Teams
Recommendation: Plexus believes that the role of public members in CODA is consistent with accepted practices.

12. Providing information to the Public
Recommendation: Plexus believes that the amount of information that CODA provides to the public conforms to accepted practices but recommends that CODA consider providing this information in more easily accessible formats for the public.

13. Role of staff
Recommendation: Plexus believes that CODA's functioning could be improved with the addition of experts in public relations/communications and in Quality Management Systems.

14. Accreditation process
    Recommendation: Plexus believes that procedures utilized by CODA (as described in materials detailing the Commission on Dental Accreditation) are in agreement with best practices of similar organizations.

15. Levels of accreditation
    Recommendation: CODA provides more information than many other higher education accreditation groups.

16. Relationship with USDE
    Recommendation: Plexus strongly recommends that CODA maintain its USDE recognition.

17. Relationship with the Council for Higher Education Accreditation (CHEA) and other Academic Accreditation Agency recognition bodies
    Recommendation: Plexus believes that CODA should investigate the benefits of CHEA recognition and should monitor the development of potential new recognition opportunities.

18. Impact on CODA when taking on an international component
    Recommendation: Plexus recommends that ADA explore opportunities to expand accreditation internationally.

19. Strategic planning and ongoing evaluation
    Recommendation: CODA should establish on-going evaluation measures to systematically monitor the use of CODA accreditation and certifications and their perceived value.

Trends in Accreditation

1. Increased use of advanced technology
   Recommendation: Plexus recommends that CODA evaluate and adopt new technological advances in accreditation.

2. Increased government interest in certification and accreditation programs
   Recommendation: Plexus recommends that the ADA continue to monitor federal activity that may impact accreditation.

Attachment 7: Report on focus groups

Task Force on the Commission on Dental Accreditation (CODA) Focus Group Session – In conjunction with the Chicago MidWinter Dental Meeting

Hyatt Regency McCormick Place, Chicago Friday, February 22, 2008 2:00 to 3:30 p.m.

Paul Duffy, Plexus Group, facilitator
Ron Polaniecki, American Dental Association, note taker

Among the key questions in the protocol for the focus group session about CODA:

- **Strengths, weaknesses**
- **Feelings about effectiveness**
- **Discussion regarding possible changes in CODA's structure**
- **USDE accreditation**
- **Communications**
- **Open discussion**

Participants

Dr. Robert Bitter, Periodontist
Glenview, IL

Dr. Susan Becker Doroshow, General dentist
Skokie, IL

Dr. Jane Grover, General dentist
Jackson, MI

Dr. Michael Higgins, General dentist
Palatine, IL

Dr. Paul Landmark, General dentist
Chicago, IL

Dr. Debra Schwenk, Public health dentist
Alton, IL

Dr. Steven Steinberg, General dentist
Skokie, IL

Dr. Willam Tonne, General dentist
Savanna, IL

Task Force on the Commission on Dental Accreditation (CODA)
Focus Group Session – In conjunction with the
American Dental Education Association (ADEA) Annual Session

Hilton Anatole, Dallas
Wednesday, April 2, 2008
1:00 to 2:30 p.m.

Paul Duffy, Plexus Group, facilitator

Among the key questions in the protocol for the focus group session about CODA:

- **Strengths, weaknesses**
- **Feelings about effectiveness**
- **USDE accreditation**
- **Communications**
- **Encourages or stifles academic creativity?**
- **What is CODA not doing?**
- **What should it stop doing or do differently?**
- **Open discussion**

Participants (Deans and Associate Deans)

Dr. Lawrence Goldbladt
Indiana University School of Dentistry

Dr. Gerald Glickman
Baylor College of Dentistry

Dr. Teresa Dolan
University of Florida College of Dentistry

Dr. Huw F. Thomas
University of Alabama School of Dentistry

Dr. R.Lamont MacNeil
University of Connecticut Health Center

Dr. Judith Buchanan
University of Minnesota School of Dentistry

Dr. Pamela Overman
UMKC School of Dentistry, Kansas City

Dr. Cecile Feldman
New Jersey Dental School

Attachment 8: CODA and USDE report

Commission on Dental Accreditation (CODA) and the UNITED STATES DEPARTMENT OF EDUCATION (USDE)

Prepared for the

AMERICAN DENTAL ASSOCIATION (ADA) TASK FORCE ON THE COMMISSION ON DENTAL ACCREDITATION (CODA)

March 19, 2008

TABLE OF CONTENTS

I. USDE ROLE IN ACCREDITATION – PAGE 3

II. ADA CODA STATUS AS A USDE RECOGNIZED ACCREDITOR – PAGE 3

HISTORY – PAGE 3

AUTHORITY TO ACCREDIT – PAGE 5

OVERVIEW OF THE SCOPE OF CODA AS REPORTED TO USDE – PAGE 7

FEDERAL FUNDING PROGRAM LINKS TO ACCREDITED DENTAL EDUCATION PROGRAMS – PAGE 9

III. OTHER HEALTH CARE ACCREDITORS THAT HAVE USDE RECOGNITION – PAGE 11

IV. OTHER AGENCIES THAT RECOGNIZE HIGHER EDUCATION ACCREDITORS – PAGE 16

V. HEALTHCARE ACCREDITORS THAT HAD BUT NO LONGER HAVE USDE RECOGNITION AND WHY THIS DECISION WAS MADE – PAGE 18

VI. PERCEIVED VALUE OF CODA PARTICIPATION WITH USDE RECOGNITION PERSPECTIVES OF CODA, ADA AND ITS STAKEHOLDERS – PAGE 18

ATTACHMENT A: CRITERIA FOR USDE RECOGNITION AS A RECOGNIZED ACCREDITATION AGENCY – PAGE 19

I. USDE ROLE IN ACCREDITATION

The USDE does not directly accredit educational programs or institutions of higher education but relies on private accrediting agencies such as CODA to make judgments about the quality of higher education institutions and programs. As noted on the Office of Postsecondary Education Web site[1], " The Secretary [of Education] recognizes accrediting agencies to ensure that these agencies are, for the purposes of the Higher Education Act of 1965, as amended (HEA), or for other Federal purposes, reliable authorities regarding the quality of education or training offered by the institutions or programs they accredit….. The Secretary lists an agency as a nationally recognized accrediting agency if the agency meets the criteria for recognition listed in subpart B of this part."

II. ADA CODA STATUS AS A USDE RECOGNIZED ACCREDITOR

HISTORY

According to the American Dental Association Commission on Dental Accreditation Evaluation Policies and Procedures[2] the "Commission on Dental Accreditation", the successor of the Council on Dental Education which had conducted the accreditation program since 1937, began operating in 1975. The Commission serves as the only nationally recognized accrediting body for dentistry and the related dental fields. The Commission receives its accreditation authority from the acceptance of the dental community and by being recognized by the United States Department of Education (USDE), a governmental agency.

Eligibility for federal funding is linked to recognition by the USDE. Statutory restrictions mandate that educational institutions or programs must be accredited by a USDE-recognized accrediting agency in order to be eligible for federal funding. The Commission has participated in governmental recognition since 1952 when the U.S. Commission of Education was first required to publish a list of "nationally recognized accrediting agencies." The USDE has established recognition requirements that an accrediting agency must meet in order to be recognized and conducts reviews for continued recognition at five-year intervals.

The United States Department of Education (USDE) periodically publishes a list of Nationally Recognized Accrediting Agencies and Associations, which is used to determine eligibility for U.S. federal funding or government assistance under certain legislation. Agencies and associations included on the USDE list are those determined to be the reliable authorities in evaluating the quality of education offered by educational

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[1] Retrieved form http://www.ed.gov/print/admins/finaid/accred/accreditation.htm.October 1, 2007.
[2] American Dental Association Commission on Dental Accreditation Evaluation Policies and Procedures. Page 7 reproduced verbatim

institutions or programs. In order for institutions to become eligible for federal funds, the accrediting agency for the institution must be recognized by the USDE. The authority and recognition responsibility of the USDE is governed by the Higher Education Act (HEA) of 1965, as amended. This important legislation is periodically reauthorized, usually at five-year intervals. Following each reauthorization, the Department promulgates new *Procedures and Criteria for Recognition of Accrediting Agencies.*

The Secretary of Education requires the Commission on Dental Accreditation to submit to the USDE the standards, policies and procedures used in its evaluation program. Periodic reviews by the USDE are conducted to determine the Commission's continued eligibility for recognition.

CODA materials[3] further state that "[t**]**he Commission on Dental Accreditation is concerned with the educational quality, allied dental and advanced and specialty dental education programs in the United States. The Commission accredits more than 1300 programs in the disciplines within its purview, conducting all aspects of excellence, supports programmatic self-improvement and assures the general public of the ongoing availability of quality dental care. These goals are an integral part of a process of evaluation which combines on-site visits with regular review of written and quantitative data".

According the USDE Web site[4] CODA has been recognized with the following scope:

> "the accreditation of predoctoral dental education programs (leading to the D.D.S. or D.M.D. degree), advanced dental education programs, and allied dental education programs that are fully operational or have attained "Initial Accreditation" status, including programs offered via distance education."
>
> However, CODA is not recognized as a Title IV gatekeeper, meaning that programs do not utilize, nor does the USDE require, CODA accreditation as a condition of participation in Title IV programs (generally encompassing the federally subsidized student loans). "
>
> As stated by USDE[5]
>
> **"Title IV Note:** *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*"

This is a critical distinction since the most value derived from being accredited by a USDE recognized accreditation agency is that such accreditation permits programs housed in accredited institutions to participate in government-subsidized student loans. Given this, the actual value that CODA accredited education programs derive from the USDE

[3] American Dental Association Commission on Dental Accreditation Evaluation Policies and Procedures. Page 7 reproduced verbatim
[4] **http://www.ed.gov/print/admins/finaid/accred/accreditation.html October 4, 2007**
[5] **http://www.ed.gov/print/admins/finaid/accred/accreditation.html October 4, 2007**

recognition of CODA will have to be carefully assessed. The research methodology that will be used by the Task Force on CODA already anticipates this issue and this issue will be explored in all phases of the Task Force research.

It should also be noted that lack of recognition as a Title IV gatekeeper also exempts CODA from certain provisions of the USDE requirement regarding the level of independence it must demonstrate from the ADA or any other related organizations. This is addressed later during this paper.

However it should also be noted that CODA's status as a non- Title IV gatekeeper is typical of the status of programmatic accreditors, that is, accreditation organizations that confine their accreditation to programs of instruction that are housed in accredited colleges and universities.

AUTHORITY TO ACCREDIT

It is important to recognize that CODA derives its authority to accredit through the American Dental Association. This link is acknowledged and approved in the USDE process and in fact the full title of the agency as recognized by the USDE is the **American Dental Association, Commission on Dental Accreditation.** This is a very important issue for the Task Force on CODA as it explores the possibility of other types of organizational relationships that might better serve the dental profession.

ADA BYLAWS[6] provide CODA with the authority to:

a. To formulate and adopt requirements and guidelines for the accreditation of dental educational and dental auxiliary educational programs.

b. To accredit dental educational and dental auxiliary educational programs.

c. To provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.

d. To submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.

e. To submit the Commission's articles of incorporation and rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

CODA defines its process, outcomes and standards as follows[7]:

[6] AMERICAN DENTAL ASSOCIATION BYLAWS, Section 130

"Decisions on accreditation status are the sole responsibility of the Commission. Neither Commission staff, site visitors, other consultants, individual members of the Commission nor any other agent of the Commission are empowered to make or modify accreditation decisions.

The Commission formulates and adopts accreditation standards for the accreditation of predoctoral dental education programs, advanced and specialty dental education programs and allied dental education programs.

The Commission, in fulfilling its accreditation responsibilities, focuses on the educational results or outcomes of the programs for which it has authority, as well as on the process used to obtain these results. During its review process, the Commission evaluates programs in relation to predetermined standards. These accreditation standards afford educational process; the Commission applies the established accreditation standards for each discipline uniformly to all programs. All accreditation actions are based on and directly linked to educational standards or required accreditation policies."

[7] American Dental Association Commission on Dental Accreditation Evaluation Policies and Procedures. Page 7 reproduced verbatim

OVERVIEW OF THE SCOPE OF CODA AS REPORTED TO USDE

The following information is repeated verbatim from documents submitted by CODA to the USDE, from the USDE staff summaries and from CODA staff reports regarding the recognition process.

GENERAL INFORMATION ABOUT THE AGENCY[8]

> "The Commission on Dental Accreditation (CODA) is a programmatic accreditor. The agency's accrediting activities include the accreditation of predoctoral dental education programs (leading to the D.D.S. or D.M.D. degree), advanced general dentistry education programs, advanced dental specialty education programs, and the allied dental education programs, including dental assisting education programs, dental hygiene education programs and dental laboratory technology education programs and those developing programs that have attained the initial accreditation status, and those programs offered via distance education.
>
> The agency accredits more than 1,300 programs currently covering sixteen dental education areas. Recognition by the Secretary allows the programs accredited by CODA to participate in Federal programs other than Title IV, specifically, the Public Health Service Act (PHSA) administered by the Department of Health and Human Services. The PHSA defines eligible programs as programs that offer post-doctoral training in the specialties of dentistry, advanced education in general dentistry or dental general practice residencies that have been accredited by the Commission on Dental Accreditation. Postdoctoral dental education programs are programs sponsored by a school of dentistry and are among the programs specifically included in the definitions covered by the various sections of PHSA. Specific sections of the PHSA include, for example:
>
> - Title 42, Public Health Service Act, (PHSA) Subchapter B Medicare Program Part 405-426 which provides direct and indirect graduate medical education funding/hospital insurance for residency programs approved by the Commission on Dental Education.
> - Title VII, Health Professions Education Section of the Public Health Service Act, Part B (Section 736) of the Centers of Excellence which includes schools of dentistry as eligible entities and Part C (Section 737) which entails training in Family Medicine, General Internal Medicine, General Pediatrics, Physician Assistants, General Dentistry, and Pediatric Dentistry.
> - Sections 739, 747, 753, 765 and 799B apply provisions of the PHSA to schools dentistry and allied health accredited by CODA, and
> - Title 26, NIV Health Care Service Program under the Ryan White Care Act, HIV/AIDS Dental Reimbursement Program names dental schools that are

[8] Staff Report To the National Advisory Committee On Institutional Quality and Integrity. pgs2-3

accredited by CODA and provide postdoctoral dental education programs, such as hospital-based residencies and dental hygiene education programs.

The agency has a non-Title IV federal link and does not have to meet the separate and independent requirements."

RECOGNITION HISTORY

The U.S. Commissioner of Education listed the Council on Dental Education (CDE) of the American Dental Association (ADA) on the first list of nationally recognized accrediting agencies published by 1952. In 1969, the Secretary expanded the CDE's scope of recognition to include the category "accreditation eligible" to the dental and dental hygiene programs. In 1972, CDE received an expansion of scope to include its accreditation of dental specialty education programs and its accreditation of dental assisting and dental laboratory technician programs in proprietary schools.

In 1975, the Council on Dental Education restructured and became the Commission on Accreditation of Dental and Dental Auxiliary Education Programs (CADDAEP). The name of the CADDAEP changes again in 1979, to its present name, the Commission on Dental Accreditation (CODA or Commission). The agency has received recognition without interruption.

During the past three years [2002-2005], the agency has transitioned 43 "accreditation eligible" programs from a CODA status of "preliminary provisional approval (PPA)" to a status of "initial accreditation." The Department did not recognize the PPA process, because its status was based on a paper review rather than on a site visit. The agency revised the procedure and coined the phrase "accreditation eligible" for developing programs and new programs. However, the accreditation eligible status suggested that programs have not achieved an accreditation status. Therefore, the agency renamed the "accreditation eligible" status. It is now "initial accreditation."

As part of its evaluation of the agency's petition, Department staff observed a CODA decision meeting in January 2006 and reviewed the supporting documentation submitted with its petition.

FEDERAL FUNDING PROGRAM LINKS TO ACCREDITED DENTAL EDUCATION PROGRAMS[9]

Legislation	Section	Applicable/eligible Education Programs
Title 42 Public Health Service Act Vol. 2, Chapter IV, Centers for Medicare & Medicaid Services, DHHS	Subchapter B Medicare Program, Part 405-426 Direct and indirect GME funding/hospital insurance	Residency programs approved by the Commission on Dental Accreditation
Title 42 Public Health Service Act Title VII, Health Professions Education	Part B Centers of Excellence Sec. 736 Grants to health profession schools and educational entities to support programs of excellence in health professions education for underrepresented minorities	Schools of dentistry*
	Part B Centers of Excellence Sec. 737 Scholarships for disadvantaged students	Schools of dentistry* Schools of public health* Schools of allied health*
	Part B Centers of Excellence Sec. 738 Loan Repayments and Fellowships Regarding Faculty Positions	Individuals who have a degree in dentistry and are enrolled in an approved graduate training program in dentistry; are enrolled full-time in an accredited school Eligible schools* include dentistry, public health
	Part B Centers of Excellence Sec. 739 Educational Assistance in the health	Schools of public health* Schools of dentistry* Schools of allied health*

[9] Neumann, Laura M. Staff Report To the National Advisory Committee On Institutional Quality and Integrity. November 2005

	professions regarding individuals from disadvantaged backgrounds	
	Part C Training in Family Medicine, General Internal medicine, General Pediatrics, Physician Assistants, General Dentistry, and Pediatric Dentistry Sec. 747 To plan, develop, operate or participate in an approved professional training program; to provide traineeships and fellowships	Dental schools*, approved residency programs in the general or pediatric practice of dentistry, approved advanced education programs in the general or pediatric practice of dentistry, or approved residency programs in pediatric dentistry.
	Part D Interdisciplinary, Community-Based Linkages Sec. 753 Education and Training Regarding Physicians and Dentists	Postdoctoral dental education program sponsored by a school of dentistry*
	Part E, Subpart 2 – Public Health Workforce Sec. 765 Grants or contracts for planning, developing or operating training programs; financial assistance to residency trainees Sec. 768 Preventive medicine; dental public health	Accredited school or program of public health, or dental public health*
	Part F General Provisions Sec. 799B, (1)(A), (E)	*School of dentistry means an “accredited public or nonprofit private school in a State that provides training leading, respectively to a degree of doctor of dentistry or an equivalent degree…and including advanced training related to such training provided by any such school”

		"The term 'accredited', when applied to a school of medicine, osteopathic medicine, dentistry, veterinary medicine, optometry podiatry, pharmacy, public health, or chiropractic, or a graduate program in health administration, clinical psychology, clinical social work, professional counseling, or marriage and family therapy, means a school or program that is accredited by a recognized body or bodies approved for such purposes by the Secretary of Education…"
Public Health Service Act Title 26 HIV Health Care Service Program	Ryan White Care Act HIV/AIDS Dental Reimbursement Program	Dental schools, postdoctoral dental education programs such as hospital-based residencies, and dental hygiene education programs that are accredited by the Commission on Dental Accreditation
Public Health Service Act	Sec. 319 F(g) Bioterrorism Training and Curriculum Development	Accredited* and licensed health professions schools

III. OTHER HEALTH CARE ACCREDITORS THAT HAVE USDE RECOGNITION[10]

The following information summarizes the other health care organizations that have USDE recognition, the scope of that recognition and provides some points of comparison for the Task Force on CODA, the status of that recognition relative to serving as a Title IV gatekeeper.

Accreditation Commission for Acupuncture and Oriental Medicine
1988/2005/F2010
Scope of recognition: the accreditation and pre accreditation ("Candidacy" status) throughout the United States of first-professional master's degree and professional master's level certificate and diploma programs in acupuncture and Oriental medicine, as well as freestanding institutions and colleges of acupuncture or Oriental medicine that offer such programs.

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[10] retrieved and reproduced verbatim from http://www.ed.gov/print/admins/finaid/accred/accreditation.html October 4, 2007

Title IV Note: *Only freestanding institutions or colleges of acupuncture or Oriental medicine may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

Accreditation Council for Pharmacy Education
1952/2006/S2011
Scope of recognition: the accreditation and preaccreditation of professional degree programs in pharmacy leading to the degree of Doctor of Pharmacy.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

Accrediting Bureau of Health Education Schools
1969/2004/F2009
Scope of recognition: the accreditation of private, postsecondary institutions in the United States offering predominantly allied health education programs and the programmatic accreditation of medical assistant, medical laboratory technician and surgical technology programs, leading to a certificate, diploma, Associate of Applied Science, Associate of Occupational Science, or Academic Associate degree, including those offered via distance education.

Title IV Note: *Only freestanding allied health education institutions and institutions that offer predominantly allied health programs may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

American College of Nurse-Midwives, Division of Accreditation
1982/2006/S2009
Scope of recognition: the accreditation and pre-accreditation of basic certificate, basic graduate nurse-midwifery, direct entry midwifery, and pre-certification nurse-midwifery education programs. The accreditation and pre-accreditation of freestanding institutions of midwifery education that may offer other related health care programs to include nurse practitioner programs, and including those institutions and programs that offer distance education.

Title IV Note: *Only freestanding institutions of midwifery education may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

American Dietetic Association, Commission on Accreditation for Dietetics Education
1974/2007/S2012
Scope of recognition: the accreditation and pre-accreditation, within the United States, of Didactic and Coordinated Programs in Dietetics at the undergraduate and graduate level, post-baccalaureate Dietetic Internships, and Dietetic Technician Programs at the associate degree level, and for its accreditation of such programs offered via distance education.

Title IV Note: *Only postbaccalaureate dietetic internship programs may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

American Occupational Therapy Association, Accreditation Council for Occupational Therapy Education
1952/2006/F2011
Scope of recognition: the accreditation of occupational therapy educational programs offering the professional master's degree, combined baccalaureate/master's degree, and occupational

therapy doctorate (OTD) degree; the accreditation of occupational therapy assistant programs offering the associate degree or a certificate; and the accreditation of these programs offered via distance education.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

American Optometric Association, Accreditation Council on Optometric Education
1952/2002/F2007
Scope of recognition: the accreditation in the United States of professional optometric degree programs, optometric technician (associate degree) programs, and optometric residency programs and for the preaccreditation categories of Preliminary Approval and Reasonable Assurance for professional optometric degree programs and Candidacy Pending for optometric residency programs in Veterans' Administration facilities.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

American Osteopathic Association, Commission on Osteopathic College Accreditation
1952/2005/F2010
Scope of recognition: the accreditation and preaccreditation ("Provisional Accreditation") throughout the United States of freestanding, public and private non-profit institutions of osteopathic medicine and programs leading to the degree of Doctor of Osteopathy or Doctor of Osteopathic Medicine.

Title IV Note: *Only freestanding schools or colleges of osteopathic medicine may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

American Physical Therapy Association, Commission on Accreditation in Physical Therapy Education
1977/2006/F2011
Scope of recognition: the accreditation and preaccreditation ("Candidate for Accreditation") in the United States of physical therapist education programs leading to the first professional degree at the master's or doctoral level and physical therapist assistant education programs at the associate degree level and for its accreditation of such programs offered via distance education.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

American Podiatric Medical Association, Council on Podiatric Medical Education
1952/2005/F2010
Scope of recognition: the accreditation and preaccreditation ("Candidate Status") throughout the United States of freestanding colleges of podiatric medicine and programs of podiatric medicine, including first professional programs leading to the degree of Doctor of Podiatric Medicine.

Title IV Note: *Only freestanding schools or colleges of podiatric medicine may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

American Speech-Language-Hearing Association, Council on Academic Accreditation in Audiology and Speech-Language Pathology
1967/2002/F2007
Scope of recognition: the accreditation and preaccreditation (Accreditation Candidate) throughout the United States of education programs in audiology and speech-language pathology leading to the first professional or clinical degree at the master's or doctoral level, and the accreditation of these programs offered via distance education.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

American Veterinary Medical Association, Council on Education
1952/2006/F2011
Scope of recognition: the accreditation and preaccreditation ("Reasonable Assurance") in the United States of programs leading to professional degrees (D.V.M. or D.M.D.) in veterinary medicine.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

Commission on Accreditation of Healthcare Management Education
1970/2007/S2012
Scope of recognition: the accreditation throughout the United States of graduate programs in healthcare management.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

Commission on Collegiate Nursing Education
2000/200/F2011
Scope of recognition: the accreditation of nursing education programs in the United States, at the baccalaureate and graduate degree levels, including programs offering distance education.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs*

Council on Accreditation of Nurse Anesthesia Educational Programs
1955/2007/S2012
Scope of recognition: the accreditation of institutions and programs of nurse anesthesia within the United States at the post master's certificate, master's, or doctoral degree levels, including programs offering distance education.

Title IV Note: *Only hospital-based nurse anesthesia programs and freestanding nurse anesthesia institutions may use accreditation by this agency to establish eligibility to participate in Title IV programs*

The Council on Chiropractic Education, Commission on Accreditation
1974/2006/S2011
Scope of recognition: the accreditation of programs leading to the Doctor of Chiropractic degree and single-purpose institutions offering the Doctor of Chiropractic program.

Title IV Note: *Only freestanding schools or colleges of chiropractic may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

Council on Education for Public Health
1974/2007/S2012
Scope of recognition: the accreditation within the United States of schools of public health and public health programs outside schools of public health, at the baccalaureate and graduate degree levels, including those offered via distance education.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

Council on Naturopathic Medical Education
2003/2005/S2008
Scope of recognition: the accreditation and pre-accreditation throughout the United States of graduate-level, four-year naturopathic medical education programs leading to the Doctor of Naturopathic Medicine (N.M.D.) or Doctor of Naturopathy (N.D.)

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs*

Joint Review Committee on Educational Programs in Nuclear Medicine Technology
1974/2006/S2011
Scope of recognition: the accreditation of higher education programs for the nuclear medicine technologist.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

Joint Review Committee on Education in Radiologic Technology
1957/2006/S2011
Scope of recognition: the accreditation of educational programs in radiography, including magnetic resonance, radiation therapy, and medical dosimetry, at the certificate, associate, and baccalaureate levels.

Title IV Note: *Only hospital-based radiologic technology programs and freestanding radiologic technology institutions may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

Liaison Committee on Medical Education
1952/2007/S2012
Scope of recognition: the accreditation of medical education programs within the United States leading to the M.D. degree.

Title IV Note: *Accreditation by this agency does not enable the entities it accredits to establish eligibility to participate in Title IV programs.*

The LCME is administered in odd-numbered years, beginning each July 1, by:

Council on Medical Education of the American Medical Association

The LCME is administered in even-numbered years, beginning each July 1, by:

Association of American Medical Colleges

Midwifery Education Accreditation Council
2001/2002/F2007
Scope of recognition: the accreditation and pre-accreditation throughout the United States of direct-entry midwifery educational institutions and programs conferring degrees and certificates, including the accreditation of such programs offered via distance education.

Title IV Note: *Only freestanding direct-entry midwifery educational institutions may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

National League for Nursing Accrediting Commission
1952/2006/F2011
Scope of recognition: the accreditation in the United States of programs in practical nursing, and diploma, associate, baccalaureate and higher degree nurse education programs.

Title IV Note: *Only diploma programs and practical nursing programs not located in a regionally accredited college or university may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

IV. OTHER AGENCIES THAT RECOGNIZE HIGHER EDUCATION ACCREDITORS

In addition the USDE, there have been several agencies which have also recognized post secondary accreditors throughout the years. Currently there is one agency that offers this recognition, the Council on Higher Education Accreditation (CHEA). The CHEA is a not-for- profit, private agency whose members are higher education institutions who are represented at CHEA primarily by their presidents and other high level institutional administrators. Higher education accrediting organizations that meet CHEA requirements are eligible to be recognized by CHEA but can not be members of CHEA, a situation that has been the focus of very public concern within the higher education accreditation community. However, recognition by CHEA is sometimes viewed as helpful especially for newer organizations that are looking for external validation of their program, especially by the decision makers who will need to decide whether accreditation by any particular accreditation organization is worth the effort and other costs that must be expended to seek accreditation or by organizations that are seeking external validation but do not qualify for USDE recognition. CHEA is currently undergoing some staff changes and also will be implementing some new recognition criteria. It is not clear how these two events will impact the number of organizations that voluntarily chose to be recognized by CHEA or the future directions of the organization.

A third organization, the American National Standards Institute, (ANSI) which is the United States government designated representative to the International Organization for

Standardization (ISO), is concurrently investigating the feasibility of developing a system to recognize programmatic higher education accreditors against and international standard for accreditation bodies (ISO17011) and/or some new ISO standards that are currently being developed that are expected to impact higher education. CODA will be invited to participate in this investigation as it progresses.

CODA has been recognized by organizations other than the USDE in the past but has currently chosen not to participate with CHEA. As noted in CODA materials:[11]

> "Since 1954, the Commission on Dental Accreditation has been recognized by the Secretary of the United States Department of Education (USDE) as the agency responsible for the accreditation of dental and dental-related educational programs. In addition, the Commission has sought and received recognition from a non-governmental recognition agency since the 1960s. These non-governmental agencies have included the National Commission on Accrediting (NCA), the Council on Postsecondary Accreditation (COPA) and the Commission on Recognition of Postsecondary Accreditation (CORPA).
>
> COPA was formed in 1975. The Commission received full recognition for the maximum period when evaluated in 1977 by COPA. In 1984 and again in 1989, the Commission submitted re-recognition materials to COPA and was awarded full recognition each time. In April 1993, the COPA Board voted to dissolve the Council on Postsecondary Accreditation, effective at the end of 1993. The Commission on Recognition of Postsecondary Accreditation (CORPA) was formed and took over the recognition function from COPA, effective January 1, 1994.
>
> The Commission submitted re-recognition materials for review by CORPA at its February 1996 meeting. In March 1996, the Commission received notification that CORPA had granted the Commission re-recognition for the maximum period of five years and cited no areas of non-compliance. The Commission's next re-recognition review by CORPA would be conducted in 2001.
>
> On December 31, 1996, CORPA filed Articles of Dissolution, as voted by COPRA at its August 1996 meeting. The Commission was informed that CORPA recognition function would become a responsibility of the newly-established Council on Higher Education Accreditation (CHEA). In February 1997, the accrediting community was informed about recent actions of the CHEA Board of Directors; the letter stated that for an accrediting agency to be eligible for CHEA recognition, it must have a majority of degree granting programs or institutions. In early March 1997 the Commission was informed that CHEA has accepted the Commission's CORPA recognition status.
>
> In January 1999, the Commission considered a report on the recently established Council on Higher Education Accreditation (CHEA) and its newly approved *Recognition of Accrediting Organizations Policy and Procedures,* effective January

[11] American Dental Association Commission on Dental Accreditation Evaluation Policies and Procedures

1999. The Commission noted that accreditation agencies are eligible to apply for recognition of CHEA if the majority of the accredited programs were granting degrees. Thus, the Commission was not eligible for CHEA recognition and would have to pursue an exemption from the eligibility requirements if CHEA recognition were to be sought. At that time, the Commission determined not to request an exemption for the Eligibility Policy, but to continue to monitor issues being addressed by the higher education community through attendance at CHEA conferences. The Commission may pursue CHEA recognition in the future."

V. HEALTHCARE ACCREDITORS THAT HAD BUT NO LONGER HAVE USDE RECOGNITION AND WHY THIS DECISION WAS MADE

The benchmarking study did not indicate that there were any healthcare accreditors, or accreditors in other industries, that had USDE recognition in the past and voluntarily chose to not to continue this recognition. Healthcare accreditors that did not have USDE recognition were those that did not qualify for recognition. For example, the Accreditation Council for Graduate Medical Education (ACGME) does not have USDE recognition and is not eligible to even apply for recognition. This is because USDE recognition is only available to higher education accrediting agencies that accredit degree granting education programs; ACGME accredits medical residency programs that do not confer degrees. The agency that accredits medical equation degree-granting programs is the Liaison Committee for Medical Education (LCME). This accreditor is recognized by USDE.

VI. PERCEIVED VALUE OF CODA PARTICIPATION WITH USDE RECOGNITION: PERSPECTIVES OF CODA, ADA AND ITS STAKEHOLDERS

There was little quantitative data available to demonstrate the exact financial impact of CODA recognition by the USDE on educational programs. This lack of quantitative data appears to be the norm for the accreditation community in general and is related to how government agencies track their funding and the relationship of this funding to the USDE recognition. However, all the research clearly supported the need for CODA to remain recognized by the USDE. Reasons stated addressed the importance of the USDE recognition to enhancing the credibility of CODA and the importance of maintaining access to all available governmental sources of funding to support dental education programs. The only dissenting opinion to this was expressed by some of the representatives of the dental advanced practice specialty community who believed that educational programs in general dentistry needed to continue to be accredited by a USDE recognized accreditation agency but that educational programs that prepare individuals for advanced specialty practice would not need to be accredited by a USDE recognized accreditation agency. However, this perspective was not consistently stated by all of the advanced specialty practice representatives.

The benchmarking study clearly demonstrated that the general perspective in the accreditation community is that the USDE recognition is very valuable. The USDE recognition adds credibility to the agency and to the processes it uses. There did not appear to be any USDE eligible accrediting agency that had declined to seek recognition.

Groups that were not eligible to apply for the USDE recognition, such as the Accreditation Council for Graduate Medical Education (ACGME) were in fact recognized by other appropriate U.S. Government agencies so that their accredited educational programs could take advantage of relevant federal funding.

Attachment A: Criteria for USDE Recognition as a Recognized Accreditation Agency

It should be noted that these requirements stated below are current effective October 2007 but were the subject of negotiated rule making by the USDE over the past several months. While the negotiated rule making has been suspended for the time being (due to protests from the accreditation community regarding the process of revision and the directions in recognition criteria that USDE were advocating) it is not clear when negotiated rule making or some other process will resume. It is also important to understand that desired new criteria from the perspective of the secretary of education would require accreditation agencies to hold accredited institutions and programs to better define education outcomes, provide more quantitative outcome measures to define student success and be more accountable for the outcomes of the education process.

Requirements [12]

BASIC ELIGIBILITY REQUIREMENTS

602.10 Link to Federal programs.

The agency must demonstrate that--

(a) If the agency accredits institutions of higher education, its accreditation is a required element in enabling at least one of those institutions to establish eligibility to participate in HEA programs; or

(b) If the agency accredits institutions of higher education or higher education programs, or both, its accreditation is a required element in enabling at least one of those entities to establish eligibility to participate in non-HEA Federal programs.

(Authority: 20 U.S.C. 1099b)

602.11 Geographic scope of accrediting activities.

The agency must demonstrate that its accrediting activities cover--

(a) A State, if the agency is part of a State government;

[12] **retrieved and reproduced verbatim from http://www.ed.gov/print/admins/finaid/accred/accreditation.html October 4**

(b) A region of the United States that includes at least three States that are reasonably close to one another; or

(c) The United States.

(Authority: 20 U.S.C. 1099b)

602.12 Accrediting experience.

(a) An agency seeking initial recognition must demonstrate that it has--

(1) Granted accreditation or preaccreditation--

(i) To one or more institutions if it is requesting recognition as an institutional accrediting agency and to one or more programs if it is requesting recognition as a programmatic accrediting agency;

(ii) That covers the range of the specific degrees, certificates, institutions, and programs for which it seeks recognition; and

(iii) In the geographic area for which it seeks recognition; and

(2) Conducted accrediting activities, including deciding whether to grant or deny accreditation or preaccreditation, for at least two years prior to seeking recognition.

(b) A recognized agency seeking an expansion of its scope of recognition must demonstrate that it has granted accreditation or preaccreditation covering the range of the specific degrees, certificates, institutions, and programs for which it seeks the expansion of scope.

(Authority: 20 U.S.C. 1099b)

602.13 Acceptance of the agency by others.

The agency must demonstrate that its standards, policies, procedures, and decisions to grant or deny accreditation are widely accepted in the United States by--

(a) Educators and educational institutions; and

(b) Licensing bodies, practitioners, and employers in the professional or vocational fields for which the educational institutions or programs within the agency's jurisdiction prepare their students.

(Authority: 20 U.S.C. 1099b)

ORGANIZATIONAL AND ADMINISTRATIVE REQUIREMENTS

602.14 Purpose and organization.

(a) The Secretary recognizes only the following four categories of agencies:

The Secretary recognizes...	that...
(1) An accrediting agency	(i) Has a voluntary membership of institutions of higher education; (ii) Has as a principal purpose the accrediting of institutions of higher education and that accreditation is a required element in enabling those institutions to participate in HEA programs; and (iii) Satisfies the separate and independent requirements in paragraph (b) of this section.
(2) An accrediting agency	(i) Has a voluntary membership; and (ii) Has as its principal purpose the accrediting of higher education programs, or higher education programs and institutions of higher education, and that accreditation is a required element in enabling those entities to participate in non-HEA Federal programs.
(3) An accrediting agency	for purposes of determining eligibility for Title IV, HEA programs-- (i) Either has a voluntary membership of individuals participating in a profession or has as its principal purpose the accrediting of programs within institutions that are accredited by a nationally recognized accrediting agency; and (ii) Either satisfies the separate and independent requirements in paragraph (b) of this section or obtains a waiver of those requirements under paragraphs (d) and (e) of this section.
(4) A State agency	(i) Has as a principal purpose the accrediting of institutions of higher education, higher education programs, or both; and (ii) The Secretary listed as a nationally recognized accrediting agency on or before October 1, 1991 and has recognized continuously since that date.

(b) For purposes of this section, the term **separate and independent** means that--

(1) The members of the agency's decision-making body--who decide the accreditation or preaccreditation status of institutions or programs, establish the agency's accreditation policies, or both--are not elected or selected by the board or chief executive officer of any related, associated, or affiliated trade association or membership organization;

(2) At least one member of the agency's decision-making body is a representative of the public, and at least one-seventh of that body consists of representatives of the public;

(3) The agency has established and implemented guidelines for each member of the decision-making body to avoid conflicts of interest in making decisions;

(4) The agency's dues are paid separately from any dues paid to any related, associated, or affiliated trade association or membership organization; and

(5) The agency develops and determines its own budget, with no review by or consultation with any other entity or organization.

(c) The Secretary considers that any joint use of personnel, services, equipment, or facilities by an agency and a related, associated, or affiliated trade association or membership organization does not violate the separate and independent requirements in paragraph (b) of this section if--

(1) The agency pays the fair market value for its proportionate share of the joint use; and

(2) The joint use does not compromise the independence and confidentiality of the accreditation process.

(d) For purposes of paragraph (a)(3) of this section, the Secretary may waive the "separate and independent" requirements in paragraph (b) of this section if the agency demonstrates that--

(1) The Secretary listed the agency as a nationally recognized agency on or before October 1, 1991 and has recognized it continuously since that date;

(2) The related, associated, or affiliated trade association or membership organization plays no role in making or ratifying either the accrediting or policy decisions of the agency;

(3) The agency has sufficient budgetary and administrative autonomy to carry out its accrediting functions independently; and

(4) The agency provides to the related, associated, or affiliated trade association or membership organization only information it makes available to the public.

(e) An agency seeking a waiver of the "separate and independent" requirements under paragraph (d) of this section must apply for the waiver each time the agency seeks recognition or continued recognition.

(Authority: 20 U.S.C. 1099b)

602.15 Administrative and fiscal responsibilities.

The agency must have the administrative and fiscal capability to carry out its accreditation activities in light of its requested scope of recognition. The agency meets this requirement if the agency demonstrates that--

(a) The agency has--

(1) Adequate administrative staff and financial resources to carry out its accrediting responsibilities;

(2) Competent and knowledgeable individuals, qualified by education and experience in their own right and trained by the agency on its standards, policies, and procedures, to conduct its on-site evaluations, establish its policies, and make its accrediting and preaccrediting decisions;

(3) Academic and administrative personnel on its evaluation, policy, and decision-making bodies, if the agency accredits institutions;

(4) Educators and practitioners on its evaluation, policy, and decision-making bodies, if the agency accredits programs or single-purpose institutions that prepare students for a specific profession;

(5) Representatives of the public on all decision-making bodies; and

(6) Clear and effective controls against conflicts of interest, or the appearance of conflicts of interest, by the agency's--

(i) Board members;

(ii) Commissioners;

(iii) Evaluation team members;

(iv) Consultants;

(v) Administrative staff; and

(vi) Other agency representatives; and

(b) The agency maintains complete and accurate records of--

(1) Its last two full accreditation or preaccreditation reviews of each institution or program, including on-site evaluation team reports, the institution's or program's responses to on-site reports, periodic review reports, any reports of special reviews conducted by the agency between regular reviews, and a copy of the institution's most recent self-study; and

(2) All decisions regarding the accreditation and preaccreditation of any institution or program, including all correspondence that is significantly related to those decisions.

(Approved by the Office of Management and Budget under control number 1845-0003)

(Authority: 20 U.S.C. 1099b)

REQUIRED STANDARDS AND THEIR APPLICATION

602.16 Accreditation and preaccreditation standards.

(a) The agency must demonstrate that it has standards for accreditation, and preaccreditation, if offered, that are sufficiently rigorous to ensure that the agency is a reliable authority regarding the quality of the education or training provided by the institutions or programs it accredits. The agency meets this requirement if-

(1) The agency's accreditation standards effectively address the quality of the institution or program in the following areas:

(i) Success with respect to student achievement in relation to the institution's mission, including, as appropriate, consideration of course completion, State licensing examination, and job placement rates.

(ii) Curricula.

(iii) Faculty.

(iv) Facilities, equipment, and supplies.

(v) Fiscal and administrative capacity as appropriate to the specified scale of operations.

(vi) Student support services.

(vii) Recruiting and admissions practices, academic calendars, catalogs, publications, grading, and advertising.

(viii) Measures of program length and the objectives of the degrees or credentials offered.

(ix) Record of student complaints received by, or available to, the agency.

(x) Record of compliance with the institution's program responsibilities under Title IV of the Act, based on the most recent student loan default rate data provided by the Secretary, the results of financial or compliance audits, program reviews, and any other information that the Secretary may provide to the agency; and

(2) The agency's preaccreditation standards, if offered, are appropriately related to the agency's accreditation standards and do not permit the institution or program to hold preaccreditation status for more than five years.

(b) If the agency only accredits programs and does not serve as an institutional accrediting agency for any of those programs, its accreditation standards must address the areas in paragraph (a)(1) of this section in terms of the type and level of the program rather than in terms of the institution.

(c) If none of the institutions an agency accredits participates in any Title IV, HEA program, or if the agency only accredits programs within institutions that are accredited by a nationally recognized institutional accrediting agency, the agency is not required to have the accreditation standards described in paragraphs (a)(1)(viii) and (a)(1)(x) of this section.

(d) An agency that has established and applies the standards in paragraph (a) of this section may establish any additional accreditation standards it deems appropriate.

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(Authority: 20 U.S.C. 1099b)

602.17 Application of standards in reaching an accrediting decision.

The agency must have effective mechanisms for evaluating an institution's or program's compliance with the agency's standards before reaching a decision to accredit or preaccredit the institution or program. The agency meets this requirement if the agency demonstrates that it--

(a) Evaluates whether an institution or program--

(1) Maintains clearly specified educational objectives that are consistent with its mission and appropriate in light of the degrees or certificates awarded;

(2) Is successful in achieving its stated objectives; and

(3) Maintains degree and certificate requirements that at least conform to commonly accepted standards;

(b) Requires the institution or program to prepare, following guidance provided by the agency, an in-depth self-study that includes the assessment of educational quality and the institution's or program's continuing efforts to improve educational quality;

(c) Conducts at least one on-site review of the institution or program during which it obtains sufficient information to determine if the institution or program complies with the agency's standards;

(d) Allows the institution or program the opportunity to respond in writing to the report of the on-site review;

(e) Conducts its own analysis of the self-study and supporting documentation furnished by the institution or program, the report of the on-site review, the institution's or program's response to the report, and any other appropriate information from other sources to determine whether the institution or program complies with the agency's standards; and

(f) Provides the institution or program with a detailed written report that assesses--

(1) The institution's or program's compliance with the agency's standards, including areas needing improvement; and

(2) The institution's or program's performance with respect to student achievement.

(Authority: 20 U.S.C. 1099b)

602.18 Ensuring consistency in decision-making.

The agency must consistently apply and enforce its standards to ensure that the education or training offered by an institution or program, including any offered through distance education, is of sufficient quality to achieve its stated objective for the duration of any accreditation or preaccreditation period granted by the agency. The agency meets this requirement if the agency--

(a) Has effective controls against the inconsistent application of the agency's standards;

(b) Bases decisions regarding accreditation and preaccreditation on the agency's published standards; and

(c) Has a reasonable basis for determining that the information the agency relies on for making accrediting decisions is accurate.

(Authority: 20 U.S.C. 1099b)

602.19 Monitoring and reevaluation of accredited institutions and programs.

(a) The agency must reevaluate, at regularly established intervals, the institutions or programs it has accredited or preaccredited.

(b) The agency must monitor institutions or programs throughout their accreditation or preaccreditation period to ensure that they remain in compliance with the agency's standards. This includes conducting special evaluations or site visits, as necessary.

(Authority: 20 U.S.C. 1099b)

602.20 Enforcement of standards.

(a) If the agency's review of an institution or program under any standard indicates that the institution or program is not in compliance with that standard, the agency must--

(1) Immediately initiate adverse action against the institution or program; or

(2) Require the institution or program to take appropriate action to bring itself into compliance with the agency's standards within a time period that must not exceed--

(i) Twelve months, if the program, or the longest program offered by the institution, is less than one year in length;

(ii) Eighteen months, if the program, or the longest program offered by the institution, is at least one year, but less than two years, in length; or

(iii) Two years, if the program, or the longest program offered by the institution, is at least two years in length.

(b) If the institution or program does not bring itself into compliance within the specified period, the agency must take immediate adverse action unless the agency, for good cause, extends the period for achieving compliance.

(Authority: 20 U.S.C. 1099b)

602.21 Review of standards.

(a) The agency must maintain a systematic program of review that demonstrates that its standards are adequate to evaluate the quality of the education or training provided by the institutions and programs it accredits and relevant to the educational or training needs of students.

(b) The agency determines the specific procedures it follows in evaluating its standards, but the agency must ensure that its program of review--

(1) Is comprehensive;

(2) Occurs at regular, yet reasonable, intervals or on an ongoing basis;

(3) Examines each of the agency's standards and the standards as a whole; and

(4) Involves all of the agency's relevant constituencies in the review and affords them a meaningful opportunity to provide input into the review.

(c) If the agency determines, at any point during its systematic program of review, that it needs to make changes to its standards, the agency must initiate action within 12 months to make the changes and must complete that action within a reasonable period of time. Before finalizing any changes to its standards, the agency must--

(1) Provide notice to all of the agency's relevant constituencies, and other parties who have made their interest known to the agency, of the changes the agency proposes to make;

(2) Give the constituencies and other interested parties adequate opportunity to comment on the proposed changes; and

(3) Take into account any comments on the proposed changes submitted timely by the relevant constituencies and by other interested parties.

(Authority: 20 U.S.C. 1099b)

REQUIRED OPERATING POLICIES AND PROCEDURES

602.22 Substantive change.

(a) If the agency accredits institutions, it must maintain adequate substantive change policies that ensure that any substantive change to the educational mission, program, or programs of an institution after the agency has accredited or preaccredited the institution does not adversely affect the capacity of the institution to continue to meet the agency's standards. The agency meets this requirement if--

(1) The agency requires the institution to obtain the agency's approval of the substantive change before the agency includes the change in the scope of accreditation or preaccreditation it previously granted to the institution; and

(2) The agency's definition of substantive change includes at least the following types of change:

(i) Any change in the established mission or objectives of the institution.

(ii) Any change in the legal status, form of control, or ownership of the institution.

(iii) The addition of courses or programs that represent a significant departure, in either content or method of delivery, from those that were offered when the agency last evaluated the institution.

(iv) The addition of courses or programs at a degree or credential level above that which is included in the institution's current accreditation or preaccreditation.

(v) A change from clock hours to credit hours.

(vi) A substantial increase in the number of clock or credit hours awarded for successful completion of a program.

(vii) The establishment of an additional location geographically apart from the main campus at which the institution offers at least 50 percent of an educational program.

(b) The agency may determine the procedures it uses to grant prior approval of the substantive change. Except as provided in paragraph (c) of this section, these may, but need not, require a visit by the agency.

(c) If the agency's accreditation of an institution enables the institution to seek eligibility to participate in Title IV, HEA programs, the agency's procedures for the approval of an additional location described in paragraph (a)(2)(vii) of this section must determine if the institution has the fiscal and administrative capacity to operate the additional location. In addition, the agency's procedures must include--

(1) A visit, within six months, to each additional location the institution establishes, if the institution--

(i) Has a total of three or fewer additional locations;

(ii) Has not demonstrated, to the agency's satisfaction, that it has a proven record of effective educational oversight of additional locations; or

(iii) Has been placed on warning, probation, or show cause by the agency or is subject to some limitation by the agency on its accreditation or preaccreditation status;

(2) An effective mechanism for conducting, at reasonable intervals, visits to additional locations of institutions that operate more than three additional locations; and

(3) An effective mechanism, which may, at the agency's discretion, include visits to additional locations, for ensuring that accredited and preaccredited institutions that experience rapid growth in the number of additional locations maintain educational quality.

(d) The purpose of the visits described in paragraph (c) of this section is to verify that the additional location has the personnel, facilities, and resources it claimed to have in its application to the agency for approval of the additional location.

(Authority: 20 U.S.C. 1099b)

602.23 Operating procedures all agencies must have.

(a) The agency must maintain and make available to the public, upon request, written materials describing--

(1) Each type of accreditation and preaccreditation it grants;

(2) The procedures that institutions or programs must follow in applying for accreditation or preaccreditation;

(3) The standards and procedures it uses to determine whether to grant, reaffirm, reinstate, restrict, deny, revoke, terminate, or take any other action related to each type of accreditation and preaccreditation that the agency grants;

(4) The institutions and programs that the agency currently accredits or preaccredits and, for each institution and program, the year the agency will next review or reconsider it for accreditation or preaccreditation; and

(5) The names, academic and professional qualifications, and relevant employment and organizational affiliations of--

(i) The members of the agency's policy and decision-making bodies; and

(ii) The agency's principal administrative staff.

(b) In providing public notice that an institution or program subject to its jurisdiction is being considered for accreditation or preaccreditation, the agency must provide an opportunity for third-party comment concerning the institution's or program's qualifications for accreditation or preaccreditation. At the agency's discretion, third-party comment may be received either in writing or at a public hearing, or both.

(c) The accrediting agency must--

(1) Review in a timely, fair, and equitable manner any complaint it receives against an accredited institution or program that is related to the agency's standards or procedures;

(2) Take follow-up action, as necessary, including enforcement action, if necessary, based on the results of its review; and

(3) Review in a timely, fair, and equitable manner, and apply unbiased judgment to, any complaints against itself and take follow-up action, as appropriate, based on the results of its review.

(d) If an institution or program elects to make a public disclosure of its accreditation or preaccreditation status, the agency must ensure that the institution or program discloses that status accurately, including the specific academic or instructional programs covered by that status and the name, address, and telephone number of the agency.

(e) The accrediting agency must provide for the public correction of incorrect or misleading information an accredited or preaccredited institution or program releases about--

(1) The accreditation or preaccreditation status of the institution or program;

(2) The contents of reports of on-site reviews; and

(3) The agency's accrediting or preaccrediting actions with respect to the institution or program.

(f) The agency may establish any additional operating procedures it deems appropriate. At the agency's discretion, these may include unannounced inspections.

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(Authority: 20 U.S.C. 1099b)

602.24 Additional procedures certain institutional accreditors must have.

If the agency is an institutional accrediting agency and its accreditation or preaccreditation enables those institutions to obtain eligibility to participate in Title IV, HEA programs, the agency must demonstrate that it has established and uses all of the following procedures:

(a) Branch campus.

(1) The agency must require the institution to notify the agency if it plans to establish a branch campus and to submit a business plan for the branch campus that describes--

(i) The educational program to be offered at the branch campus;

(ii) The projected revenues and expenditures and cash flow at the branch campus; and

(iii) The operation, management, and physical resources at the branch campus.

(2) The agency may extend accreditation to the branch campus only after it evaluates the business plan and takes whatever other actions it deems necessary to determine that the branch campus has sufficient educational, financial, operational, management, and physical resources to meet the agency's standards.

(3) The agency must undertake a site visit to the branch campus as soon as practicable, but no later than six months after the establishment of that campus.

(b) Change in ownership.

The agency must undertake a site visit to an institution that has undergone a change of ownership that resulted in a change of control as soon as practicable, but no later than six months after the change of ownership.

(c) Teach-out agreements.

(1) The agency must require an institution it accredits or preaccredits that enters into a teach-out agreement with another institution to submit that teach-out agreement to the agency for approval.

(2) The agency may approve the teach-out agreement only if the agreement is between institutions that are accredited or preaccredited by a nationally recognized accrediting agency, is consistent with applicable standards and regulations, and provides for the equitable treatment of students by ensuring that--

(i) The teach-out institution has the necessary experience, resources, and support services to provide an educational program that is of acceptable quality and reasonably similar in content, structure, and scheduling to that provided by the closed institution; and

(ii) The teach-out institution demonstrates that it can provide students access to the program and services without requiring them to move or travel substantial distances.

(3) If an institution the agency accredits or preaccredits closes, the agency must work with the Department and the appropriate State agency, to the extent feasible, to ensure that students are given reasonable opportunities to complete their education without additional charge.

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(Authority: 20 U.S.C. 1099b)

602.25 Due process.

The agency must demonstrate that the procedures it uses throughout the accrediting process satisfy due process. The agency meets this requirement if the agency does the following:

(a) The agency uses procedures that afford an institution or program a reasonable period of time to comply with the agency's requests for information and documents.

(b) The agency notifies the institution or program in writing of any adverse accrediting action or an action to place the institution or program on probation or show cause. The notice describes the basis for the action.

(c) The agency permits the institution or program the opportunity to appeal an adverse action and the right to be represented by counsel during that appeal. If the agency allows institutions or programs the right to appeal other types of actions, the agency has the discretion to limit the appeal to a written appeal.

(d) The agency notifies the institution or program in writing of the result of its appeal and the basis for that result.

(Authority: 20 U.S.C. 1099b)

602.26 Notification of accrediting decisions.

The agency must demonstrate that it has established and follows written procedures requiring it to provide written notice of its accrediting decisions to the Secretary, the appropriate State licensing or authorizing agency, the appropriate accrediting agencies, and the public. The agency meets this requirement if the agency, following its written procedures--

(a) Provides written notice of the following types of decisions to the Secretary, the appropriate State licensing or authorizing agency, the appropriate accrediting agencies, and the public no later than 30 days after it makes the decision:

(1) A decision to award initial accreditation or preaccreditation to an institution or program.

(2) A decision to renew an institution's or program's accreditation or preaccreditation;

(b) Provides written notice of the following types of decisions to the Secretary, the appropriate State licensing or authorizing agency, and the appropriate accrediting agencies at the same time it notifies the institution or program of the decision, but no later than 30 days after it reaches the decision:

(1) A final decision to place an institution or program on probation or an equivalent status.

(2) A final decision to deny, withdraw, suspend, revoke, or terminate the accreditation or preaccreditation of an institution or program;

(c) Provides written notice to the public of the decisions listed in paragraphs (b)(1) and (b)(2) of this section within 24 hours of its notice to the institution or program;

(d) For any decision listed in paragraph (b)(2) of this section, makes available to the Secretary, the appropriate State licensing or authorizing agency, and the public upon request, no later than 60 days after the decision, a brief statement summarizing the reasons for the agency's decision and the comments, if any, that the affected institution or program may wish to make with regard to that decision; and

(e) Notifies the Secretary, the appropriate State licensing or authorizing agency, the appropriate accrediting agencies, and, upon request, the public if an accredited or preaccredited institution or program--

(1) Decides to withdraw voluntarily from accreditation or preaccreditation, within 30 days of receiving notification from the institution or program that it is withdrawing voluntarily from accreditation or preaccreditation; or

(2) Lets its accreditation or preaccreditation lapse, within 30 days of the date on which accreditation or preaccreditation lapses.

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(Authority: 20 U.S.C. 1099b)

602.27 Other information an agency must provide the Department.

The agency must submit to the Department--

(a) A copy of any annual report it prepares;

(b) A copy, updated annually, of its ulectory of accredited and preaccredited institutions and programs;

(c) A summary of the agency's major accrediting activities during the previous year (an annual data summary), if requested by the Secretary to carry out the Secretary's responsibilities related to this part;

(d) Any proposed change in the agency's policies, procedures, or accreditation or preaccreditation standards that might alter its--

(1) Scope of recognition; or

(2) Compliance with the criteria for recognition;

(e) The name of any institution or program it accredits that the agency has reason to believe is failing to meet its Title IV, HEA program responsibilities or is engaged in fraud or abuse, along with the agency's reasons for concern about the institution or program; and

(f) If the Secretary requests, information that may bear upon an accredited or preaccredited institution's compliance with its Title IV, HEA program responsibilities, including the eligibility of the institution or program to participate in Title IV, HEA programs. The Secretary may ask for this information to assist the Department in resolving problems with the institution's participation in the Title IV, HEA programs.

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(Authority: 20 U.S.C. 1099b)

602.28 Regard for decisions of States and other accrediting agencies.

(a) If the agency is an institutional accrediting agency, it may not accredit or preaccredit institutions that lack legal authorization under applicable State law to provide a program of education beyond the secondary level.

(b) Except as provided in paragraph (c) of this section, the agency may not grant initial or renewed accreditation or preaccreditation to an institution, or a program offered by an institution, if the agency knows, or has reasonable cause to know, that the institution is the subject of--

(1) A pending or final action brought by a State agency to suspend, revoke, withdraw, or terminate the institution's legal authority to provide postsecondary education in the State;

(2) A decision by a recognized agency to deny accreditation or preaccreditation;

(3) A pending or final action brought by a recognized accrediting agency to suspend, revoke, withdraw, or terminate the institution's accreditation or preaccreditation; or

(4) Probation or an equivalent status imposed by a recognized agency.

(c) The agency may grant accreditation or preaccreditation to an institution or program described in paragraph (b) of this section only if it provides to the Secretary, within 30 days of its action, a thorough and reasonable explanation, consistent with its standards, why the action of the other body does not preclude the agency's grant of accreditation or preaccreditation.

(d) If the agency learns that an institution it accredits or preaccredits, or an institution that offers a program it accredits or preaccredits, is the subject of an adverse action by another recognized accrediting agency or has been placed on probation or an equivalent status by another recognized agency, the agency must promptly review its accreditation or preaccreditation of the institution or program to determine if it should also take adverse action or place the institution or program on probation or show cause.

(e) The agency must, upon request, share with other appropriate recognized accrediting agencies and recognized State approval agencies information about the accreditation or preaccreditation status of an institution or program and any adverse actions it has taken against an accredited or preaccredited institution or program.

(Approved by the Office of Management and Budget under control number 1845-0003)

(Authority: 20 U.S.C. 1099b)

Why does the Secretary recognize accrediting agencies?

(a) The Secretary recognizes accrediting agencies to ensure that these agencies are, for the purposes of the Higher Education Act of 1965, as amended (HEA), or for other Federal purposes, reliable authorities regarding the quality of education or training offered by the institutions or programs they accredit.

(b) The Secretary lists an agency as a nationally recognized accrediting agency if the agency meets the criteria for recognition listed in subpart B of this part.

(Authority: 20 U.S.C. 1099b)

(c) The agency may grant accreditation or preaccreditation to an institution or program described in paragraph (b) of this section only if it provides to the Secretary, within 30 days of its action, a thorough and reasonable explanation, consistent with its standards, why the action of the other body does not preclude the agency's grant of accreditation or preaccreditation.

(d) If the agency learns that an institution it accredits or preaccredits, or an institution that offers a program it accredits or preaccredits, is the subject of an adverse action by another recognized accrediting agency or has been placed on probation or an equivalent status by another recognized agency, the agency must promptly review its accreditation or preaccreditation of the institution or program to determine if it should also take adverse action or place the institution or program on probation or show cause.

(e) The agency must, upon request, share with other appropriate recognized accrediting agencies and recognized State approval agencies information about the accreditation or preaccreditation status of an institution or program and any adverse actions it has taken against an accredited or preaccredited institution or program.

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(Authority: 20 U.S.C. 1099b)

Attachment 9: Task Force on the Commission on Dental Accreditation (CODA)
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March 2008

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Resolution No. 39 New ■ Substitute ☐ Amendment ☐

Report: Board Report 10 Date Submitted: August 2008

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: Up to $5 million

Amount One-time $ Amount On-going $

ADA Strategic Plan Goals: Achieve Effective Advocacy; Lead in the Advancement of Standards (Required)

1 **REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**
2 **UPDATE ON THE COMMUNITY DENTAL HEALTH COORDINATOR PILOT**
3 **PROGRAM**

4 **Brief Summary:** This report provides an update on the Community Dental Health Coordinator
5 (CDHC) Pilot Program, including a description of the final curriculum, the pilot training sites and
6 the proposed evaluation component. The Board heard a presentation by Dr. Robert Brandjord on
7 the program at its August 2008 meeting. The Board found the presentation to be very helpful to
8 their understanding of the CDHC concept and has directed that the presentation be made available
9 to all members of the House of Delegates. The Board strongly supports the CDHC program and
10 adopted resolutions approving next steps for program implementation and evaluation. The Board
11 reviewed current funding status as well as anticipated additional financial implications for the
12 ongoing operations and evaluation of the pilot sites and has made a recommendation that the
13 ADA commit to long term financial support of the program.

14 **Background:** In October 2007, the ADA House of Delegates fully supported the Community
15 Dental Health Coordinator (CDHC) Project and adopted the following resolution:

16 **54H-2007. Resolved,** that the Board of Trustees encourages the Workforce Models
17 National Coordinating and Development Committee (NCDC) to complete Phase 1 of the
18 CDHC workforce model initiative, i.e., the comprehensive CDHC curriculum, by
19 December 2007, and be it further

20 **Resolved,** that the Board strongly supports Phase 2, i.e., piloting and evaluating the
21 model training program in at least three sites, with at least six students per year per site,
22 over a three-year period, and be it further

23 **Resolved,** that the Workforce Models National Coordinating and Development
24 Committee select the pilot sites on or before December 2007, and be it further

25 **Resolved,** that up to $2,000,000 from reserves be allocated to fund selected pilot
26 programs over a three-year period, and be it further

27 **Resolved,** that the ADA Executive Director, in cooperation with the NCDC, oversee the
28 allocations of these funds and work with each pilot site to seek additional local funding to
29 complement the ADA funding where feasible, and be it further

1 **Resolved,** that the Board of Trustees provide a progress report to the 2008 House of
2 Delegates on the status of the CDHC pilot project.

3 **Phase 1 – the CDHC Curriculum:** The Workforce Models National Coordinating and
4 Development Committee (Dr. Robert Brandjord, chair, Dr. Amid Ismail, Dr. John W. McFarland,
5 Dr. Kathy O'Loughlin, Dr. Vincent Filanova and Dr. Ken Rich; Dr. Mark Feldman and Dr. John
6 Findley, *ex officio*) and its CDHC Curriculum Committee (Dr. Amid Ismail, chair, Dr. Paul
7 Glassman, Dr. Marshall W. Kreuter, Ms. JoAnn Nyquist, Dr. Judith Skelton, Adm. Carol Turner,
8 and Dr. Robert J. Weyant) have completed the development of a model CDHC training program.

9 The 18-month training program has been designed to prepare individuals to work under a
10 dentist's supervision in health and community settings such as schools, churches, senior citizen
11 centers, Head Start Programs, and other public health settings with people similar to their own
12 ethnic and cultural background. Particularly in low income communities and rural areas, they
13 will be trained to promote oral health and provide preventive services including screenings,
14 fluoride treatments, placement of sealants, placement of temporary fillings and simple teeth
15 cleanings (selective scaling for plaque-induced gingivitis, i.e., removing gross debris, stains, and
16 calculus using anterior and posterior sickle hand scalers) until the patient can receive
17 comprehensive preventive services from a dentist or dental hygienist. This new team member
18 will increase access to dental care and has the potential to increase the number of Medicaid
19 recipients or residents in an area who see a dentist.

20 With a $334,000 grant from the ADA Foundation, the CDHC comprehensive curriculum was
21 developed, including objectives, outlines, teaching resources, learning activities and evaluation
22 mechanisms. The draft, "Community Dental Health Coordinator Curriculum: Community Health
23 Worker and Health Promotion Skills and Dental Skills" (Appendix 1), briefly outlines the training
24 modules and includes the foundation knowledge and clinical/practical skills for each module.
25 The modules, primarily designed for online delivery, were prepared by a cadre of curriculum
26 writers with expertise in their assigned subjects. A sample copy of the CDHC curriculum will be
27 on display for ADA delegates during annual session at the Information Resource Office in the
28 Delegate Registration Area.

29 **Phase 2 - The Pilot/Demonstration Sites:** In February 2007 the ADA circulated a call for letters
30 of interest to institutions interested in participating as a pilot training site. Eight letters were
31 received from institutions in six different states (none from Alaska) addressing the following
32 requirements:
33
34 1. Affiliation with a dental, advanced dental, dental hygiene or dental assisting program
35 accredited by the ADA Commission on Dental Accreditation.
36 2. Commitment from a state coordinating committee (e.g., state board of dentistry, state or
37 local dental society, academic institution) to collaborate on the development of the
38 proposed program.
39 3. Commitment from a leading community organization representing the targeted
40 community that can play a key role in planning and implementation of the pilot program
41 (e.g., local departments of health, tribal councils, community health organizations; local
42 public health associations; and faith-based organizations).
43 4. Commitment from community health centers, preferably Federally Qualified Health
44 Centers, or private practices devoted to serving individuals residing in areas with no or

limited access to care to collaborate on the development of the proposed program. [The number of clinical sites to be determined based on the number of proposed trainees.]

5. Agreement to establish admissions criteria for the pilot program that includes a high school diploma or its equivalent. [Bilingual candidates should be encouraged to apply. Applicants to the program may be, but need not be limited to: high school graduates, college students/graduates, social workers, dental assistants, dental hygienists, dentists, and other healthcare providers.]
6. Agreement to establish a certificate of completion that is awarded by the institution, attesting to the graduate's completion of all program training requirements and competencies. [Achievement of each core competency to be clearly specified on the certificate.]
7. Agreement to work with the NCDC in implementation and coordination of all activities of the pilot program.
8. Agreement to work with the national evaluation team by collecting and sharing of outcome measures.

After careful consideration, the following three institutions and sites were selected to recruit and train approximately 18 CDHCs in the three-year period starting this fall:

1. The Native American site is a partnership between the University of California-Los Angeles and Salish Kootenai College (SKC) of Pablo, Montana, a tribal college on the Flathead Indian Reservation with a CODA-accredited dental assisting program. The hands-on clinical training will occur in Native American facilities in several different states. Nancy Reifel, DDS, MPH, a public health dentist retired from the Indian Health Service presently a professor at the UCLA Dental School, and Donna Kotyk, director of the dental assisting program at SKC, are directing the program.

2. The urban site is the Michigan Coalition for Development and Implementation of the Community Dental Health Coordinators. Pending state approval, this training will occur in Federal Qualified Health Centers. Amid Ismail, BDS, MPH, PHD, MBA and professor at the University of Michigan Dental School will serve as the pilot director.

3. The rural site is the University of Oklahoma, with hands-on clinical training occurring in Native American facilities. Pending final approval by the Oklahoma State Board of Dentistry, clinical experiences will also be provided in Federally Qualified Health Centers. Dunn Cumby, DDS, MPH, MTH, chair, and Rosita Long, Ph.D., assistant professor of research in the College of Dentistry's Division of Community Dentistry, will direct this pilot program.

The Rio Salado College's (AZ) online learning management system will be used by three sites to support delivery of the instruction. Rio Salado College also offers an online dental assisting program accredited by the ADA Commission on Dental Accreditation as well as an accredited dental hygiene program. Enrollees will complete their didactic instruction electronically and their laboratory and clinical experiences together via a series in-person sessions.

Evaluation of the Pilot Programs: Phase 2 also provides for evaluating the overall success of the pilot programs to train individuals as well as success in improving access to dental care and in reducing disparities of care in the selected communities. Two independent research agencies interested in conducting the evaluation component of the CDHC pilot project submitted proposals

to the CDHC Implementation and Evaluation Committee (Dr. Carol Turner, chair, and Dr. Amid Ismail, Dr. Dunn Cumby, Dr. John McFarland, Nancy Reifel and Dr. Robert Brandjord, *ex officio*). The Committee met in June 2008 to review the two proposals and determine their potential for assessing:

1. Number of people who are receiving care at the clinic that is attributed directly or indirectly to the CDHC;
2. Types and mix of services provided to patients recruited by the CDHC versus a matched sample of other patients;
3. Number of Medicaid recipients who are new patients recruited to the clinic by the CDHCs;
4. Satisfaction of the CDHCs with their tasks;
5. Satisfaction of patients cared for by the CDHC;
6. Quality of life improvement by community members seen by the CDHC;
7. Reduction in untreated disease in patients recruited by the CDHC (interviews, and audit of patient records);
8. Financial outcomes: cost of the CDHC to the clinic; increased revenues generated by the CDHC;
9. Number of home visits or community activities generated by the CDHCs; and
10. Perception of community organizations who have been contacted by the CDHC.

At the meeting, one of the agencies withdrew its proposal due to internal personnel issues. However, representatives of the National Opinion Research Center (NORC) at the University of Chicago presented the NORC proposal to conduct a comprehensive outside evaluation of the CDHC Pilot Program. NORC is a not-for-profit organization pursuing objective research in the public interest since 1941. The Center has pioneered studies in health, education, economics and demography, substance abuse, criminal justice and other areas of public policy.

The Committee also considered a third proposal from another agency, Outcome Sciences, Inc., to create a web-based tool known as the "continuity of care record," that could provide data collection and reporting to support the community-based care management program and the data necessary for NORC to conduct its evaluation. This agency is a provider of outcome studies and patient registries with more than 100 programs initiated and more than four million patients enrolled. The company has experience with long-term programs focused on outcomes, quality improvement and departments of public health, healthcare organizations, and manufacturers. Clients include the American Heart Association, American Association of Oral and Maxillofacial Surgeons, American Orthopaedic Association, and American Society of Plastic Surgeons. Outcomes representatives conducted a webinar presentation for the Committee.

The Committee concluded that NORC and Outcome Sciences, Inc. together would meet the needs of the CDHC Evaluation Project and recommended that the ADA pursue arrangements with NORC to conduct the overall evaluation ($477,000) and a contract with Outcome Sciences, Inc. to develop the clinical care data management system ($550,000) to support the CDHC program and evaluation. With the Board's approval, the Committee will move forward with hosting a meeting of NORC and Outcomes representatives to collaborate on the development of a comprehensive program evaluation, using quantitative and qualitative methods.

Communications Plan: The ADA has also developed an overall communications plan for the CDHC program. Many activities are underway to promote the CDHC model and communicate

1 the project's progress to the communities of interest. Presentations have been made at more than
2 27 dental organization meetings during 2007 and 2008. Several presentations were also made to
3 key staff of U.S. Senate and House of Representatives Committees associated with health care.
4 Numerous articles have appeared in the *ADA News*. Talking points were distributed to the ADA
5 Board of Trustees and others in leadership roles. Information about the CDHC Pilot Program,
6 including Frequently Asked Questions, is posted on ADA.org.

7 **Next Steps and Financial Implications:** Association representatives have networked with
8 potential funding sources and the NCDC has researched more than 100 foundations and federal
9 grant-making agencies for possible funding. Local funding support for the CDHC pilot programs
10 has also been encouraged. The CDHC Philanthropic Committee (Dr. Vincent Filanova (chair),
11 Dr. Kathleen O'Loughlin and Dr. Ken Rich; Dr. Robert Brandjord, Dr. Mark Feldman and Dr.
12 John Findley, *ex officio*) continues to explore foundations, federal agencies and grant makers to
13 fund the ongoing operations of the pilots as well as the evaluation piece.

14 Each of the three pilot sites will cost a minimum of $1.5 million to operate for three years. The
15 evaluation component including the clinical care data management system will be about $1
16 million. To date approximately $170,000 in project administrative costs (volunteer meetings,
17 travel and temporary staff, etc.) have been paid from the $2 million granted by the ADA to run
18 the project; that figure will increase to $250,000 by the end of this year. Total funding for the
19 CDHC pilot program will be almost $8 million, including project support costs for temporary
20 staff, volunteer meetings and promotion. Anticipated annual expenses for the conduct of the
21 pilot program through 2012 are summarized in the following table:

	2008	2009	2010	2011	2012	2013	**Total**
3 pilot sites		$636,000	$1,206,000	$1,326,000	$696,000	$126,000	**$3,990,000**
Management of online curriculum	$155,500	$122,000	$183,000	$183,000	$21,000		**$664,500**
Evaluation of Program	0	250,000	250,000	250,000	250,000		**$1,000,000**
Project Support	250,000	200,000	200,000	100,000	100,000		**$850,000**
Equipment and Supplies		$324,000	$486,000	$486,000	$162,000		**$1,458,000**
Total	**$405,500**	**$1,532,000**	**$2,325,000**	**$2,345,000**	**$1,229,000**	**$126,000**	**$7,962,500**

22 Dr. Robert Brandjord, chair of the Workforce Models National Coordinating and Development
23 Committee (NCDC), reported progress on the CDHC Pilot Program to the ADA Board of
24 Trustees on August 12, 2008 and to the ADA Foundation Board of Directors on August 13, 2008.
25 He reported that the NCDC has accomplished its charge and can now be dismissed. He also
26 summarized the activities of the CDHC Implementation and Evaluation Committee and the
27 CDHC Philanthropic Committee as outlined in this report. Dr. Brandjord described several
28 initiatives currently underway to secure the additional $5 million needed to complete the pilot
29 program. He emphasized that potential support is more likely if there is clear support including a
30 financial commitment from the Association.

Summary: This report provides an update on the Community Dental Health Coordinator (CDHC) Pilot Program. Phase I is complete: a sample copy of the CDHC curriculum will be on display for ADA delegates during annual session at the Information Resource Office in the Delegate Registration Area. Phase 2 is well underway: Three pilot sites have been selected and two reputable outside evaluation agencies have been identified to conduct the evaluation component of the project. The Board is pleased with the progress to date and strongly supports continuation of the project as proposed, and adopted the following resolution at its August 2008 meeting.

> **B-61-2008. Resolved,** that the CDHC Implementation and Evaluation Committee engage with appropriate outside agencies to conduct a comprehensive evaluation of the CDHC pilots, and be if further
>
> **Resolved,** that the CDHC Philanthropic Committee pursue funding opportunities with organizations, foundations, the pilot sites and other entities to support this effort, and be it further
>
> **Resolved,** that the CDHC Implementation and Evaluation Committee and the Philanthropic Committee provide a progress report on the status of the CDHC pilot project, including any additional financial implications for the Association, to the Board of Trustees by August 2009.

Funding: The $2 million (from reserves) approved by the 2007 House of Delegates has been allocated to support the overall management of the online curriculum, initiate the training programs, and develop the comprehensive evaluation component in 2008 and 2009. By early 2010 those funds will be fully allocated. Additional financial support of $5 million over the next five years will likely be required to complete this project. Because the program evaluation will be a multi-year endeavor with a formal agreement, the Board believed that the ADA should formally commit to long-term support for the program while continuing aggressive efforts to seek external funding. Accordingly, the Board recommends adoption of the following resolution by the House of Delegates:

Resolution

39. Resolved, that the ADA commit up to $5 million to support the CDHC model.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	□	□	□	CADLE	■	□	□	□	GROVER	■	□	□	□	SMITH C
■	□	□	□	CALNON	■	□	□	□	KELL	■	□	□	□	SYKES
■	□	□	□	FAIELLA	■	□	□	□	KREMPASKY SMITH	■	□	□	□	TANKERSLEY
■	□	□	□	FINDLEY	■	□	□	□	LONG	■	□	□	□	THOMPSON
■	□	□	□	ELLIOTT	■	□	□	□	MANNING	■	□	□	□	VERSMAN
■	□	□	□	GIST	■	□	□	□	NICOLETTE	■	□	□	□	WEBB
■	□	□	□	GLECOS	□	■	□	□	SCHWEINEBRATEN				Res. 39	

Resolution No. 39S-1 New ☐ Substitute ■ Amendment ☐

Report: Board Report 10 Date Submitted: September 2008

Submitted By: Twelfth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: Up to $5 million

Amount One-time $ Amount On-going $

ADA Strategic Plan Goals: Achieve Effective Advocacy
Lead in the Advancement of Standards (Required)

1 **SUBSTITUTE FOR RESOLUTION 39:**
2 **FINANCIAL SUPPORT FOR CDHC MODEL**

3 The following substitute for Resolution 39 (Worksheet:4042) was submitted by the Twelfth Trustee
4 District and transmitted on September 23, 2008, by Mr. Kevin J. Robertson, executive director, Kansas
5 Dental Association.

6 **Resolution**

7 **39S-1. Resolved,** that the ADA commit up to $5 million to support the continuation of the CDHC
8 pilot programs in order to evaluate the effectiveness of the CDHC model.

9 **BOARD COMMENT:** The Board agrees with the Twelfth District's alternative language. The
10 substitute language better reflects the Board's intent for up to $5 million to be committed to support the
11 full implementation and evaluation of the CDHC pilot programs over the next five years, if funds are not
12 granted by external entities.

13 **BOARD RECOMMENDATION: Vote Yes.**

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CADLE	■	☐	☐	☐	GROVER	■	☐	☐	☐	SMITH C
■	☐	☐	☐	CALNON	■	☐	☐	☐	KELL	■	☐	☐	☐	SYKES
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FINDLEY	■	☐	☐	☐	LONG	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GIST	■	☐	☐	☐	NICOLETTE	■	☐	☐	☐	WEBB
■	☐	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN					Res. 39S-1

14
15
16

Resolution No. 39S-2 New ☐ Substitute ■ Amendment ☐

Report: Board Report 10 Date Submitted: September 2008

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: Up to $1 million over a three-year period beginning in 2010

Amount One-time $ Amount On-going $Up to $1 million

ADA Strategic Plan Goals: ______ (Required)

1 **SUBSTITUTE FOR RESOLUTION 39:**
2 **FINANCIAL SUPPORT FOR CDHC MODEL**

3 The following substitute for Resolution 39 (Worksheet:4042) was submitted by the Sixteenth Trustee
4 District and transmitted on September 25, 2008, by Mr. Phil Latham, executive director, South Carolina
5 Dental Association.

6 **Background:** If the Community Dental Health Coordinator (CDHC) is an ADA project then it makes
7 sense to fund the management of the entire curriculum and evaluation of the program. The three pilot
8 sites, project support and equipment and supplies will benefit the local communities and should not be the
9 responsibility of the ADA, therefore:

10 **Resolution**

11 **39S-2. Resolved,** that the ADA commit up to a total of $1 million over a three year period beginning
12 in 2010 to support the management of the online curriculum for the Community Dental Health
13 Coordinator (CDHC) model and the evaluation of the CDHC Program, and be it further

14 **Resolved,** that the ADA identify outside funding for the three pilot sites, project support and
15 equipment and supplies.

16 **BOARD COMMENT:** The Board believes that potential for success of the CDHC model workforce
17 initiative will be substantially diminished by piece-mealing the components of the demonstration project.
18 Management of the online curriculum and evaluation cannot proceed as independent activities without
19 fully supported pilot sites. These sites were carefully selected for their unique characteristics to
20 demonstrate the applicability of the model and it is not feasible to expect local communities with access
21 problems to provide resources to support start-up costs. However, it is more likely that external support
22 can be obtained to sustain programs based on ADA’s commitment and a track record of initial success.

23 The Board supports a financial commitment to fund the project over the next five years, if necessary, to
24 properly conduct and evaluate the pilot training programs, while continuing aggressive efforts to seek
25 external funding from sources such as foundations, corporations and government agencies.

26 **BOARD RECOMMENDATION: Vote No.**

27 **BOARD VOTE: UNANIMOUS.**

28

APPENDIX

AMERICAN DENTAL ASSOCIATION
Community Dental Health Coordinator Curriculum

It is the vision of the American Dental Association that the Community Dental Health Coordinators will assist in the reduction of disparities in oral health and improving access to dental care through organized community development in an integrated dental care system provided in community-based clinics. The Community Dental Health Coordinator will provide oral health promotion, prevention, palliative care and patient navigation.

TABLE OF CONTENTS

Title	Page number
Community Dental Health Coordinator Competencies*	3
<u>Community Health Promotion Modules</u>	
Module 1 Advocacy and Outreach	5
Module 2 Communication and cultural competency	6
Module 3 Interviewing skills	7
Module 4 Coordination, documentation, and reporting	8
Module 5 Teaching and learning skills	9
Module 6 Legal and ethical issues	10
<u>Dental Skills Modules</u>	
Module 7 Introduction to dentistry	11
Module 8 Screening and Classification	11
Module 9 Prevention of dental caries	13
Module 10 Prevention of periodontal diseases	13
Module 11 Prevention of oral cancer	14
Module 12 Palliative care	14
Module 13 Financing and payment for dental care	15
<u>Community-based field experience</u>	
Module 14 Training at a Community Health Clinic	15

Modules 1 through 13 will be completed in a maximum of 12 months. Module 14 requires 3-6 months of on-site practice depending on prior experience of the student.

This document is based on the American Dental Association Workforce Models Task Force Report, June 2006.

Competencies of the Community Dental Health Coordinators*

1. The CDHC must be competent in the development and implementation of community-based oral health prevention and promotion programs.
    a. Support water fluoridation programs
    b. Collaborate and develop community oral health initiatives
    c. Collaborate and develop oral health programs with other health and social services organizations and providers to promote oral health (e.g., Women, Infants and Children Programs, Head Start, mental health organizations, healthy baby initiatives, long-term care providers, hospices, senior citizen centers, substance abuse clinics, cancer societies, chambers of commerce, local businesses, school boards)

2. The CDHC must be competent in the knowledge and skill required to collect diagnostic data.
    a. Medical and dental histories
    b. Dental health screening/assessment (data collection) via:
        1. Visual inspection of the oral cavity for carious lesions and other hard tissue anomalies
        2. Visual soft tissue inspection
        3. Take radiographs, when appropriate
    c. Vital Signs
    d. Dental Charting

3. The CDHC must be competent in the knowledge and skill required to perform a variety of clinical supportive treatments:
    a. Practice infection and hazard control protocol consistent with published professional guidelines
    b. Prepare tray set-ups
    c. Prepare and dismiss patients
    d. Apply topical anesthetics (not realistic for CDHC per Curriculum Committee)
    e. Assist with or apply fluoride agents
    f. Process and store <u>digital</u> radiographs
    g. Provide oral health instruction
    h. Maintain accurate patient treatment records
    i. Maintain operatory area and dental equipment <u>in a community setting.</u>
    j. Assist in the management of medical and dental emergencies
    k. Administer basic life support
    l. Clean removable oral appliances and prostheses in community settings

4. The CDHC must be competent in the knowledge and skill required for administrative procedures:
    a. Collaborate with community partners including telephone management and communication skills
    b. Maintain supply inventory
    c. Control appointments and manage recall systems
    d. Operate business equipment, including computers
    e. Complete and process appropriate reimbursement papers and online forms.
    f. Facilitate basic legal and regulatory compliance, (e.g., HIPAA, Informed Consent)

5. The CDHC must be competent in the knowledge and skill required to prioritize population/patient groups:
    a. Identify potential emergent dental care needs
    b. Communicate findings to the supervising dentist using electronic or paper transmissions
    c. Revise the screening/assessment based upon dentist directive
    d. Develop a referral recommendation and submit it to the dentist for approval
    e. Develop an oral preventive recommendation and submit it to the dentist for approval

6. The CDHC must be competent in the knowledge and skill required to provide individual preventive services based upon plans, including:
    a. Oral hygiene education
    b. Tobacco cessation
    c. Dietary counseling
    d. Fluoride applications
    e. Sealant applications
    f. Coronal polishing
    g. Scaling for periodontal Type I (gingivitis) patients in community settings

7. The CDHC has the knowledge and skill required to temporize dental cavities in preparation for restorative care by a dentist:
    a. Hand instrumentation only
    b. Only open cavities that are accessible to hand instruments
    c. Manual removal of debris from cavities
    d. Placement of temporary materials such glass ionomer materials

*Based upon the American Dental Association Workforce Models Task Force Report, June 2006.

Community Health Worker and Health Promotion Skills

Module 1: Advocacy and Outreach

Clock Hours: 32-40

Foundation Knowledge

1. Community health workers: historical perspective and future development in the field
2. Definition of health from a community perspective
3. Social, behavioral, cultural, community, and environmental determinants of health
4. Public health practice
5. ABC of advocacy in local communities
6. How to build and maintain social networks

Community organizational skills

1. Foster local partnerships that will improve service delivery
2. Assist individuals and groups in identifying and pursuing personal and community goals
3. Develop leadership skills in community members to improve oral health
4. Assess and assist in prioritizing the oral health and general health care needs and assets of the community
5. Map out the social and health support networks within a community; access the resources; and inform community members of the available resources.

Advocacy Skills

1. Demonstrate the role of advocacy within the scope of practice of the CDHC
2. Inform community members of their rights and responsibilities in obtaining needed services*
3. Represent and provide a voice for members of the community, their individual needs and the needs of the community as a whole
4. Promote organized action related to identified community needs, and mobilize community members, existing resources and data to support the action
5. Identify and work with advocacy groups, local community leaders, and with local dental societies.

*Ethics

Module 2: Communication and cultural competency

Clock Hours: 22-30

Foundation knowledge

1. Communication strategies with individuals and groups
2. Culturally-, gender-, and age-appropriate verbal and non-verbal communications
3. Literacy and its impact on health
4. Oral health literacy

Communication skills

1. Speak and write with individuals and community groups in their preferred and plain language
2. Recognize and adapt to verbal and non-verbal communication
3. Assist community members in understanding technical/dental/legal processes, documents and information
4. Present information in a clear and concise way
5. Listen actively and non-judgmentally
6. Organize, work, and communicate with groups
7. Provide clear and constructive feedback to the dental team and to other groups

Interpersonal Skills

1. Show sensitivity, respect and empathy*
2. Gain and maintain trust, integrity, and reliability*
3. Initiate and maintain respectful and mutually supportive relationships with community members, organizations, and service providers
4. Assist individuals and groups in resolving conflicts
5. Recognize and appropriately respond to the beliefs, values, cultures, languages and points of view of the individuals and communities served [cultural competence]
6. Maintain confidentiality of client information*

*Ethics

Module 3: Interviewing skills

Clock Hours: 32-40

Foundation knowledge

1. Human behaviors and health
2. When and how behaviors change: life stories
3. The difference between reported and actual behaviors
4. The difference between different types of questions (biased, double barreled, confusing questions, assumptive questions)
5. Types of interviews (face-to-face, telephone, email, chats)
6. Interviews do's and don'ts

General interviewing skills

1. Prepare for an interview with community members and potential patients
2. Introduce and explain the purpose of the interview
3. Read or ask open and closed questions without directing the respondents
4. Listen to respondents' questions
5. Probe for answers
6. Provide appropriate feedback or clarifications
7. Appropriately manage rejections and unpleasant behaviors

Motivational interviewing skills

Foundation knowledge

1. Behavioral change theories and why we need them
2. History and background on motivational interviewing

Skills

1. Develop a collaborative environment with the interviewee
2. Practice the principle of autonomy
3. Probe with evocative questions
   a. Ask open-ended questions
   b. Affirm the responses
   c. Reflect on the responses
   d. Summarize responses of interviewees
4. Express empathy
5. Develop discrepancy
6. Roll with the resistance
7. Support self-efficacy
8. Start and maintain a change talk
9. Assess the intention to change
10. Assist in developing personal goals
11. Assist in defining the next steps and milestones for behavioral change

Module 4: Coordination, documentation, and reporting

Clock Hours: 22-30

Foundation knowledge

1. Health care system serving the community
2. Insurance program for community members
3. Medicaid, SCHIP, and other special programs
4. Social, mental, and family support systems
5. Local health and human services organizations and programs
6. Laws and regulation affecting community health

Interpersonal skills

1. Work effectively by balancing the demands and needs as a member of the clinical and community teams
2. Demonstrate the capability to resolve conflicts between different stakeholders

Service Coordination Skills

1. Recognize situations appropriate for referrals to various agencies and programs
2. Refer community members to appropriate service providers and assure completion of the referral by supporting/coaching and follow-up
3. Develop and maintain active referral networks and coalitions with other healthcare professionals and agencies
4. Serve as a liaison between organizations, community and clinical groups
5. Coordinate the dental care with the clinical team and communicate to the community members the progress in their care

Organizational Skills

1. Record and maintain information on individuals, referrals, appointments, activities and outcomes* using the continuity of care record,
2. Plan, organize and set up events as needed to achieve work objectives
3. Effectively manage time
4. Prioritize activities while remaining flexible
5. Create a community-specific resource directory

*Ethics

Module 5: Teaching and learning skills

Clock Hours: 22-30

Foundation knowledge

1. Definition of teaching and learning
2. Definition and resources for life-long learning
3. The Web as a source for information

Individual and group teaching skills

1. Identify and explain the goals and objectives of a training program
2. Use culturally-appropriate methods for individual and group teaching sessions
3. Employ instructional and coaching techniques that address various learning styles
4. Organize culturally-appropriate presentation materials using various media
5. Evaluate the success of a training program and measure the progress of individual learners*

Life-long learning skills

1. Achieve competency in computer skills (install, troubleshoot, and use programs necessary for the CDHC work)
2. Identify and access resources for life-long learning and to answer questions on oral and health issues facing the community
3. Search and identify reliable access to information on the WW Web

*Ethics

Module 6: Legal and ethical issues

Clock Hours: 11-15

Foundation knowledge

1. Laws, policies and regulations, especially concerning consumer rights
2. Legally mandated reporting requirements
3. Work contract for CDHC

Ethical analysis skills

1. Apply an ethical decision model to community and individual dilemma and decide what is the most appropriate action
2. Advocate for human rights and welfare in the community

Dental Skills

Module 7: Introduction to Dentistry

Clock Hours: 120-130

Foundation knowledge

1. Dental anatomy
2. General microbiology
3. Infection control
4. Oral Pathology
5. History of dentistry
6. Dental organizations
7. Interpret and read prescriptions written by the supervising dentist

Clinical skills:

1. Infection Control
2. Positioning, Ergonomics and Basic Instrumentation

This module provides foundation knowledge, as necessary, to the dental modules (8-14)

Module 8: Screening and classification

Clock Hours: 100

Foundation knowledge: General

1. Definition of an emergency
2. Definition of urgent dental care
3. Definition of dental and oral conditions and their signs and symptoms
4. Accuracy of dental screening criteria

Foundation knowledge: Dental

1. Gross anatomy of head and neck

2. Introduction to microbiology, oral pathology (general principles, the disease specific pathologies will be discussed in the disease-focused modules) and radiation safety

(Note: other background knowledge for dental practice is covered by Module 13)

Clinical skills

1. Collect the following information to assist the dentist to prepare a preliminary (interim) management plan for patients who do not have an emergency or are in need for urgent care:
    a. History of the chief complaint of the potential patient
    b. Medical and dental history including collection of information on reported chronic and infectious conditions
    c. Signs and symptoms of cavitated carious lesions
    d. Signs of questionable carious lesions (in children <6 years old, signs of early carious lesions on the facial and lingual surfaces of anterior teeth)
    e. Presence of root recession
    f. Visual signs of gingival bleeding
    g. Signs and symptoms of swellings indicative of infection
    h. Presence of any other swelling (hard or soft) of the mouth, throat, face and neck
    i. Presence of white, red, or mixed mucosal lesions
    j. Presence of ulcers
    k. Presence and status of dentures
    l. Presence of loose (mobile) teeth
    m. Presence of moderate or severe fluorosis
    n. Presence of any limitation of jaw movement
    o. Presence of pain on palpation of jaw muscles
    p. Other signs and symptoms reported by the potential patient

2. Understand the importance of keeping the Continuity of Care Record (CCR) to document the following:
    a. Clinical records of all information collected following the protocol described in Modules 9-12.
    b. Medical records including all relevant information on medical history and presence of chronic or acute conditions that may impact the oral health or care of a patient
    c. Updates of clinical records (after delivery of preventive care as well as once a year)
    d. Services rendered and dates
    e. Quality of preventive services rendered (using criteria defined by the State Executive Committee)
    f. Scheduling information (CDHC has direct access to the schedule of the clinic and can enter information at any time)
    g. Follow-up of dental visits
    h. Recall preventive visits when directed by the supervising dentist
    i. Referral status and follow-up
    j. Communication with the supervising dentist
    k. Payment method and eligibility/registration for government programs as described in Module 13
3. Follow the instructions of the supervising dentist regarding the immediate scheduling of patients with emergencies or urgent care
4. Collect information on risk factors using ADA-approved risk assessment protocols
5. Describe how to adhere to applicable HIPAA regulations in community-based settings
6. Take digital bitewing or periapical radiographs utilizing appropriate radiation safety techniques
7. Take digital photographs for areas which the dentist may need to see the physical appearance of the intra-oral tissues
8. Take alginate impressions and pour models as directed

Module 9: Prevention of dental caries

Clock Hours: 50.75

Foundation knowledge

1. The caries process
2. The determinants (biological, behavioral, social, community) of dental caries
3. The difference between primary and secondary prevention
4. The rationale and efficacy of different preventive approaches of dental caries
5. The American Dental Association Clinical Recommendations for application of topical fluorides and sealants

Clinical/practical skills

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Apply fluoride varnish and other topical fluorides following the ADA Clinical Recommendations and manufacturers' instructions.
2. Apply sealants following manufactures' recommendations
3. Identify stagnation areas where the biofilm is retained and using the motivational interviewing skills learned in Module 3 to encourage the patient to remove the biofilm
4. Advice individuals on best dietary practices to prevent dental caries
5. Follow-up on the preventive care (recall care) provided by CDHC or dentist
6. Develop community networks to support water fluoridation campaigns

Module 10: Prevention of periodontal diseases

Clock Hours: 47

Foundation knowledge

1. The classification and definition of periodontal diseases
2. The association between systemic conditions and periodontal diseases
3. The determinants (biological, behavioral, social, community) of periodontal diseases
4. The rationale and efficacy of different preventive approaches of periodontal diseases
5. The American Dental Association and American Academy of Periodontology Clinical Recommendations relevant to the prevention of periodontal diseases

Clinical skills:

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Perform gross debridement in community settings which may include scaling using anterior and/or posterior sickle hand scalers for patients with Perio type I (gingivitis) and have calculus that impedes maintaining good oral hygiene
2. Perform rubber cup (coronal) polishing using a fluoridated paste and a handpiece
3. Identify stagnation areas where the biofilm is retained and using the motivational interviewing skills learned in Module 3 to encourage that the biofilm is effectively and consistently removed using a toothbrush and a floss (when indicated)
4. Follow-up on the preventive care provided

Module 11: Prevention of oral cancer

Clock Hours: 16

Foundation knowledge

1. The classification and definition of oral cancer
2. The association between use of tobacco, alcohol, and infection with human papilloma virus (HPV) and oral cancer
3. The importance of early detection on survival rates
4. The different treatments of oral cancer.

Clinical/practical skills

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Apply the National Cancer Institute 5A program using a motivational interviewing approach to develop personal goals for change in the use of tobacco products and heavy use of alcohol
2. Identify community support resources for cancer patients.
3. Track patients with suspicious oral mucosal lesions and assist them to see the supervising dentist
4. Educate and promote early screening for oral cancer
5. Organize community screening programs in collaboration with local dentists and clinics

Module 12: Palliative care

Clock Hours: 44-60

Foundation knowledge

1. The definition and classification of different restorative materials
2. The benefits and risks associated with each restorative material
3. The properties of the temporary and interim restorative materials

Clinical skills

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Using only an air syringe and a large spoon excavator, clean a cavity from loose debris
2. Apply a temporary or interim restorative material (glass ionomer cements) following the manufacturers' instructions
3. Check for presence of high spots and remove excess material using hand instruments or a slow-speed handpiece.
4. The slow speed handpiece will ONLY be used to polish teeth (Perio I care) and remove high spots from the temporary glass ionomer restorations (GIC). The CDHC will only be provided with a prophylaxis head and a large finishing bur for use with the handpiece.

Module 13: Financing and Payment for dental care

Clock Hours: 11-15

Foundation knowledge

1. Financing of dental care
2. Who pays for dental care for the poor and those with special needs
3. Type of services covered
4. Eligibility
5. Registration
6. Navigation of the system

Skills

1. Screen subjects for their eligibility
2. Assist individuals in registering for programs to pay for dental care
3. Conduct a financial needs assessment and incorporate in the continuity of care record (CCR)

Module 14: Internship at a Community-based Dental Clinic

Clock Hours: 3 to 6 months

Duration: 3-6 months depending or prior experience

Under the supervision of a dentist and the administrators of a community dental clinic perform the duties of the Community Dental Health Coordinators.

A structured program and evaluation system will be developed by the National Coordinating and Development Committee and the State Executive Committees.

1. Manage a triage, referral and tracking system
2. Maintain all portable dental equipment
3. Operate dental equipment safely and ergonomically
4. Communicate with and manage patients of different age groups in the portable dental chair
5. Obtain and maintain current certification in CPR (Level II)
6. Apply infection control practices in every location where the portable clinic will be set-up

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 5 Date Submitted: August 2008

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

1 **REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**
2 **INTERNATIONAL CONSULTATION AND ACCREDITATION**

3 **Background:** In October 2005, the American Dental Association's House of Delegates adopted
4 Resolution 39H-2005—Consultation and Evaluation of International Dental Schools:

5 **Resolved,** that the ADA and its Board of Trustees support the Commission on Dental Accreditation's
6 initiative to offer consultation and accreditation services to international dental schools, and be it
7 further

8 **Resolved,** that the ADA and Commission on Dental Accreditation establish a standing, joint advisory
9 committee to provide guidance to the Commission in the selection, development and implementation
10 of an international program of consultation and accreditation for dental education, and be it further

11 **Resolved,** that the advisory committee include two representatives from the Commission and three
12 representatives from the ADA with one of these representatives from the ADA Board of Trustees as
13 chair and two at-large members from the practicing community appointed by the President, and be it
14 further

15 **Resolved,** that the terms of office of the ADA representatives be a staggered three-year term and be
16 eligible for one additional term of appointment, and be it further

17 **Resolved,** that the advisory committee in conjunction with the Commission on Dental Accreditation
18 provide a report annually on the progress of international activities to the House of Delegates.

19 In response to Resolution 39H-2005, the Joint Advisory Committee on International Accreditation was
20 appointed. Dr. Donald I. Cadle, Jr. (chair), Dr. Steve Bruce and Dr. Roger Simonian were appointed from
21 the ADA. Dr. James R. Cole, II and Dr. Cecile A. Feldman were appointed to represent the Commission
22 on Dental Accreditation (CODA).

23 The following is a status report of activities to date that was submitted by the Joint Advisory Committee
24 to both the ADA Board of Trustees and the Commission. The Board is transmitting this as an
25 informational report to the House.

1 The Advisory Committee met twice in 2006, on March 16 and May 12, 2006, at ADA Headquarters.
2 Resources used by the Advisory Committee members during their deliberations included:
3
4 - Joint International Consultation and Accreditation Business Plan;
5 - CODA Meeting Reports;
6 - Accreditation Standards for Dental Education Programs;
7 - United States-based accreditation and site visit process;
8 - Reciprocity Agreement with the Commission on Dental Accreditation of Canada (CDAC);
9 - American Veterinary Medical Association's (AVMA) International Policies and Procedures; and
10 - 2005 Council on Higher Education Association (CHEA) Almanac of External Quality.

11 After careful consideration, the Advisory Committee drafted policies and procedures specific to the
12 international consultation and accreditation fee-based services to be made available, upon request, to
13 established international predoctoral dental education programs. Highlights of the international policies
14 and procedures include:
15
16 - Three types of site visits that may be conducted;
17 - Broad Eligibility Criteria for Preliminary Accreditation Consultation Visit; and
18 - A summary, in bullet form and diagrammatically, of the CODA-Preliminary Accreditation
19 Consultation Visit (PACV) Process.

20 The Advisory Committee determined that the Eligibility Criteria should require that an international
21 dental education program seeking consultation and accreditation services submit a written request for a
22 PACV and complete a PACV Survey. The Committee designed the PACV Survey to provide them with
23 specific programmatic information. In accord with the proposed CODA-PACV Process, the Advisory
24 Committee reviews the international predoctoral dental education program's request and survey in
25 determining whether a PACV to the program is appropriate.

26 The Committee began to entertain requests for fee-based international consultation services in January
27 2007. Information regarding the PACV process was disseminated and CODA staff began to receive
28 inquiries regarding the process early in 2007. The first PACV requests were received late in 2007.

29 **January 23, 2008, Meeting and July 17, 2008, Conference Call:** Current members of the Joint
30 Advisory Committee on International Accreditation are Dr. Donald Cadle, chair, Dr. Steven Bruce, Dr.
31 Cecile Feldman, Dr. James Koelbl and Dr. Roger Simonian. Dr. Mark Feldman and Dr. Jeffrey Hutter
32 are *ex officio* members. Staff attending all or part of the meetings included Dr. Laura Neumann, Dr. Tony
33 Ziebert and Dr. Lorraine Lewis. The Committee met at the ADA Headquarters Building on January 23,
34 2008. A conference call was held on July 17, 2008. Dr. Feldman and Dr. Cadle were unable to attend the
35 July 17 meeting.

36 **Approval of Preliminary Accreditation Consultation Visit (PACV) Surveys:** To date, there have
37 been 21 inquiries from international programs regarding the process for obtaining accreditation from
38 CODA. Of the 21 inquiries, seven programs have submitted PACV surveys and were considered at either
39 the January or July meetings. After review and discussion, the following six international programs were
40 approved for the next step in the international accreditation process, the submission of a preliminary
41 accreditation consultation visit self-study by the international program and the scheduling of a site visit.
42 These programs are:

1. Saraswati Medical and Dental College, Lucknow, India
2. King Abdulaziz University School of Dental Medicine, Jeddah, Saudi Arabia
3. Seoul National University Seoul, Republic of Korea
4. Universidad de la Salle Bajio AC Dental Education Program, Leon, Mexico
5. Universidad de San Martin de Porres, Lima, Peru
6. Yonsei University College of Dentistry, Seoul, South Korea

The dental education program at Yeditepe University, Istanbul, Turkey also submitted a PACV survey for consideration at the July 17 conference call. One committee member recused himself from discussion and voting on this application which resulted in less than a quorum. The PACV survey for Yeditepe University will be considered at the next meeting.

Consideration of Matters Related to International Accreditation Policy and Procedures: The Committee discussed the time interval between site visits for international programs, currently at seven years for U.S.-based programs. Concern was expressed that monitoring programs from such a great distance will be difficult and a shorter time interval between regular site visits may be prudent. The Committee also came to consensus regarding notification of relevant national dental associations, government agencies, and internal accrediting agencies. Policy will be modified to require international programs to inform the national dental associations in their country, along with the appropriate government ministry and/or accrediting agency, that the program has begun the process of U.S. accreditation. The program will be required to request the appropriate government ministry and/or accrediting agency submit a letter of acknowledgement directly to the Committee. The Committee noted there is no process for international programs to challenge an adverse committee decisions at the PACV survey stage and at the PACV self-study and site visit report stage. The Committee requested the CODA staff and Outcomes Assessment Committee to develop a draft policy on appeal and due process for programs wishing to challenge committee decisions. In addition, the Committee voted to place a time limit of 12 months on program reapplication if an adverse decision is received at the survey stage or the PACV self-study/site visit report stage.

Update of Business Plan: The Committee considered the original budget projections for revenues and expenses related to international accreditation from 2005. Projections of the number of programs submitting PACV surveys and PACV self-studies along with revenue appear to be more optimistic than originally anticipated, although the timeframe has been slower than expected. As a result, no revenue has been received, while some expenses have been incurred for committee travel/meeting, telephone calls/routine office expenses and staff time. An updated budget was developed based on the current number of PACV surveys received which projected two possible site visits in 2008 and three site visits in 2009. The Committee noted there are no fees associated with submission of the PACV survey, even though there are expenses associated with the consideration of the survey. The Committee therefore voted to institute an application fee of $2,000 for the PACV survey.

Consideration of Matters Related to Site Visitor Selection and Training: The Committee discussed the nomination and training process for site reviewers. Current policy for a PACV site visit the team requires four consultants (curriculum specialist, basic science specialist, clinician educator and clinician practitioner representing the ADA).

1 The Committee considered criteria for the ADA practitioner consultants for the PACV site visit. After
2 discussion, the following criteria will be used to evaluate potential ADA consultants for the site visits: 1)
3 ADA membership, 2) some experience serving as a volunteer with the ADA, 3) international experience
4 and travel, 4) possession of a current passport, 5) may be a general dentist or a specialist, 6) primary
5 activity is private practice, and 7) language skills in the country being visited.

6 The Committee determined that a future meeting should focus on the selection and training of
7 international site visitors so that a process could be put in place soon. During the request for availability
8 for 2009 U.S. comprehensive dental school visits, several current site visitors indicated a willingness to
9 serve on international visits. The Committee identified additional issues and questions that need to be
10 addressed on policies and procedures related to the training and selection of consultants in international
11 site visits. For example: should nominations for international site visitors be solicited, and if so which
12 groups should be involved? How should the training for international site visitors differ from the training
13 already provided by CODA? Should educators from other dental schools or dental practitioners in the
14 country where the site visit is occurring serve as consultants? Should familiarity with the culture or
15 educational system of the country where the site visit is occurring be a consideration when selecting site
16 visitors?

17 The Committee determined that a meeting in late August or early September be held to begin to discuss
18 selection and training of consultants for international site visits as well as consider any new or
19 outstanding PACV surveys.

20 This report is informational and intended to keep the House of Delegates apprised of the activities of the
21 Joint Advisory Committee and progress toward the Commission on Dental Accreditation's initiation of
22 international consultation and accreditation services.

23 **Resolutions**

24 This report is informational and no resolutions are presented.

25 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

26 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—**
27 **NO BOARD DISCUSSION)**

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2008

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goals: Achieve Effective Advocacy
Lead in the Advancement of Standards (Required)

1 **REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**
2 **UPDATE ON THE ORAL PREVENTIVE ASSISTANT CURRICULUM PROJECT**

3 **Summary Brief:** This report provides a summary of the Oral Preventive Assistant (OPA) curriculum,
4 which has been developed as requested by the House of Delegates in an effort to develop new workforce
5 positions to support the dental profession. The OPA Program is designed as a defined capability set to
6 cover a particular preventive treatment need. The OPA provides preventive services for patients
7 exhibiting relatively uncomplicated plaque-induced gingivitis. The OPA curriculum and
8 recommendations for implementation will be offered to state associations for their use. Individual state
9 boards of dentistry and/or legislatures will determine specific duties to be delegated as well as education
10 and credentialing requirements for this personnel category.

11 **Background:** The Association's Workforce Models Taskforce Report to the 2006 House of Delegates
12 noted that the oral preventive assistant, "can provide some of the routine preventive services that are
13 important to maintain the oral health of the American people at its current high level. This new member
14 of the oral health care team can supplement the services of the dentist and/or dental hygienist, allowing
15 them to deliver more advanced preventive services. The primary location of the OPA will be in private
16 dental offices. However, the OPA also can fill an important role in public facilities such as community
17 health centers and schools. The OPA is a career "entry-point" position. This model is designed to create
18 an assistant who has solid background in providing patients with oral health education and information as
19 well as the basic elements of preventive care; coronal polishing for all patients and scaling for periodontal
20 Type I (gingivitis) patients."

21 The House of Delegates directed that the President appoint a work group to design and develop pilot
22 projects that could be carried out to test the OPA model in selected states or locales, and that the relevant
23 constituent dental societies and licensing boards be urged to collaborate on these pilot projects. Because
24 the skill set of the OPA was considered a subset of the Community Dental Health Coordinator (CDHC)
25 skill set, the CDHC curriculum was developed first.

26 Dr. Mark Feldman then appointed members to the Oral Preventive Assistant Curriculum Committee and
27 charged the Committee with modifying relevant CDHC modules to create the OPA curriculum. The
28 OPA Curriculum Committee was chaired by Admiral Carol Turner; Committee members included Dr.
29 Pam Baldassarre (NH), Dr. Milton Lawney (NY), Dr. Ken Rich (KY), Dr. Kevin D. Wallace (MO) and

Dr. Robert Brandjord, *ex officio*, (MN). The Committee met at ADA Headquarters in April 2008 and conducted the remainder of its business electronically.

Program Eligibility Requirements: Initially, the Workforce Models Committee believed that this oral preventive capability set would be a new type of provider, requiring 12 months of training. However, after further investigation comparing the proposed OPA competencies to those competencies required for Commission on Dental Accreditation (CODA) accredited dental assisting education programs, which are nine months in length, the Committee concluded that the OPA Program would be developed by building on existing CODA accredited dental assisting programs. This approach is consistent with how the Navy and Army train dental assistants to be prophy technicians in three months. Accordingly, under the leadership of Admiral Carol Turner, the OPA Curriculum Committee designed a modular OPA curriculum (approximately three months in length), under the assumption that enrollees will have met one of the following eligibility pathways:

1. Graduate of an accredited dental assisting program (accredited by the Commission on Dental Accreditation [CODA]); or
2. Certified Dental Assistant by the Dental Assisting National Board (DANB); or
3. Graduate of a non-accredited (by CODA) dental assisting program who is a Certified Dental Assistant by DANB; or
4. On-the-job trained dental assistant who is a Certified Dental Assistant by DANB.

OPA Competencies: Many of the skill sets for the OPA already are incorporated in CODA-accredited dental assisting programs, e.g., application of fluoride, placement of sealants and oral hygiene instruction. The OPA program will expand in those areas and will include selective clinical applications to better understand the instruments, instrumentation and competency in scaling for patients with plaque-induced gingivitis. The main focus of this new category of dental personnel is to provide the dentist/dental team an expanded preventive capability, thus allowing more flexibility to support increased access to care. The highly trained and licensed hygienist can focus on the more involved patients while the OPA can handle the less complex gingivitis cases.

The OPA program should be open to students who meet one of the eligibility pathways described above. Because of this diversity, the program will begin with a focused review of topics such as infection control, HIPAA compliance, emergencies, medications, gingival anatomy, tissue/body responses, plaque and calculus. Early on, OPA students will engage in patient positioning, tray set ups, dialogue and patient communications. Although previous dental assisting training will have focused students on *the* patient, the OPA curriculum now will focus the students on *their* patients. Proper types of instruments, use of instruments, care and sharpening of instruments and equipment maintenance will be covered in preclinical labs and on manikins. Periodontal charting in support of the dentist and dental hygienist and identifying deposits on radiographs will be reinforced.

The OPA student will be required to demonstrate clinical competence in providing gingivitis therapy along with appropriate oral hygiene instruction for each patient. If the patient has an appliance, the OPA must be able to instruct the patient in the proper cleaning regimens for the appliance. If the patient has bridges, the OPA must instruct the patient in the proper use of floss threaders. If the child has excessive caries, the OPA must provide instruction regarding diet and nutrition, brushing and flossing techniques. The OPA also will be required to demonstrate clinical competence in placing sealants and applying fluoride. Clinical competency evaluations will be conducted by calibrated evaluators (e.g., dental faculty, dentists, dental hygienists) in appropriate settings (e.g., dental school clinics, accredited program facilities, dental clinics) using the curriculum's evaluation instruments. Although the skill sets of patient

records and HIPAA compliance are encompassed in the capabilities of the certified dental assistant, developing and managing a recall system is included in the OPA's required competencies.

The OPA Curriculum Committee recognized that there is a broad spectrum of dental assisting programs with an even broader level of personnel with diverse dental assisting capabilities and experiences. Those who have completed formal dental assisting training may find some of the didactic material to be a refresher as they prepare for their clinical phases. Students that come with extensive in-office experience may be more challenged by the didactic requirements but feel very comfortable with the patient interaction and instruction. In either case, the OPA curriculum will identify the instructional content and competencies required to be successful as an oral preventive assistant and a valued member of the dental team.

OPA Curriculum: The OPA curriculum has been defined via a series of six modules, designed primarily for online delivery. Each begins with an overall module syllabus and includes a series of lessons (appended). Each lesson includes a Concepts and Principles document, lesson syllabus, faculty guide, Power Point Presentation and Script (separate WORD document to accompany slides), Tasks, Performance Evaluation (as appropriate) and Examination (as appropriate). A sample copy of the OPA curriculum will be on display for ADA delegates during annual session at the Information Resource Office in the Delegates Registration Area.

Frequently Asked Questions About OPAs: The OPA Curriculum Committee prepared the following questions and answers about the Oral Preventive Assistant initiative. This information is posted in the Careers in Dentistry section on www.ADA.org.

1. Why is the American Dental Association (ADA) developing a new personnel category of Oral Preventive Assistant (OPA)?

The ADA has been very proactive with their workforce development models focusing on the treatment needs of the entire population. As a result, the 2006 House of Delegates has directed the development of new workforce positions to support the dental profession and expansion of the current workforce scope of practice. The OPA Program is designed as a defined capability set to cover a particular preventive treatment need. The OPA provides preventive services for patients exhibiting relatively uncomplicated plaque-induced gingivitis. The dental hygienist and the dentist then can concentrate on patients with more complicated needs. This will lead to increased access, increased efficiency and more cost effective care both for the patient and the provider.

2. Where will the OPA work?

The OPA has two potential points of impact. The first is within the private dental office. The OPA has the skills to provide a wide variety of preventive services within the dental office, allowing the dentist and/or dental hygienist to provide care to patients requiring services that are more complex. Ultimately, this will provide the opportunity to treat more patients. The second area of impact is that the OPA will have expertise in providing patient oral health education. This will permit the OPA to work directly in schools, community health centers and other appropriate venues to raise oral health literacy and educate patients. Based on state regulations, the OPA may also be able to deliver preventive services, e.g., sealants, fluoride applications, in these settings.

1 **3. What are some of the services that OPAs will provide?**

2 Collection of diagnostic data such as: medical histories, vital signs, charting, radiographs;
3 preventive services for all types of patients, including: preventive and oral hygiene instruction,
4 application of fluoride and sealants, coronal polishing for all patients, scaling for plaque induced
5 gingivitis patients; and general office duties including: facilitate basic legal and regulatory
6 compliance, e.g., HIPAA compliance, maintain patient treatment records, managing a recall
7 system.

8 **4. What does scaling for the plaque-induced gingivitis patients encompass?**

9 The patients who may receive services by an OPA are those who present with a plaque-induced
10 gingivitis. Specifically, these patients exhibit no attachment loss. Bleeding may or may not be
11 present. Pseudo pockets may be present. The gingival tissues only have been affected by the
12 inflammatory process. The overseeing dentist will assign patients to the OPA.

13 **5. Are these all the services that an OPA may provide?**

14 Duties assigned to the OPA may vary from state to state based on duties currently assigned to
15 dental assistants. Specific education and credentialing (licensure/ certification) requirements are
16 determined by the state boards of dentistry and/or legislatures. The OPA services may be
17 provided by the creation of a new category of allied dental personnel (OPA) or added to an
18 existing certification/licensure category.

19 **6. Once a dental assistant completes OPA training, can s/he perform as a dental assistant?**

20 Absolutely, this is an expansion of the capabilities/duties for a dental assistant. That does not
21 preclude the individual from performing as a chairside dental assistant. In a more remote or rural
22 location this individual with the expanded capability set may be perfect for a environment where
23 the practice uses both roles; preventive services for the gingivitis patients to include the oral
24 hygiene instruction, and assist chairside as the dentist does more involved procedures. The task
25 force sees this training as a step on the career ladder for the dental assistant.

26 **7. What education/training will be required for the OPA?**

27 The OPA model requires the development of a new educational program that will encompass
28 approximately a three-month time period to complete based on the following eligibility
29 requirements:
30

31 - Graduate of an accredited dental assisting program (accredited by the Commission on
32 Dental Accreditation [CODA]); or
33 - Certified Dental Assistant by the Dental Assisting National Board (DANB); or
34 - Graduate of a non-accredited (by CODA) dental education program who is a Certified
35 Dental Assistant by DANB; or
36 - On-the-job trained dental assistant who is a Certified Dental Assistant by DANB.

37 The training will require didactic, laboratory and clinical elements with an emphasis on not only
38 the preventive care directly rendered to patients, but patient education, teaching and
39 communication techniques. Online didactic and laboratory learning combined with in-person

1 supervised clinical experience will be recommended as one method to deliver the training.
2 Alternatively, the curriculum may be presented in a traditional in-classroom format for lecture,
3 laboratory and clinical sessions. Allied dental educational programs should consider granting
4 credit or advanced standing for previously completed course work in lieu of program
5 requirements.

6 **8. Where can individuals get this training?**

7 The OPA curriculum will be made available to states wishing to implement the program. States
8 may choose to implement all or some of the OPA functions. The ADA suggests multiple options
9 for delivering the OPA training and assessing competencies. Examples include:
10

11 - Full- or part-time online didactic and in-person clinical instruction, and competency
12 evaluations through a partnership between the ADA and an accredited dental assisting
13 education program;
14 - Full- or part-time online didactic and in-person clinical instruction and competency
15 evaluations through a partnership between a state dental association and an accredited
16 dental assisting education program; or
17 - On-line didactic and in-person clinical instruction offered via a continuing education
18 program through the ADA, a state dental association or an accredited program.

19 **9. How long is the program?**

20 Approximately three months of equivalent full-time study. In comparing curriculums for the
21 proposed OPA capabilities and the existing standards for the CODA accredited dental assisting
22 education programs, it was felt that the OPA Program could be developed as a
23 certification/certificate program that would be an extension of existing CODA accredited dental
24 assisting programs or would be made available to individuals who have been trained on-the-job
25 and have displayed knowledge and skills of dental assisting through successful completion of the
26 DANB Certified Dental Assistant examination. By way of example, the military has had
27 successful “Prophy Technician” programs for years. The time frame for these military personnel
28 is generally an additional three months added on their dental assisting programs.

29 **10. What is the Dental Assisting National Board (DANB)?**

30 The Dental Assisting National Board, Inc. is the certifying board for dental assistants recognized
31 by the American Dental Association. DANB is located in Chicago, IL - www.danb.org.

32 DANB offers a variety of certification examinations. Eligibility requirements for entry into the
33 OPA curriculum require completion of the DANB Certified Dental Assistant examination. This
34 is a four-hour exam consisting of 320 multiple-choice items. The exam includes items covering
35 three components; general chairside, radiation health and safety and infection control and
36 occupational health and safety protocols based on the current OSHA Standards and CDC
37 Guidelines.
38

1 **11. What are the eligibility requirements for taking DANB's Certified Dental Assistant**
2 **examination?**

3 There are three pathways to certification:

4 **CDA Pathway I**: 1) graduation from a CODA-accredited dental assisting or dental hygiene
5 education program **and** 2) Cardiopulmonary Resuscitation (CPR) certificate from a DANB-
6 accepted CPR course earned within two years prior to the exam date.

7 **CDA Pathway II**: 1) high school graduation or equivalent **and** 2) minimum of two (2) years
8 full-time work experience (at least 3,500 hours accumulated over a continuous 24-month period)
9 as a dental assistant verified by a dentist employer **or** at least 3,500 hours of a combination of
10 continuous full- and/or part-time work experience earned over a minimum of 24 months and a
11 maximum of 48 months as a dental assistant verified by a dentist-employer **and** 3)
12 Cardiopulmonary Resuscitation (CPR) certificate from a DANB-accepted CPR course earned
13 within two years prior to the exam date.

14 **CDA Pathway III:** 1) a) Status as a current or former CDA **or** 1) b) graduation from a CODA-
15 accredited DDS or DMD program **or** 1) c) graduation from a foreign dental degree program **and**
16 2) Cardiopulmonary Resuscitation (CPR) certificate from a DANB-accepted CPR course earned
17 within two years prior to the exam date.

18 **12. When will the OPA curriculum be available?**

19 The curriculum will be available by fall 2008 and reported to the 2008 House of Delegates. The
20 curriculum and associated recommendations for implementation will be offered to state
21 associations for their use. Individual state boards of dentistry and/or legislatures will determine
22 specific duties to be delegated as well as education and credentialing requirements for this
23 personnel category.

24 **13. Why do the dental assistants have to go through accredited programs or pass the Dental**
25 **Assisting National Board (DANB) to enroll in the OPA program?**

26 This is a new level of provider for the dental profession. Eligibility through the above two
27 pathways provides for a student with significant background in dental assisting along with a level
28 of observed clinical experience in the dental office or by program faculty to ensure that the OPA
29 competencies are achieved.

30 **14. What are the recommended supervision levels for the OPA?**

31 Given the nature of the OPA position, two levels of supervision are appropriate, based upon the
32 nature of the procedure performed. For those procedures that involve rendering direct patient
33 care, direct or indirect supervision is required (as approved by procedure and as determined by
34 each state board and state law). For the patient education functions, general supervision is
35 recommended.
36

15. Will certification/licensure be required for an OPA?

States will determine eligibility, training, and certification and/or licensure requirements specific for their state. Individuals completing the training recommended by the ADA will receive a certificate of completion.

Summary: This report describes the development of the Oral Preventive Assistant curriculum, as requested by the ADA House of Delegates. The design of the OPA curriculum permits several options for delivery, including online (as appropriate), classroom and clinical settings. Ultimately, state dental boards will determine eligibility, training, and certification and/or licensure requirements specific for their state. It is a state's prerogative to determine if and how to implement an OPA training program.

A sample copy of the OPA curriculum will be on display for delegates during annual session at the Information Resource Office in the Delegates Registration Area. The OPA curriculum can be available to state dental associations and educational institutions in late 2008, once dissemination and operational mechanisms are instituted. For example, fee structures for recovering curriculum development costs and covering ongoing operational expenses should be determined. A process for developing licensing agreements between the ADA and entities wishing to use the OPA curriculum should be defined.

The Board reviewed the information on the completed OPA curriculum at its August 2008 meeting and affirmed its support for the OPA concept. The Board believes that the OPA materials are ready for dissemination and approved the following resolution:

B-63-2008. Resolved, that appropriate staff develop the operational mechanisms for making the OPA curriculum materials available to state dental associations and educational institutions and provide a report to the Board in September 2009 on the dissemination and utilization of the OPA curriculum.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Oral Preventive Assistant Program Training Modules

Module 1 - Basics Review

Lesson 1 - Microbiology: Concepts of Infection and Disease
Lesson 2 - Microbiology: Oral Biofilm
Lesson 3 - Medications Commonly Used in Dentistry
Lesson 4 - Oral Pathology: General Terminology
Lesson 5 - Oral Pathology: General Principles of Observation
Lesson 6 - Oral Pathology: Variants of Normal
Lesson 7 - Oral Pathology: Developmental Abnormalities of the Teeth
Lesson 8 - Oral Pathology: Common Soft Tissue Lesions
Lesson 9 - Oral Pathology: Injuries to the teeth and Soft Tissue
Lesson 10 - Oral Cancer – Scenario

Module 2 - Oral Disease Etiology and Prevention Background

Lesson 1 - Introduction to Dental Caries
Lesson 2 - Structures of the Periodontium
Lesson 3 - Prevention of Periodontal Disease: Soft Deposits
Lesson 4 - Prevention of Periodontal Disease : Calculus – View on Radiographs
Lesson 5 - Prevention of Periodontal Disease: Introduction to Periodontal Disease
Lesson 6 - Prevention of Periodontal Disease: Gingivitis and Periodontal Disease
Lesson 7 - Collect Preventive Data

Module 3 - Clinical Training Armamentarium and Competencies

Lesson 1 - Patient Positioning and Ergonomics
Lesson 2 - Use of Hand Instruments: The Dental Mirror
Lesson 3 - Use of hand Instruments: Use of the Explorer
Lesson 4 - Use of Hand Instruments: Assist in Periodontal Charting
Lesson 5 - Use of Hand Instruments: Principles of Instrumentation
Lesson 6 - Use of Hand Instruments: Finger Rests
Lesson 7 - Use of Hand Instruments: Use of the Scaler
Lesson 8 - Use of Hand Instruments: Use of the Universal Curet
Lesson 9 - Use of Hand Instruments: Instrumentation - Problem Areas
Lesson 10 - Use of Hand Instruments – Sharpening
Lesson 11 - Use Power Driven Debridement Instruments
Lesson 12 - Coronal Polishing: Dental Stains
Lesson 13 - Coronal Polishing: Armamentarium
Lesson 14 - Coronal Polishing: Selective Polishing Technique
Lesson 15 - Coronal Polishing: Describe and Use the Air Polishing Unit

Lesson 16 - Set Up for Plaque Induced Gingivitis Debridement
Lesson 17 - Debridement Procedures

Module 4 - Clinical Training in Material Applications to the Tooth Surface
Lesson 1 - Fluoride: Fluoride and Dental Caries Prevention
Lesson 2 - Fluoride: Topical Fluoride
Lesson 3 - Fluoride: Administer Topical Fluoride
Lesson 4 - Fluoride: Fluoride Varnish
Lesson 5 – Sealants

Module 5 - Patient Instruction
Lesson 1 - Oral Hygiene Instruction: Brushing and Flossing
Lesson 2 - Oral Hygiene Instruction: Supplemental Aids
Lesson 3 - Oral Hygiene Instruction: Improvement Plan: Child Patient
Lesson 4 - Oral Hygiene Instruction: Care of Prosthetic Appliances
Lesson 5 - Dietary Practices
Lesson 6 - Tobacco and Alcohol

Module 6 Recall Management

Resolution No. 70 New ■ Substitute □ Amendment □

Report: NA Date Submitted: October 2008

Submitted By: AAOMP, AAPD, AAP, AAOMS, AAO, AAPHD and ACP

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going

ADA Strategic Plan Goals: (Required)

1 **JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS (JCNDE)**
2 **USE OF PASS/FAIL ON NATIONAL BOARD EXAMS**

3 The following resolution was submitted by the American Academy of Oral and Maxillofacial Pathology
4 (AAOMP), the American Academy of Pediatric Dentistry (AAPD), the American Academy of
5 Periodontology (AAP), the American Association of Oral and Maxillofacial Surgeons (AAOMS), the
6 American Association of Orthodontists (AAO), the American Association of Public Health Dentistry
7 (AAPHD) and the American College of Prosthodontists (ACP) and transmitted on October 2, 2008, by
8 Ms. Carla Qualls, director of leadership entities, AAO.

9 **Background:** The JCNDE recently decided to report only pass/fail on the National Board Exams and to
10 eliminate the ranking of all dental students. This is a substantial departure from past approaches, and
11 eliminates a valuable evaluation tool for dental students, dental schools and the dental profession.

12 The current system of scoring students is a critical aspect of promoting excellence in both predoctoral and
13 advanced program education. It encourages both individuals (students) and educational institutions to
14 promote higher levels of learning and performance. The elimination of traditional grading systems
15 undermines a principal aspect of the current measurement approach: competition. Without competition, it
16 is obvious that the motivation to be better on the part of all communities will be lessened, if not
17 nonexistent. The end result of this new approach will inevitably be a lower standard of dental care for the
18 public.

19 In addition, these scores are used by the General Practice Residency and Specialty Programs to evaluate
20 applicants for advanced dental education opportunities. A pass/fail score would mean that these programs
21 may be required to develop an additional test of their own, which would result in an unnecessary burden
22 on the students.

23 Further inquiry should be undertaken as to the JCNDE's rationale for its action. Are there other ways to
24 address any weaknesses of the current approach, absent wholesale abandonment of a system that has
25 worked well for so long? Are the perceived problems with the current system as pervasive as the JCNDE
26 believes?

27 Dentistry has always met challenges with positive action and instituted responses methodically. The new
28 approach, as recommended by the JCNDE, is a tremendous departure from that standard – it is

1 tantamount to a "giving up" approach to issues that can otherwise be successfully addressed. The public
2 and other relevant audiences will undoubtedly perceive it as such.

3 **Resolution**

4 **70. Resolved,** that the Joint Commission on National Dental Examinations (JCNDE) be requested to
5 reconsider pass/fail on National Board Exams; reinstate the dental student rankings and standard
6 scores; and report results to both students and dental schools retain its quantitative nature.

7 **BOARD COMMENT:** The Board appreciates the challenges facing advanced education programs in
8 evaluating applicants and acknowledges the beliefs of educators involved in advanced education that the
9 National Board scores have provided an effective evaluation tool for students, dentals schools and the
10 dental profession. While understanding the Joint Commission's rationale for its recent policy decisions,
11 the Board is concerned that no clear alternative assessment tools are currently available to fill the void.
12 The Board believes that more time is needed to allow stakeholders to dialogue about alternative
13 information and assessment models that would meet the needs of advanced education programs and
14 others who have traditionally used National Board results for a variety of purposes beyond licensure. The
15 Board, therefore, recommends the following substitute resolution:

16 **70B. Resolved,** that the ADA House of Delegates urge the Joint Commission on National Dental
17 Examinations (JCNDE) to retain its current system of score reporting and delay implementation of its
18 policy of reporting only pass/fail results from the National Board Exams until such time as alternative
19 assessment models are available to education programs and other stakeholders.

20 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

21 **BOARD VOTE: UNANIMOUS.**

22

Resolution No. 76 New ■ Substitute □ Amendment □

Report: NA Date Submitted: October 2008

Submitted By: Fifth, Sixteenth and Seventeenth Trustee Districts

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going

ADA Strategic Plan Goals: (Required)

1 **SUSPENSION OF INTERNATIONAL CONSULTATION**
2 **AND ACCREDITATION ADVISORY COMMITTEE**

3 The following resolution was submitted by the Fifth, Sixteenth and Seventeenth Trustee Districts and
4 transmitted on October 10, 2008, by Dr. Marie Schweinebraten, trustee, Fifth District.

5 **Background:** In 2005, the ADA House of Delegates adopted resolution 39H-2005, which created a
6 Commission on Dental Accreditation advisory committee to provide guidance in selecting, developing,
7 and implementing an international program of dental education consultation and accreditation. However,
8 after being contacted by several international dental schools, the committee has identified many
9 unanticipated obstacles, including difficult-to-overcome language and cultural barriers. These obstacles
10 will make the consulting and accreditation process more labor intensive and expensive than initially
11 believed. Additionally, while accreditation of international schools was meant to at least be revenue
12 neutral and perhaps provide outside revenue, to date no income has been generated.

13 Since the committee was established, several parallel factors have also come into play, not the least of
14 which are those related to controversies over dental tourism and concerns about the worldwide economic
15 situation. The ADA must now also address the recommendations of the CODA Task Force report over
16 the coming year. In short, pursuing international accreditation and consulting at this time creates a
17 financial and resources burden for CODA. Instead, Commission members should use all available
18 resources to help CODA become a more efficient and effective organization. Therefore, the following
19 resolution is proposed.

20 **Resolution**

21 **76. Resolved,** that the ADA urge the Commission on Dental Accreditation (CODA) to suspend
22 operation of its Advisory Committee on International Consultation and Accreditation while CODA
23 considers whether and, if so, how to implement the recommendations of the CODA Task Force, and
24 be it further

25 **Resolved,** that the ADA urge CODA to include in its 2009 report to the ADA House of Delegates a
26 report detailing any plans by CODA to implement the recommendations of the CODA Task Force
27 and a report detailing any evaluation by CODA of the logistics of continuing to accredit international
28 dental programs, with a report of that evaluation and subsequent conclusions, and be it further

1 **Resolved,** that if CODA determines to suspend operation of its Advisory Committee on International
2 Consultation and Accreditation, the ADA urge CODA to seek the input of the ADA House of
3 Delegates before reinstating that Committee.

4 **BOARD COMMENT: Received too late for Board comment.**

5 C:\\annual session 2008\W2\NEW 4074 (Res 76).doc

Resolution No. 79 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 2008

Submitted By: Third Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

1 **DENTISTS EDUCATION IN A CHANGING ENVIRONMENTAL MARKETPLACE**

2 The following resolution was submitted by the Third Trustee District and transmitted on October 16, 2008, by
3 Dr. Gary Davis, secretary, Third District Caucus.

4 **Background**: Years ago physicians faced the issue regarding the business aspect of office management.
5 Practice management had become increasingly complex and many physicians decided to concentrate on
6 patient care and left the management of their offices to others. Varied types of corporations saw the
7 profitability in medical offices and started buying them out. In 1998 more physicians were working for other
8 entities than had their own practices. Today, more than 75% of all physicians work for corporate entities. As
9 dental offices become bigger businesses, business will become more interested in our profession. This
10 process is currently becoming more evident.

11 It is in the profession and public's best interest that dentists be fully involved in ownership, management and
12 provision of care. The future of the current model is tied to the effective utilization of an expanding dental
13 team and the efficient management of expanding practices. In order to accomplish this it is imperative that
14 dental students and dentists become better educated on the business aspect of dentistry. Dental students for
15 many years have rated their educational experience in dental management as inadequate at best. It is
16 becoming more difficult and complex to manage a dental practice in this changing environment.

17 **Resolution**

18 **79. Resolved,** that the appropriate agencies of the ADA investigate the best means of providing
19 educational opportunities in dental practice management that will help dental students and dentists
20 adjust to a changing practice environment and report their findings and recommendations for action to
21 the 2009 House of Delegates.

22 **BOARD RECOMMENDATION: Received after this section had been reproduced for House**
23 **distribution.**

24

Resolution No. 82 New ■ Substitute □ Amendment □

Report: ______ Date Submitted: October 2008

Submitted By: Fifth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ ______ Amount On-going $ ______

ADA Strategic Plan Goal: ______ (Required)

1 **ECONOMIC STUDY OF EXPANDED WORKFORCE MODELS**

2 The following resolution was submitted by the Fifth Trustee District and transmitted on October 17, 2008, by
3 Dr. James R. Dumas, Jr., chair.

4 **Background**: The American Dental Association has prided itself on the value of the tripartite structure of the
5 organization and the hearty efforts of a dedicated force of volunteers who have shaped the organization by
6 internal debate through a strong House of Delegates.

7 However, in recent years some concerns have arisen within the ranks of the volunteers. Many who have
8 served on association councils and task forces have voiced concerns that the opinion of the volunteer has been
9 devalued and that the ADA's annual meeting has been encumbered by more and more mandatory forums and
10 speakers so as to reduce the time for the volunteers to interact and share their concerns with each other. Many
11 council members have voiced that their input is being overlooked. However, because of actions of the Board
12 of Trustees of the Association, we are in a transitional period searching for a new executive director. The
13 former leadership of the ADA has been strongly directing the Association to deal with the access to care
14 problem and create some type of mid-level provider until recently when the AGD produced a white paper
15 with their definition of a mid-level provider. Following that presentation, the ADA has hastened to provide
16 its own definition of mid-level provider in a time frame that did not allow vetting of the subject through the
17 normal council process.

18 Lack of a definition of access to care and mid-level provider may or may not be serious stumbling blocks.
19 The membership of the ADA has been led to believe that access to care is our problem. While we share
20 responsibility for trying to assist in the dilemma, the ADA did not create the problem and the governments
21 who have mandated the care in question have not been willing to deal with the fiscal requirements necessary
22 to produce even the most basic program. In places where adequate funding has been provided, the problem of
23 access has at the very least been greatly diminished.

24 The commodity of manpower is obviously important in dealing with this concern. There have been various
25 manpower suggestions from training more dentists to creating broadened scopes of practice for an entirely
26 new group of dental adjuncts including the community dental health coordinator (CDHC) and the oral
27 preventive assistant (OPA) and others. In statements to the Congress of the United States, the President of the
28 ADA labeled the CDHC as a mid-level provider. Therefore, irrespective of the duties of the various
29 adjunctive providers, they have been acknowledged as mid-level providers to the world outside of the
30 profession of dentistry.

1 ADA statistics have claimed that any increase in the levels of dental manpower could have serious
2 ramifications on the profession. These statistics were developed with the assumptions that the economic
3 forces in place for dentistry would be historic in nature.

4 And now we come to new and serious realizations that apply to the ADA's attempt to follow the scope
5 expansion of various new auxiliaries. We are trying to fix problems that have not been defined with entities
6 that are misunderstood by the general membership and we are now facing a potentially protracted period
7 when dental care is reverting to discretionary income status for a large portion of the population. If we
8 continue with our efforts to increase the number of auxiliaries who are producing dentistry, we may destroy
9 the capacity of the dentist to cope in the current economic environment. Therefore, be it

10 **Resolution**

11 **82. Resolved,** that all studies relative to the community dental health coordinator (CDHC) and (oral
12 preventive assistant (OPA) be suspended for one year while the Council on Dental Practice studies the
13 economic feasibility of the CDHC and the OPA in the current economic environment.

Membership and Planning

Resolution No. 10 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 2008

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

1 **PARALLEL MEMBERSHIP CATEGORIES**

2 **Background**: (*Reports*:156)

3 **Membership Study:** January 1, 2008, saw the implementation of Resolution 10H-2007 (*Trans.*2007:400),
4 the result of the Council on Membership's multi-year study of membership. As a result of the *Bylaws* change,
5 the following changes were implemented:

6 • The *Bylaws* changes resulted in the creation of a new membership category for nonpracticing dentists,
7 defined as individuals who hold a dental degree but not a U.S. license, dentists not providing patient care
8 for remuneration but living in the U.S. and/or its territories. Dentists who are now invited to join the
9 ADA under this category may include policy makers; government officials; dental industry
10 representatives; dentists in the corporate world; as well as researchers, educators and deans of dental
11 schools who were previously eligible to join as associate members. The first to join the ADA under this
12 category is five-term U.S. Congressman Mike Simpson (R-Idaho). This category is helping to encourage
13 contributions from more dentists, including those not in clinical practices. As of April 30, 2008, there are
14 ten members in the new nonpracticing membership category. By 2009 there will be additional members in
15 the nonpracticing category that will be transferred from the previous associate member category.

16 • The *Bylaws* changes also allowed for an International Dental Student Membership category that mirrors
17 ASDA membership. This category, which was implemented in April 2008, has two members.

18 • The *Bylaws* change regarding the way reduced dues for graduate students is applied also went into effect
19 in 2008. This change allows for dentists entering a graduate program during their reduced dues eligibility
20 period to "stop the clock" and continue on their reduced dues progression upon completion of their
21 graduate program.

22 • As a result of the new $0 dues waiver for charitable organization practitioners, there were only five
23 members taking advantage of this waiver as of April 30, 2008 compared to 40 at this same time in April
24 2007 when they paid $5 as a charitable practitioner.

25 • The final *Bylaws* change implemented changed the qualifications for dues waivers to be based on
26 financial need rather than the previous option of financial need or permanent disability. All existing dues
27 waivers based on permanent disability have been grandfathered in and will not need to apply for another
28 waiver. As of April 30, 2008, there are 2,451 members on a financial hardship waiver, as opposed to the

1 2,568 members on financial hardship waiver/permanent disability waivers at the same time in 2007.
2 When comparing these numbers, it should be noted that there were more dues waivers given in 2007,
3 approximately 80, for relief assistance, during this time period due to the continuation of the assistance
4 given to dentists affected by hurricanes in the southern part of the U.S. in 2006 that are no longer being
5 given in 2008.

6 Since adopting the bylaws change set forth in Resolution 10H-2007, allowing for a one-time strategic
7 promotional incentive as a tool for the TGMI to penetrate target markets, the Council has been researching
8 which groups may be appropriate to target based on need and financial impact. The Council has also been
9 contacting constituent and component societies in order to encourage them to mirror this incentive in order to
10 make the largest impact. The Council resumes its discussions at its June 2008 meeting and will look to
11 propose an incentive that would improve market share, especially in lagging target markets. It is hoped that a
12 plan will be advanced to the Board of Trustees in 2008 with the intent of implementing in 2009.

13 Also, in response to Resolution 10H-2007, the American Association of Public Health Dentistry (AAPHD)
14 submitted written testimony to the 2007 ADA Reference Committee on Communications and Membership
15 Services seeking reduced membership dues for public health dentists. In response to this testimony, the
16 Council on Membership invited the president of AAPHD to address the Council at its February meeting
17 regarding the testimony. As a result, the Council has formed a workgroup with members of the ADA's
18 Council on Access, Prevention and Interprofessional Relations to discuss the needs of the public health
19 dentists and to make recommendations to the House if deemed necessary. The first conference call with this
20 workgroup took take place in May 2008.

21 Through further discussion on the progress of the membership study at its February 2008 meeting, the
22 Council proposes the following resolution for consideration by the 2008 House of Delegates:

23 **Resolution**

24 **10. Resolved,** that constituent societies be urged to develop opportunities for direct members to join the
25 tripartite by creating parallel membership categories at the state and local levels to mirror those available
26 at the ADA level.

27 **BOARD RECOMMENDATION: Vote Yes.**

28 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
29 **BOARD DISCUSSION)**

Resolution No. 11 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2008

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

1 **FOUR-YEAR RECENT GRADUATE REDUCED DUES PROGRAM**

2 **Background**: (*Reports*:156)

3 **Membership Study:** While reviewing ADA current policies, the Council noted that there was not a policy in
4 place that urged constituent and component societies to mirror the four-year recent graduate reduced dues
5 program. Therefore, the Council proposes the following resolution:

6 **Resolution**

7 **11. Resolved,** that the ADA urges constituent and component societies to adopt the ADA four-year
8 reduced dues structure for recent dental school graduates.

9 **BOARD RECOMMENDATION: Vote Yes.**

10 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
11 **BOARD DISCUSSION)**

Resolution No. 31 New ■ Substitute ☐ Amendment ☐

Report: Board Report 11 Date Submitted: August 2008

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication:

Amount One-time $ Amount On-going $ 7,750

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

REPORT 11 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES:
ANNUAL REPORT OF THE STANDING COMMITTEE ON THE NEW DENTIST

1 **Overview:** This annual report will summarize the programs and activities of the Board of Trustees Standing
2 Committee on the New Dentist.

3 **Background:** The Committee on the New Dentist (CND), as a standing committee of the ADA Board of
4 Trustees, is charged through the ADA *Bylaws* to accomplish the following: to provide the Board of Trustees
5 with expertise on issues affecting new dentists less than ten years following graduation from dental school; to
6 advocate to the Board of Trustees and other ADA agencies the perspectives of the new dentist in the
7 development of policies, programs, benefits and services of the ADA; to identify the needs and concerns of
8 new graduate dentists and make recommendations for any programs to assist with their transition to practice;
9 to stimulate the increased involvement and active participation of new dentists in organized dentistry; to serve
10 as *ex officio* members, without the power to vote, of councils and commissions of the ADA on issues
11 affecting new dentists; and to enhance communications with constituent and component new/young dentist
12 networks.

13 **Committee Composition:** The following individuals served as members of the Standing Committee on the
14 New Dentist in 2007-08: Dr. Jennifer Barrington, Texas, chair; Dr. Brandon Maddox, Illinois, vice chair; Dr.
15 Benjamin Adams, South Carolina; Dr. Jeremy Albert, Florida; Dr. Jennifer Davis, Pennsylvania; Dr. John
16 Dale Dumas, Mississippi; Dr. Benjamin Jensen, South Dakota; Dr. Jennifer Jerome, Ohio; Dr. Christopher
17 Liang, Maryland; Dr. Robert Leland, Massachusetts; Dr. Garrick Lo, Washington; Dr. Ioanna
18 Mentzelopoulou, New York; Dr. Deepinder Nijjar, California; Dr. Ian Paisley, Colorado; Dr. Danielle Ruskin,
19 Michigan; Dr. J. Christopher Smith, West Virginia; and Dr. Stacey Swilling, Arkansas.

20 **The Strategic Plan of the American Dental Association:** Committee activities support many of the
21 objectives of the *ADA Strategic Plan*, primarily those of Build Dynamic Communities. At its January and
22 June 2008 meetings, the Committee evaluated its current activities and evaluation criteria in keeping with the
23 strategic planning process and prioritized its budgeted programs within the framework of the strategic plan.
24 The Committee has also begun the internal environmental scanning process, focusing on trends in
25 demographics and generational preferences, use of technology and similar topics.

26 **Leadership Development:** The Committee is keenly interested in the development of ADA's future leaders.
27 It supports the development of new dentist committees throughout the tripartite. There are currently 42
28 constituent new dentist committees and 160 component committees in the New Dentist Committee Network.
29 To aid in the development of new committees and enhance effectiveness of established committees, the
30 Committee offers the basic and advanced new dentist committee workshops. A workshop is scheduled for

1 September with the Minnesota Dental Association new dentist committee. The Committee is also exploring
2 the use of the online "Webinar" format for enhancing outreach and strategic planning for small new dentist
3 committees and those where distance makes it difficult for in-person meetings. The Committee encourages
4 the Board of Trustees to consider involvement in new dentist activities at the local and state level when
5 selecting nominees for the ADA Committee on the New Dentist.

6 The Committee's Network Communications Program helps new dentist volunteers across the country keep in
7 touch with news in organized dentistry. From the Committee chair to all Network leaders and staff contacts,
8 Network Updates are disseminated five times each year by mail. Electronic copies are posted for download
9 on Dental Society Resources (DSR), a special Web site for tripartite staff and volunteers. Topics range from
10 ADA awards programs and the ADA New Dentist Conference to resource availability and initiatives of
11 interest to new dentists, such as the ADA-Pankey Education Connection, ADA online continuing education
12 opportunities, legislative updates and ADA Catalog products.

13 The ADA New Dentist Conference plays an important role in volunteer leadership development. In addition
14 to offering continuing education for the general new dentist member, the 2008 conference offered extensive
15 leadership programming as pre-conference workshops. The Committee monitors the number of leaders
16 attending as well as the feedback they provide; at the 2008 New Dentist Conference in New Orleans, a total of
17 73 New Dentist Committee Network volunteers attended from 28 states. Also in attendance were 17 officers
18 and members of the Board of Trustees as well as 17 members of the Committee. The 2008 conference
19 offered leadership development programming for new and experienced volunteers, as well as a session to
20 facilitate networking and peer sharing for all Network leaders.

21 In an effort to offer leadership development opportunities outside of the New Dentist Conference, the
22 Committee offers conference call/web seminar opportunities for leadership development outreach.

23 To recognize and support individuals and programs that contribute significantly to the tripartite on issues of
24 special interest to new dentists, the Committee sponsors several awards. Individual awards include the
25 Golden Apple Awards for New Dentist Leadership, New Dentist Legislative Leadership and Outstanding
26 Leadership in Mentoring. Society awards include the Golden Apple for Achievement in Dental
27 School/Dental Student Involvement in Organized Dentistry and the New Dentist Committee Outstanding
28 Program Award of Excellence (recognizing a single program of a state or local new dentist committee). The
29 Committee monitors the number and quality of nominees. In 2008, Dr. Peter Theodorou of New York, Dr.
30 Sammy Pak of Washington and Dr. Irvin Silverstein of California were honored with the New Dentist
31 Leadership award, New Dentist Legislative Leadership award and the Outstanding Leadership in Mentoring
32 award, respectively. The Committee selected the Pennsylvania Dental Association as the 2008 award
33 recipient of the New Dentist Committee Outstanding Program Award of Excellence for its New Dentist
34 Reception. These receptions were hosted twice a year with locations rotated throughout the state. New
35 dentist members and non members were invited to join constituent and component leaders for drinks,
36 appetizers and conversation. Each program included a short presentation from a leader encouraging attendees
37 to join the tripartite or become a more active member. The Dallas County Dental Society was the 2008 award
38 recipient of the Golden Apple for Achievement in Dental School/Dental Student Involvement for its Great
39 Expectations program. This program emphasized a partnership between students, faculty and Dallas County
40 Dental Society members.

41 In order to make resources more conveniently available to the Network and dental society staff, many
42 Committee resources are posted on the DSR Web page. Publicizing this site, and gaining feedback to
43 enhance it, is an ongoing opportunity for the Committee. DSR is frequently highlighted in New Dentist

Committee Network Updates and is included in the Basic and Advanced New Dentist Committee Workshops curriculum.

All Committee resources and outreach to the New Dentist Committee Network were evaluated through a Web survey of Network volunteers and staff contacts, which was completed in the fall of 2007. The leadership development offerings were rated excellent by 24.6% of the respondents and 64.9% rated them as good.

New Dentist Membership: One key role for the Committee is the facilitation of new dentist involvement in organized dentistry. To encourage tripartite membership for dental school graduates, the ADA implemented an expanded reduced dues program in 2003. In addition, those in the reduced dues program who enter a graduate program can now put the reduced dues program on hold until they finish their training, then pick up the reduced dues where they left off. Membership among active licensed new dentists increased from 28,580 in 2006 to 29,711 in 2007, an additional 1,131 new dentist members. The Committee supports the availability of these membership options and encourages state and local dental societies through new dentist committee networks to match the ADA Reduced Dues Program for recent dental school graduates and establish reduced dues for graduate students. Since its inception in 2003, the average market share of dentists in their first year out of school was 67.6% compared to an average of 55% in the four years before the reduced dues program began, an increase of 12.6%. Promotional materials about the reduced dues program were provided to the senior class as part of the Success Dental Student Programs and through various recruitment campaigns to recent graduates.

The Committee supports the goal of achieving a 75% membership market share for all dentists, including recent graduates, through outreach to dental students and new dentists. In 2007, an interagency advisory group recommended that ADA's dental school programs, including the stand alone Smart Start and Transitions programs presented under the auspices of the New Dentist Committee, be consolidated under the Success umbrella. Additionally, the advisory group recommended that revisions be made to programming and new programs be developed in order to provide valuable content to students in every year of dental school, each year and at each school. The Board of Trustees approved an implementation plan and the Committee's programs were incorporated into the Success: Dental Student Programs continuum in fall 2007. Several Committee members serve as presenters for these programs, providing a valuable perspective to the next generation of dentists.

The Committee provides targeted resources to meet new dentists' needs. One of these is the quarterly publication, *ADA New Dentist News*, which is distributed free of charge to member new dentists and dental students as a wrap on *ADA News*. Its purpose is to provide practical information to help new dentists succeed in practice. The publication showcases member resources of particular interest to new dentists and includes a Network News section twice a year written by Committee district representatives to highlight activities in the New Dentist Committee Network. The publication is sponsored by Matsco, an *ADA Member Advantage* endorsed provider offering practice acquisition, start-up and expansion loans; its focus is a particularly good fit with *ADA New Dentist News* readers. The 2009 editorial calendar includes the following topics: an expanding and contracting economy, access to care, internet marketing, business planning, lead in dental restorations and tooth whitening services by non-dentists; state law and actions, among others.

Another resource to meet new dentist needs is the ADA New Dentist Conference, which has been offered every summer for the past 22 years. The 2008 conference provided up to 11 hours of high quality continuing education at a low registration fee and was designed to facilitate peer sharing and social opportunities. Ratings for the conference have been consistently high and the Committee continues to consider opportunities to improve the conference experience.

1 In support of new dentist membership, the Committee has also been very active with the Tripartite Grassroots
2 Membership Initiative (TGMI**)**. Information about the Membership Initiative has been included in mailings
3 to the New Dentist Committee Network, as well as *ADA New Dentist News*. TGMI team members also
4 receive the monthly e-publication, *Initiative Insider*. TGMI managers work with constituent dental societies
5 and their membership committees to promote recruitment of nonmember new dentists. The Committee
6 monitors the percentage of Membership Initiative volunteers who are new dentists; as of July 2008, 17.4% of
7 Membership Initiative volunteers are new dentists.

8 **Mega Issue Discussions:** At its January and June 2008 meetings, the Committee participated in mega issue
9 discussions. The January discussion focused on Universal Coverage in Dentistry. The Committee examined
10 universal healthcare and explored how medicine and dentistry might be positioned within universal coverage.
11 The Committee answered numerous questions which examined dentistry's role in coverage, access to care,
12 and what drives healthcare policy.

13 The June discussion examined Diversity and Inclusivity. The discussion was on for-profit and non-profit
14 organizational learnings. In addition, the facilitator discussed diversity and inclusion definitions, top ten
15 critical success factors for diversity, lessons learned, a Case Study: AARP African American Research,
16 corporate diversity best practices and membership diversity.

17 **Response to 2007 House of Delegates Assignments:** There were no resolutions from the 2007 House of
18 Delegates assigned to the Committee on the New Dentist. The Committee continues to implement activities
19 in response to Resolution 107H-1996 (*Trans*.1996:710), which directed the ADA to formulate a
20 comprehensive plan to assist and educate dental students and recent graduates on issues such as debt
21 management and financing their dental education responsibly, and Resolution 52H-1997 (*Trans*.1997:669)
22 which directed the ADA to implement the plan. These activities include offering the Success Smart Start for
23 Freshmen program to every first-year class of dental students at every school during every academic year. In
24 addition, the Committee collects and provides financial information and data through various publications,
25 including *ADA New Dentist News, Financial Planning Issues for Dental Students* and results from the *2002*
26 *Survey of New Dentist Financial Issues* and the *2005 Committee on the New Dentist Constituent and*
27 *Component Dental Society Survey* and the *2006 Survey of New Dentist Occupations*, a quantitative survey to
28 provide insight into new dentists' career choices and related income.

29 **New Dentist Issues:** There are several issues of special interest to new dentists and the Committee is active
30 in monitoring those issues and providing insight and information.

31 *Financial Issues*. The Committee follows the escalating level of student debt and serves as a resource to
32 dental students through its dental school outreach, while also continuing to develop financial resources for
33 new dentists and dental students. The Committee examined the 2007 American Dental Education Association
34 Survey of Dental School Seniors and determined that the graduating debt from public schools among the
35 Class of 2007 was $148,777 (up $24,077) and from private and private-state related schools was $206,956,
36 (up $32,715). The Committee will continue to provide information to dental students to assist them in
37 making wise financial decisions that will help them anticipate financial issues related to the transition to
38 dental practice. Through the Success programs and other financial resources provided, the Committee will
39 continue to address the issues of educational debt and provide new information to students as it relates to
40 managing adequate finances.

41 *Practice Transition*. The Committee is dedicated to helping dental students and new dentists make a
42 successful transition to practice, recognizing the diversity of dental occupations that new dentists may choose.

The Committee works to educate dental students and new dentists about practice options, including dental research, dental education, public health, federal services and alternative practice settings.

Through the New Dentist Committee Network, the Committee supports the establishment of mentor programs, peer-sharing opportunities and practice management and clinical continuing education to meet new dentist needs. In 2007, the Committee updated and distributed to dental societies the *Mentor Program Manual* and the *Career Network Manual.* At the national level, the Committee continuously provides resources to new dentists via its New Dentist conference, *ADA New Dentist News*, the new dentist section of ADA.org, Dental Society Resources and the New Dentist Resource Kit (provided free to new dentists on request). The Committee believes that all ADA resources related to associateships and the purchase of a dental practice reflect both the perspectives and needs of the new dentist as well as the more established dentist.

Dental Education. The Committee follows dental education issues, particularly as they impact dental students and new dentists.

Dental Licensure. Each year, the Committee on the New Dentist continues to play an active role in educating dental students about the licensure process through the expanded publication *Dental Boards and Licensure Information for the New Graduate* which is distributed to all senior dental students and made available for download to members on ADA.org.

The Voice of the New Dentist: On other councils, Committee members have provided insight on diverse topics: access to care; course offerings at the ADA annual session; wellness resources for new dentists; legislative issues; membership outreach and conversion of dental students and new dentists to active tripartite membership; risk management; advocacy for dentists and patients; dental workforce issues; evidence-based dentistry; and licensure issues.

Representatives of the Committee also serve on other committees and task forces for the ADA, including: ADA Strategic Planning Committee, Symposium on Integrity and Ethics in Dental Education, Center for Education and Lifelong Learning (CELL) CE Online Advisory Group and CELL CE Online Editorial Board.

The Committee seeks to accurately represent the views and needs of new dentists, including those in occupations other than private practice, such as federal service, graduate students and dental education. In order to do so, the Committee requests a consultant each year from each branch of the federal dental services, as well as a liaison to the American Student Dental Association (ASDA). Consultants this year included: Dr. Macy Hyvonen (ASDA); Major Katherine Morganti, D.D.S. (U.S. Air Force Dental Corps); Captain Kathleen Seiler, D.D.S. (U.S. Army Dental Corps); Lieutenant Commander Rasha Hanna, D.D.S. (U.S. Navy Dental Corps); Lieutenant Commander Jane Bleuel, D.M.D. (U.S. Public Health Service); and Sarah Knowles, D.D.S. (Department of Veterans Affairs). Dr. Hyvonen provided information to the Committee regarding dental student issues related to membership, dental careers and transition to dental practice as well as conversion of dental students to active membership. The consultants from the branches of the federal dental services provided insight into the concerns of new dentists in the military and other federal services, including income, membership dues, special pays, licensure issues and advocacy initiatives.

As a result of the *ex officio* appointment to the Council on Scientific Affairs, the Committee on the New Dentist and the Council on Scientific Affairs will provide, for the fifth year, *The Little Dental Drug Booklet* free of charge to the senior class. Additionally, the Committee and the Council on ADA Sessions will be co-sponsoring 15 workshops at the 2008 ADA annual session.

1 The Committee currently provides the voice of the new dentist to nine ADA agencies, through its *ex officio*
2 assignments. Agencies include: Council on Access, Prevention and Interprofessional Relations, Council on
3 ADA Sessions, Council on Communications, Council on Dental Education and Licensure, Council on Dental
4 Practice, Council on Government Affairs, Council on Membership, Council on Scientific Affairs and ADPAC
5 Board.

6 Several councils which do not currently have *ex officio* participants have indicated a desire for such. These
7 include the Council on Dental Benefits Programs, the Council on Members Insurance and Retirement
8 Programs, and the Council on Ethics, Bylaws, and Judicial Affairs. At its June 2008 meeting, the Committee
9 recommended that three additional members of the Committee be placed as ex-officio appointees to these
10 Councils. There are budget implications with this recommendation. The Committee's 2009 budget would
11 require an additional $7,750 to cover travel expenses. The Board supports this recommendation and proposes
12 the following resolution:

13 **31. Resolved**, that an additional $7,750 be allocated in the 2009 ADA annual budget to fund three
14 additional members of the Committee on the New Dentist to serve as ex officio members of ADA
15 councils.

16 **BOARD RECOMMENDATION: Vote Yes.**

17 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
18 **BOARD DISCUSSION)**

Resolution No. 36 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2008

Submitted By: Thirteenth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: ______ (Required)

1 **MARKET RESEARCH PROJECT**

2 The following resolution was submitted by the Thirteenth Trustee District and transmitted on August 6, 2008,
3 by Ms. Diane Schaubach, grassroots administrator, California Dental Association.

4 **Background:** Many of the key strategic projects and decisions within dentistry require a market
5 understanding of dentists and their expectations of membership organizations. The California Dental
6 Association (CDA) believes the ADA could benefit from a similar undertaking, which would help move the
7 ADA toward organizational efficiency and transparency with a member-focused approach. The California
8 Dental Association conducted extensive market research of its members in 2005 with follow-up surveys in
9 2006. The information was critical in determining and understanding members' potential, addressing the
10 needs of the membership as a whole, and planning and implementing new programs and services.

11 The California Dental Association urges the American Dental Association to conduct a full assessment of the
12 market research needs within the association. Gathering sound market data on a variety of subjects and issues
13 in several areas within the organization, addressing the needs of a growing and varied membership, and
14 recruiting and retaining members is essential to the success of the American Dental Association.

15 The goal would be to receive 300 completed interviews in each of the 17 trustee districts (total base sample of
16 5,100). States that do not have 50 completed interviews would be over-sampled. States that may fall under
17 that threshold are New Hampshire, Rhode Island, Vermont, North Dakota and Wyoming, so the final sample
18 size will be roughly 5,300.

19 Assuming an even mix of online and mail-completed studies, the total cost would be $280,000. The online
20 versus mail mix has a major impact on cost. The more studies conducted online the lower the cost and the
21 more conducted via mail, the higher the cost.
22
23 **Resolution**

24 **36. Resolved,** that the ADA conduct an assessment of the market research needs within the Association,
25 and be it further

26 **Resolved,** that based on this assessment, market data be collected on a variety of subjects and issues,
27 including but not limited to, addressing the needs of a growing and varied membership, and be it further

1 **Resolved,** that the Board of Trustees be urged to fund the research project from Reserves.

2 **BOARD COMMENT:** The Board applauds the California Dental Association's extensive market research
3 efforts and agrees that a comprehensive, tripartite understanding of members' needs is critical to the success
4 of an association's recruitment and retention efforts. The Council on Membership supports this priority,
5 through a membership marketing research agenda; conducting various types of in-depth member research
6 (quantitative, qualitative and conjoint analysis). Various projects have been completed over the past two
7 years, including surveys conducted to gain an understanding of the needs and opinions of members and
8 nonmembers, as well as target markets (new and reinstated members, graduate students, federal dentists) and
9 critical issues that the profession faces.

10 The Board agrees that an assessment of market research needs would be a valuable first step and recommends
11 that CDA's research be compared to ADA's completed and planned member research in order to ensure that
12 the outcome of the proposed study is meaningful and provides a return on investment. The Council may wish
13 to reach out to CDA and gain a deeper understanding of its research and desired outcome. This can be
14 accomplished through the marketing research function within the ADA's centralized marketing department,
15 under the leadership and direction of the Council on Membership. Therefore, the Board recommends that
16 Resolution 36 be referred to the Council on Membership for further study and report to the Board at its April
17 2009 meeting.

18 **BOARD RECOMMENDATION: Vote Yes on Referral.**

19 **BOARD VOTE: UNANIMOUS.**

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CM Supplemental Report 1 Date Submitted: August 2008

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

1 **COUNCIL ON MEMBERSHIP SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:**
2 **RECENT COUNCIL ACTIVITIES**

3 **Background:** Since its annual report was submitted in 2008, the Council on Membership met once more in
4 June. This report will address the subjects brought forth at that meeting as well as the response to a 2007
5 House of Delegates assignment, Resolution 53-2007, Study of Effect of Group Acceptance of International
6 Dentists and ADA Branding (*Trans*.2007:399).

7 **Tripartite Grassroots Membership Initiative (TGMI) Update:** At its June 2008 meeting, the Council
8 continued to discuss ways to reinvigorate the TGMI program including a possible name change and ways to
9 better recognize TGMI volunteer leaders based on a TGMI volunteer recognition e-survey done in May 2008.
10 Results of the survey indicated that the TGMI volunteers would like to be recognized with a letter of thanks
11 upon signing up to be a TGMI volunteer leader or to be recognized publicly in an *ADA News* article.

12 The Council approved the following key strategies to encourage more active participation in the TGMI among
13 constituent and component societies and the TGMI volunteer team leaders:

14 • Developing a commitment card for volunteer leaders to gauge their interest in different areas when
15 volunteering in order to keep the volunteers engaged in the TGMI;
16 • Developing and implementing a “call a nonrenew” month in 2009;
17 • Encouraging more states to join the TGMI Membership Academy;
18 • Having Council members accompany TGMI managers on site visits to states whenever possible; and,
19 • Forming a workgroup which will include dentists from diverse ethnic backgrounds to gather
20 information, develop recruitment and retention strategies and provide value to this segment.

21 Further, the Council would like to report to the House that it is urging all volunteer leaders, such as delegates,
22 alternate delegates, council and committee members, presidents and trustees, etc., on the national, state and
23 local levels to become involved in recruitment and outreach efforts.

24 **Collaboration with the American Student Dental Association:** Based on a desire from the American
25 Student Dental Association (ASDA) to collaborate with the ADA, the Council took action to approve a
26 recommendation that will promote collaboration and the value of membership in both organizations, fostering
27 the ADA relationship with ASDA. The Council recommends that ASDA members and activities be

1 integrated into state and local dental society activities (e.g., through use of the ADA block grants), with a
2 report to the Council on such activities in February 2009.

3 **Constituent Marketing Collaborative:** The Council discussed, and is in the process of developing, a
4 program wherein constituent dental societies can receive expert marketing assistance from the ADA in the
5 form of the development of hands-on marketing strategies for low market share areas. This program will
6 allow states to identify areas where they need help in membership recruitment and have ADA staff assist in
7 developing an individualized comprehensive targeted marketing plan.

8 **Membership Vulnerability and Market Share in Urban Areas Study:** The Council received a
9 presentation from the ADA Health Policy Resources Center on its Membership Vulnerability and Market
10 Share in Urban Areas Study. This study identified the most densely populated areas of U.S. cities as
11 Metropolitan Areas Central City (MACC) and studied the market share in these areas. The long-standing
12 belief that urban dentists are less likely to become ADA members is statistically supported by the results of
13 the urban settings study. The quality of being urban, as measured by a dentist office being inside of a MACC,
14 results in a 5% decrease in membership, and is a unique factor identifying non-membership all by itself.
15 Including MACC as a factor increases the number of nonmembers that can be target-marketed by 18% to a
16 total of 71%. The Council discussed the impact this information had on membership recruitment and
17 retention activities and voted to further research the states with the largest MACCs. At its February 2009
18 meeting, the Council will consider MACCs as candidates for the Constituent Marketing Collaborative
19 Program.

20 **Online Tripartite Membership Application:** ADA staff reported to the Council that the Division of
21 Technology, Standards and Salable Materials has begun developing the online tripartite membership
22 application for ADA.org and that the project is expected to be live by September 2008.

23 **Strategic Promotional Incentive Update:** At its June 2008 meeting the Council further discussed the one-
24 time strategic promotional incentive and possible recommendations on the groups that would be most
25 beneficial to target with this promotion. The Council has decided to bring two proposals to the Board. The
26 first proposal will request a one-time 50% dues reduction for nonmember dentists who practice in public
27 health settings for the 2009 membership year. The second proposal will be sent to the Board for approval in
28 April 2009 to be implemented in 2010.

29 **Activities at the Annual Session:** In order to enhance the experience of nonmember, new dentist and first-
30 time attendee registrants at the ADA annual session, the Council voted to urge TGMI and dental society
31 volunteers to contact these groups prior to the annual session to engage them, begin a relationship and
32 establish a mentoring-type connection.

33 **Federal Dental Service Membership:** The Council also voted to collect state Roadmaps, guides that assist
34 dentists transitioning out of federal dental services (FDS) and into private practice, to be displayed on the
35 FDS Web page.

36 **Limited and Part-time Practicing Dentist Survey:** The Council reviewed the results of the limited and
37 part-time practicing dentist survey and recommended that further study on the ages of non-renews from the
38 past few years be done in order to help determine financial implications of offering reduced dues to dentists
39 near retirement. This report will be reviewed by the Council at its February 2009 meeting.

40 **Public Health Dentist Membership Issues:** The Council is continuing its study in identifying membership
41 issues related to public health dentists. The Council has approved the formation of a workgroup with

1 members of the Council, the director of the Council on Access, Prevention and Interprofessional Relations
2 and public health dentists to meet and further study the issues and report to the Council in February 2009.

3 **Council on Communications Liaison:** The Council emphasized in discussion the importance of reaching
4 out to the public to stress the significance of ADA membership to practicing dentists. The Council
5 maintained that the face of technology and how people receive their information is changing and that public
6 influence will be a factor in recruitment and retention strategies going forward. The Council is committed to
7 exploring new methods to communicate the importance of ADA membership, building value and
8 strengthening the ADA brand.

9 It became clear that the continued collaboration between the Council on Membership, the ADA agency that
10 shapes the ADA member communications and the Council on Communications, the ADA agency that shapes
11 the ADA's communications to the public made sense. The Council felt strongly that it was imperative to add
12 a Council on Communications liaison to the Council on Membership. Both Councils are exploring ways to
13 expand online networking and podcasts. A liaison could benefit members by strengthening the ADA brand
14 with the public. The Council voted unanimously to support the Council on Communications recommendation
15 to have a representative serve as a liaison to the Council on Membership. If this request is approved by the
16 2008 House of Delegates, the Council will have a liaison from the Council on Communications beginning in
17 2009.

18 **Response to Assignments from the 2007 House of Delegates:** The following Resolution 53-2007, Study of
19 Effect of Group Acceptance of International Dentists and ADA Branding (*Trans*.2007:399), was referred to
20 the Councils on Membership, Communications and the Center for International Programs and Development.

21 **53-2007. Resolved,** that the appropriate bodies of the ADA including the Council on Membership and
22 Council on Communications study the potential effects of accepting members in groups rather than on
23 an individual basis with regards to the value of the ADA brand and how it would be affected by
24 potential misuse of ADA membership representation and report to the ADA House of Delegates in
25 2008 as a report with enabling resolutions, if necessary, and be it further

26 **Resolved,** that the ADA does not engage in group acceptance of members until ADA policy has been
27 resolved by the ADA House of Delegates.

28 In response, the Council reviewed its report on the administrative flexibility for the affiliate membership
29 category, which included the results from a study done by the Council in 2005 on corporate/organizational
30 membership, and shared it with the Council on Communications and the Committee on International
31 Programs and Development (CIPD). In reviewing this report the Council discussed the pros and cons of
32 pursuing group memberships in the current landscape as well as the effect the new ADA brand
33 implementation may have on how affiliate membership is marketed and reaffirmed its previous
34 recommendation to not pursue group memberships at this time.

35 In response to this report and a presentation given to the CIPD at its February 2008 meeting by Ms. Wendy-Jo
36 Toyama, senior vice president, Membership, Tripartite Relations and Marketing, the chair of CIPD reported
37 via memo to the Council chair that the CIPD has chosen to defer this issue and will look to the Council on
38 Membership for future updates and courses of action in dealing with this matter.

1 The Council on Communications discussed the report and also received a presentation from Ms. Toyama at
2 its June 2008 meeting and voted to support the Council on Membership's recommendation that the House of
3 Delegates not pursue group membership at this time.

4 **Resolutions**

5 This report is informational and no resolutions are presented.

6 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

7 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
8 **BOARD DISCUSSION)**

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 7 Date Submitted: August 2008

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

1 **REPORT 7 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**
2 **ANNUAL REPORT OF STRATEGIC PLANNING ACTIVITIES**

3 **Background:** This report to the House of Delegates on the ADA's annual strategic planning activities is
4 submitted as required by Resolution 104H-1990 (*Trans*.1990:570) which directs the Board and staff to
5 establish and implement the ADA strategic planning process and to provide annual reports on its progress.

6 **Environmental Scanning:** Environmental scanning is an analytical process through which organizations
7 identify the forces that will affect their future. For the ADA these are forces of significance to associations,
8 dentistry, and healthcare generally. By routinely "scanning" the published literature, technical journals,
9 popular press, professional meeting findings and other resources, the ADA can anticipate and address
10 upcoming challenges and opportunities of potential importance to the public and to ADA members.
11 Environmental scanning will help the ADA recognize shifts in key trends and to "connect-the-dots" among
12 developments that might otherwise appear unrelated. Guided by such knowledge, the ADA will be better-
13 prepared to act strategically and consider emerging issues.

14 Under the leadership of the Strategic Planning Committee (SPC) of the ADA Board of Trustees, the Office of
15 Strategic Management (OSM) has been implementing a collaborative process for ongoing environmental
16 scanning and has utilized 2008 to evaluate and revise the process, as necessary.

17 The collaborative scanning process involves all the ADA councils, key ADA staff and an initial group of
18 tripartite states. Participants have contributed information for consideration and comments on periodic
19 reports by providing feedback on potential implications of the scan information. The councils are being asked
20 especially to focus on their various areas of expertise when scanning for potential emerging trends and issues.
21 Participation has been slow initially though the comfort level with the system and technology appears to be
22 improving.

23 *2008 Findings*. A year-end report has identified key trends and issues of significance through this
24 collaborative process. These are highlighted below and will be shared with all scanning participants and
25 ADA agencies to consider as they begin their planning for the year ahead. These issues and trends have been
26 identified through literature searches, forecasts provided by think-tanks and comments by Scan Sentinels
27 (council and tripartite volunteers).

1 1. **Oral and Overall Health:** Evidence of the impact of oral disease on overall health is prompting efforts
2 by insurers, employers and consumers to include coverage for oral disease prevention services in health
3 care benefit programs.
4 *The bottom line: Oral health services increasingly provided by medical professionals and para-*
5 *professionals.*

6 2. **Changing Communications:** Internet-based discussion forums, also referred to as social networks, are
7 changing the parameters of individual interaction and the flow of information. Information, credible or
8 not, is exchanged quickly and without censure or caveats.
9 *The bottom line: The role of traditional membership organizations in informing and advising members*
10 *may erode as consumers and professionals participate in online affinity groups and referral services.*

11 3. **Price/Quality Trade-Off:** Faulty products exported from China have been prominently featured in
12 recent news stories. Though not a "trend" per se, such incidents may prompt American regulators to take
13 a closer look at import safety and to establish regulations to protect American consumers and producers.
14 At the same time, "medical tourists" are seeking treatments unapproved in the U.S. Most seem to be
15 looking for lower cost care.
16 *The bottom line: Cost differentials drive many consumer and provider purchasing decisions. Domestic*
17 *manufacturers and professional services providers must demonstrate higher or comparable quality and*
18 *lower or comparable prices to compete effectively with international producers.*

19 4. **Open Source Culture:** An open source culture is one in which information is shared, collective
20 decisions are made and sometimes "knowledge" is created communally.
21 *The bottom line: Research, development and decision-making processes are becoming increasingly*
22 *collaborative.*

23 5. **Increasing Debt:** Growing debt among students influences their career choices. Growing debt among
24 consumers affects their ability to pay for needed care.
25 *The bottom line: Debt influences professional development, individuals seeking care and dental*
26 *practices.*

27 6. **Changing Business Model:** Economic pressure, underserved markets and changing consumer attitudes
28 are driving interest in alternative dental care delivery models.
29 *The bottom line: Non-traditional dental practices compete with traditional delivery styles as consumers*
30 *seek convenience, lower cost and good quality.*

31 7. **Environmental Sustainability:** Environmental concern and sustainability have become a consumer
32 marketing strategy and point of product differentiation. Regulatory oversight may be likely.
33 *The bottom line: Businesses of all sorts must address growing pressure for environmentally sustainable*
34 *practices.*

35 8. **Cultural Competency:** Third Culture Kids (TCKs) are individuals who as adolescents lived in a foreign
36 country. Having been raised in a culture not one's own, TCKs can be unusually sensitive to others'
37 needs, respectful of others' values, qualities some analysts believe are essential to leadership in diverse
38 societies.
39 *The bottom line: Individuals that can identify with, understand and respect other cultures will be highly*
40 *sought employees/leaders.*

1 9. **The Skill of Synthesis and Leadership Development:** The steady shift toward a knowledge-based
2 economy challenges leaders' ability to synthesize information quickly, accurately and decisively. Trends
3 in educational achievement do not appear to be in sync with the expected need, making it potentially
4 difficult to recruit qualified candidates and necessary to consider new leadership development strategies.
5 *The bottom line: Educational systems are not adequately preparing leaders for a knowledge-based*
6 *economy.*

7 10. **Consumerism Takes a Detour:** Despite the growing abundance of information available to health care
8 consumers, there is no centralized agency of accountability that, like the Security and Exchange
9 Commission (SEC), aims for order. Some experts predict a "backlash," as consumers reject medical
10 advice despite financial incentives encouraging compliance.
11 *The bottom line: Consumers' willingness and ability to assume responsibility for their care decisions*
12 *requires better, clearer information.*

13 11. **Emerging Markets:** By 2030 about 25% of the population in the developed world will be age 25 or
14 older and 50% of the U.S. population will be eligible for AARP membership. The vast majority of the
15 world's population, 80%, lives in "developing" countries, with increasing numbers of "middle-class"
16 consumers.
17 *The bottom line: In communities across the U.S., the professional's ethnicity, and that of his or her office*
18 *staff, and the practices' reputation for serving patients of different cultural backgrounds, will become the*
19 *basis of market competition.*

20 12. **Little Trends—Big Changes:** In *Microtrends: The Small Forces Behind Tomorrow's Big Changes,*
21 Mark Penn observes that big changes are set into motion by relatively small numbers of people who share
22 similar objectives and beliefs.

23 13. **Business Models Change to Support Innovation:** Traditional "linear" business models are giving way
24 to "value webs," as businesses conceptualize integrated systems rather than straightforward chains of
25 production, distribution and sales. Models that utilize a value web structure recognize the value of both
26 tangible and intangible values and may be better positioned to recognize threats and opportunities, and to
27 support innovation and accommodation.
28 *The bottom line: Organizational structure and process is changing to capitalize on the efficiencies and*
29 *effectiveness created by electronic communication and decision-making models.*

30 14. **Privacy and the New Panopticon** (Opticon—observe, pan—all)**:** Society seems willing to balance the
31 desire for privacy with the need for safety and security.
32 *The bottom line: Everything said or done can be heard or seen by millions in minutes.*

33 15. **Volunteers and Venture Philanthropy:** Organizations that rely on unpaid workers, advisors and leaders
34 may be challenged to recruit and retain qualified people. The marketplace for committed and capable
35 volunteers is becoming more competitive as potential volunteers have new avenues for engagement and
36 can select from a vast menu of rewarding opportunities. Some observers believe a new "volunteer ethos"
37 is emerging and that volunteers seek opportunities to fulfill their needs, not someone else's, and are more
38 inclined to make short-term, rather than long-term, commitments.
39 *The bottom line: Recruiting and retaining long-term volunteers is becoming increasingly difficult, but*
40 *there will be a good supply of people willing to perform short-term tasks.*

41 16. **Changing Attitudes about Information Ownership:** Copyright restrictions on digital media have
42 become a source of debate as more and more collaborative work is conducted online.

The bottom line: New ways to "value" information and research will become increasingly important to assure adequate return on investment and maintain information access as a core membership benefit.

17. **Blue Oil—Water Scarcity:** While water shortages are thought to be a problem of developing countries, inadequate water supplies, improper sanitation and poor water management practices threaten health and economic development in many industrialized nations as well.
    The bottom line: Increasing pressure to reduce water consumption throughout the U.S.

18. **Socio-Demographic Change—Beyond the Numbers:** A February 2008 report issued by the Pew Research Center caught the nation's attention when it projected that by 2050 the non-Hispanic white population in America will become a minority and that the Latino population will jump from 14% to 29% of the U.S. population.
    The bottom line: Opportunities for practice growth will be found in immigrant and first-generation communities.

19. **Constant Connectivity:** Mobile communications technology provides timely access to information of all sorts, from medical reminders to individual advice. Mobile phones support economic development, public safety and physical mobility.
    The bottom line: Time-sensitive information will be communicated via mobile phones.

20. **Customization and Customer Loyalty:** A survey of global managers finds that more than half of the companies' services and products will be mostly or totally personalized within five years because personalization is: (1) a better differentiator than cost in saturated markets; (2) meets a growing psychological need to "stand out"; and, (3) increases customer loyalty by deepening relationships between customer and provider.
    The bottom line: The ability to provide personal services at mass-production prices will be critical to market success.

The Strategic Planning Committee (SPC) of the Board held two meetings during 2008. The SPC members are: Dr. Teri Barichello, chair, Oregon; Dr. Jennifer Barrington, Texas; Dr. William Calnon, trustee, Second District; Dr. John Findley, president-elect; Dr. William Glecos, trustee, Third District; Dr. Bradley Harrelson, Virginia; Dr. Jerry Long, trustee, Fifteenth District; Dr. Jeanne Nicolette, trustee, Seventh District; Dr. Carol Summerhays, California; Dr. M. Lyn Wallace, South Carolina and Ms. Beril Basman, SPC facilitator, managing vice president, ADA Office of Strategic Management. Mr. Thomas Elliott, Esq., Division of Legal Affairs provided staff support to the Committee.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 42 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 2008

Submitted By: Second Trustee District

Reference Committee: Membership and Planning

Total Financial Implication:

Amount One-time $ Amount On-going $ 11,000 annually

ADA Strategic Plan Goal: (Required)

1 **STUDENT BLOCK GRANT PROGRAM**

2 The following resolution was submitted by the Second Trustee District and transmitted on August 26, 2008,
3 by Mr. Roy Lasky, secretary, Second Trustee District Caucus.

4 **Background:** Currently, the ADA Student Grant program provides state societies with $3,000 per dental
5 school for student programs held on behalf of organized dentistry. The grants have been a valuable resource
6 for state societies as they reach out to the profession's future members. In New York, the dental school
7 population ranges from a low of 40 to more than 500 members per class year. As a result, events held at some
8 of the larger schools tend to be more limited as funds are depleted quickly. The New York State Dental
9 Association urges the ADA to carry out an assessment of the student population at each dental school and
10 consider awarding grant amounts based on the class size at each dental school.

11 **Resolution**

12 **42. Resolved,** that the American Dental Association reconsider its student grant funds provided to
13 constituent societies, so that awards are dispersed based on the student population at each dental school.

14 **BOARD COMMENT:** The Board of Trustees applauds the constituent societies' efforts to engage dental
15 students in organized dentistry and supports these efforts through the ADA student block grant program. The
16 purpose of the program is to increase conversion rates to membership upon graduation by encouraging
17 personal outreach with students at the state level.

18 The grants have been a valuable resource for state societies as they reach out to the profession's future
19 members. In New York, the dental school population ranges from a low of 40 to more than 350 students per
20 class year. New York University is the largest school by a wide margin with 1,295 students enrolled in 2007-
21 2008, which is approximately 7% of the total dental student population and 613 more students than the next
22 largest school. Nationally, in 2007-2008, there were five dental programs with total enrollment above 500
23 (New York University, Tufts University, University of Southern California, Boston University and the
24 University of Pennsylvania).

25 Currently, the ADA student block grant program provides state societies with $3,000 per dental school for
26 student programs that include a personal outreach component held on behalf of organized dentistry. The
27 budget for the program is $153,000. Last year, 32 states (of 36 eligible) applied for $131,500 of the available
28 funds. In 2006, 33 states participated in the block grant program and received nearly $134,000 of the
29 available funds. Not all state societies take advantage of the available grant funds. As of September 10,

1 2008, only five states have submitted reimbursement forms for the year. As in the past, it is anticipated that
2 most forms will reach the ADA in December.

3 The Board understands that events held at some of the larger schools have limited options as funds are
4 depleted quickly. In an attempt to improve the scope and effectiveness of student outreach programs in these
5 larger schools, the Board recommends the adoption of Resolution 42B in lieu of Resolution 42.

6 **Resolution**

7 **42B. Resolved,** that the current $3,000 per dental school limit for distribution to constituent dental
8 societies under the ADA student block grant program be increased to $5,000 for any dental school with a
9 total enrollment greater than 500 students and $6,000 for enrollments greater than 750 as of January 1 of
10 the prior budget year.

11 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

12 **BOARD VOTE: UNANIMOUS.**

Resolution No. 43 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 2008

Submitted By: Second Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

1 **MANDATE TRIPARTITE MEMBERSHIP**
2 **FOR GRADUATE STUDENT/RESIDENT MEMBERS**

3 The following resolution was submitted by the Second Trustee District and transmitted on October 5, 2008,
4 by Dr. William Calnon, trustee, Second District.

5 **Background:** Membership in the tripartite system is a cornerstone of our professional association. This
6 system offers many obvious benefits including exposure to a broader perspective of major issues facing the
7 profession. This wider vantage point could be most beneficial to graduate student/resident members as they
8 form early opinions of organized dentistry. A positive experience in the tripartite system while still in an
9 educational environment would assist component and constituent societies in converting graduate
10 students/residents to active membership later in their careers.

11 Currently, the ADA *Bylaws* may not allow other than direct membership for graduate students/residents.
12 Constituents can offer parallel membership categories. Many do, but a large number do not. Many graduate
13 students/residents are not licensed or are licensed in jurisdictions other than where they are practicing. These
14 issues are barriers to tripartite membership.

15 In an attempt to encourage tripartite membership as a life-long professional goal and to expose the next
16 generation of members to the benefits gained by membership in the component, constituent and national
17 associations, the Second Trustee District offers the following *Bylaws* amendment.

18 **Resolution**

19 **43. Resolved,** that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES
20 AND SPECIAL ASSESSMENTS, Subsection E. STUDENT MEMBERSHIP, subsection a.
21 QUALIFICATIONS, of the ADA *Bylaws* be amended by addition as follows (new language
22 underscored):
23
24 a. QUALIFICATIONS. A student member shall be (1) a pre-doctoral student of a dental school
25 accredited by the Commission on Dental Accreditation of this Association, (2) a predoctoral student
26 of a dental school listed in the World Directory of Dental Schools compiled by the FDI World
27 Federation or (3) a dentist eligible for membership in this Association who is engaged full time in an
28 advanced training course of not less than one academic year's duration in an accredited school or
29 residency program and is a member in good standing of the constituent and component societies of
30 this Association that (i) are within the territorial jurisdiction that issued the dentist's license, or (ii) in

1 which the educational institution or residency program attended by the dentist is located, at the
2 dentist's option.

3 and be it further

4 **Resolved,** that CHAPTER II. CONSTITUENT SOCIETIES, *Section 40.* MEMBERSHIP, of the ADA
5 *Bylaws* be amended as follows (new language underscored):

6 A. The active, life, and retired membership of each constituent society, except as otherwise provided
7 in these *Bylaws*, shall consist solely of dentists practicing within the territorial jurisdiction of the
8 constituent society; dentists retired from active practice; dentists engaged in activities furthering the
9 object of this Association; dentists serving on the faculty of a dental school or receiving compensation
10 as a dental administrator or consultant within the jurisdiction of the constituent society but are
11 licensed in another jurisdiction; and dentists in a federal dental service (provided that the federal
12 dentist is either licensed in or serving within the confines of the constituent society's jurisdiction),
13 provided that such dentists are active, life or retired members in good standing of a component of the
14 constituent (except for the federal dentists), if such exists, and this Association. In addition, the
15 student membership of each constituent society, except as otherwise provided in these *Bylaws*, shall
16 consist of, but shall not be limited to, dentists who are engaged full-time in an advanced training
17 course of not less than one academic year's duration in an accredited school or residency program and
18 who have chosen to become members of such constituent society pursuant to Chapter I, Section
19 20E(a) of these *Bylaws*.

20 and be it further

21 **Resolved,** that CHAPTER III. COMPONENT SOCIETIES, SECTION *10*. ORGANIZATION, of the
22 ADA *Bylaws* be amended as follows (new language underscored):
23
24 A. Component societies may be organized in conformity with a plan approved by the constituent
25 society of which they shall be recognized entities provided, however, that the active, life or retired
26 members of each component society shall consist of dentists who are members in good standing of
27 their respective constituent societies and of this Association. The plan adopted by the constituent
28 society may or may not limit active membership in a component society to dentists who reside or
29 practice within the geographic area of that component society. The student membership of a
30 component society, except as otherwise provided in these *Bylaws*, shall consist of, but shall not be
31 limited to, dentists who are engaged full-time in an advanced training course of not less than one
32 academic year's duration in an accredited school or residency program and who have chosen to
33 become members of such component's constituent society pursuant to Chapter I, Section 20 E(a) of
34 these *Bylaws*.

35 B. Each component society shall adopt and maintain a constitution and bylaws, which shall not be in
36 conflict with, or limit, the *Constitution and Bylaws* of this Association or that of its constituent
37 society, and shall file a copy thereof and any changes which may be made thereafter with the
38 Executive Director of this Association.

39 and be it further

40 **Resolved,** that the foregoing changes to the ADA *Bylaws* take effect January 1, 2010.

1 **BOARD COMMENT:** The Board understands the importance of attracting graduate students into tripartite
2 membership and the reality that some may not choose to become tripartite members on completion of their
3 graduate program. While requiring tripartite membership at all three levels of the tripartite is a requirement
4 for licensed dentists practicing at a state or other jurisdiction of the United States, it is not required for dental
5 students.

6 In 2005, as part of the comprehensive membership study completed by the Council on Membership, a survey
7 was conducted to determine how many constituent societies had various membership categories. The survey
8 found that of the 40 dental societies that responded to the survey, 36 indicated that licensed graduate students
9 were allowed to become active members.

10 Additionally, the Council on Membership is forwarding Resolution 10 (Worksheet:5001) to the House of
11 Delegates which urges constituent societies to develop opportunities for direct members to join the tripartite
12 by creating parallel membership categories at the state and local levels to mirror those available at the ADA
13 level. If Resolution 10 is adopted by the 2008 House of Delegates, states would be encouraged to develop
14 membership categories such as a category for graduate student/resident members, which would provide
15 graduate students/residents the opportunity to be a direct member or to have a tripartite experience by
16 becoming a member of their state and/or local society.

17 The proposed *Bylaws* changes may have unintended consequences. Since many graduate students may either
18 1) not be licensed or 2) be licensed in a state other than where they are doing their graduate training, they
19 would likely be ineligible for membership in the state in which they are practicing. While the proposed
20 bylaws amendment offers a possible solution, the impact on students and dental societies is unknown.
21 Additionally, while there may be graduate students who plan to continue their career in the location of the
22 graduate/residency program; there may also be many who plan to return to another state or leave the country.
23 As such, the Board believes that it is important for the Council on Membership to study the implications of
24 the *Bylaws* change and report to the Board of Trustees in 2009.

25 **BOARD RECOMMENDATION: Vote Yes on Referral.**

26 **BOARD VOTE: UNANIMOUS.**

Resolution No. 50 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2008

Submitted By: Thirteenth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: See Below for Details

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

1 **LOWER ELECTRONIC DUES PAYMENT PROGRAM THRESHOLD**

2 The following resolution was submitted by the Thirteenth Trustee District and transmitted on September 9,
3 2008 by Ms. Diane Schaubach, grassroots administrator, caucus secretary, Thirteenth Trustee District.

4 In 1998, the ADA House of Delegates approved the Electronic Dues Payment (EDP) program
5 (*Trans.*1998:693) and it was implemented in 1999. The EDP program is one of the payment options available
6 to members to renew their membership each year. It is a monthly installment plan that allows members to
7 pay their dues over a period months. Upon approval of the program, an administrative decision was made by
8 the ADA to establish a required minimum dues threshold in order for members to enroll in the program. The
9 threshold was set at 50% of full active ADA dues, currently $249 but will be $256 if the dues are increased by
10 $14 as proposed. While this may not seem like an excessive amount, by the time state and local dues are
11 included, the total tripartite dues owed can easily reach over $700, not including optional amounts such as
12 PAC contributions.

13 Many dentists, primarily new and retired, pay minimum ADA dues falling below the 50% threshold. They
14 have expressed that oftentimes it is difficult to pay the entire required dues amount at one time. Spreading
15 their dues payment over several months would enable them to retain their membership and to participate in
16 the optional contributions when they might not otherwise be able to renew.

17 It is requested that the ADA lower its minimum threshold for EDP participation to $125 from $249 (50% of
18 ADA dues). This change to the EDP program benefits new dentists and retired members, but could also be
19 viewed as a valuable recruitment and retention opportunity.

20 If members maintain their membership instead of dropping out of organized dentistry, all levels of the
21 tripartite will benefit from continued dues payments.

22 **Resolution**

23 **50. Resolved,** that the ADA support lowering the minimum amount required to $125 to participate in the
24 Electronic Dues Payment Program.

25 **BOARD COMMENT:** The Board agrees that eliminating barriers to ADA membership benefits all levels of
26 the tripartite. There is no *Bylaws* requirement that establishes the 50% threshold, but rather an administrative
27 policy that was established to manage installment dues processing. In 1999, when the *Bylaws* were changed
28 to allow for active and active life members to participate in an installment dues payment program, an
29 administrative decision was made by the ADA to only accept partial payments from constituent societies for

1 active and active life members who would be paying at least 50% of the full dues amount in order to be able
2 to handle the volume of partial payments that the ADA was expected to receive as a result of this *Bylaws*
3 change.

4 Many constituent societies utilize some form of dues installment program, but not all constituent societies
5 administer it in the same manner as the California Dental Association. Some constituent societies are
6 administrated by allowing for automated electronic transfer of funds, some by automatically charging the
7 payment to a pre-approved credit card, and some by check payments. Those states that handle credit card
8 payments are provided a credit card processing fee rebate of 2% of the total credit card payments made. It is
9 difficult to estimate what the financial impact would be to rebate the state societies on any additional credit
10 card payments incurred as a result of accepting partial payments for members paying 25%, or $125 in 2008,
11 in dues owed to the ADA who chose to participate in an installment program. However, the amount is
12 expected to be minimal.

13 From an administrative perspective, since 1999, programming has been put in place to allow payments to be
14 expedited and dues payments can be applied directly into the Tripartite System (TS) at the ADA. This has
15 eliminated much of the costly manual payment processing that was done previously. The administrative costs
16 associated with handling the anticipated additional partial payments for active members expected to pay $125
17 or more in dues to the association each year could be absorbed at the ADA.

18 The graduate student category of membership is the only active member category at this time that is expected
19 to pay less than 25% ($125) of the full active dues amount and as such, would not be eligible for installment
20 payments. Further, it would not be practical or economically sound to allow someone who owes $30 for
21 graduate student dues to make monthly installments.

22 The Board believes the resolution is addressing an administrative policy, not a bylaws requirement. Since a
23 change to this administrative policy can be made without further discussion and can be made beginning with
24 the 2009 membership year, the Board recommends adoption of Resolution 50B in lieu of Resolution 50.
25

26 **50B. Resolved,** that the ADA support the concept of lowering the administrative minimum payment for
27 acceptance of installment payments for dues for active members to 25% of the full active dues amount.

28 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

29 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
30 **BOARD DISCUSSION)**

Resolution No. 54 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 2008

Submitted By: Twelfth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication:

Amount One-time $ Amount On-going $ 48,000 annually

ADA Strategic Plan Goal: (Required)

1 **ALLOCATION OF STUDENT BLOCK GRANT PROGRAM FUNDS**

2 The following resolution was submitted by the Twelfth Trustee District and transmitted on September 22,
3 2008, by Mr. Kevin Robertson, executive director, Kansas Dental Association.

4 **Background:** The ADA Student Block Grant Program was first implemented in 2001 with Resolution 3H-
5 2001 (*Trans*.2001:421) and then reinstated with the passage of Resolution 12H-2004 (*Trans*.2004:297). This
6 program provides constituent dental societies with up to $3,000 per dental school located within participating
7 states for the purposes of student recruitment activities. Evidence presented to the House of Delegates in
8 2004 showed that the Student Block Grant Program had resulted in an increase in new graduate ADA
9 membership from 2002 to 2004.

10 The Program does not provide reimbursement to constituent societies that do not have a dental school within
11 its boundaries. As such, it does not recognize the student membership recruitment activities of the following
12 16 constituent dental societies: Alaska, Arkansas, Delaware, Hawaii, Idaho, Kansas, Maine, Montana, New
13 Hampshire, New Mexico, North Dakota, Rhode Island, Utah, South Dakota, Vermont and Wyoming,

14 Though these constituent dental societies do not have a dental school within their boundaries, many (perhaps
15 all) of them have formal arrangements with one or more dental schools to reserve seats for students from their
16 state wanting to pursue a dental degree. The state of Kansas, for example, has an agreement with the
17 University of Missouri-Kansas City (UMKC) School of Dentistry to accept 20 Kansas students per year into
18 their class of 100 total dental students. The Kansas Dental Association relationship with UMKC and its
19 "Kansas" dental students includes sponsoring a student to attend the annual ASDA Conference, purchasing a
20 booth and attending the annual UMKC Student Exhibitor Fair, organizing a Lunch and Learn each semester,
21 hosting a "Career Opportunity Fair" for students and complimentary student membership/publications.

22 **Resolution**

23 **54. Resolved,** that the American Dental Association amend the Student Block Grant Program to allow
24 constituent dental societies that do not have a dental school within its boundaries to be eligible for total
25 funding of $3,000 per year for the purpose of student outreach and recruitment activities.

26 **BOARD COMMENT:** The Board applauds the student outreach efforts of the Kansas Dental Association
27 (KDA) and encourages other constituent societies without dental schools in their states to conduct similar
28 student activities if not already doing so. The Board agrees that student outreach is vital to the future success
29 of the ADA.

1 Through the current Student Block Grant Program, constituent societies with dental schools in their state are
2 eligible to apply for up to $3,000 annually in grant funding for each school to conduct student outreach
3 activities. The activities must include personal outreach with students to be eligible for funding. Funding is
4 distributed through reimbursement following the activities. In addition to including a personal interaction,
5 constituent societies must complete the Reimbursement Request Form in its entirety, include original receipts
6 for all expenses and meet the annual deadline to be eligible for funding. The budget for the program in 2008
7 is $153,000. Last year, 32 constituents (of 36 eligible) applied for $131,500 of the available funds. In 2006,
8 33 constituent societies participated in the Student Block Grant program and received nearly $134,000 of the
9 available funds. Not all constituent societies with dental schools in their states are taking advantage of the
10 available grant funds.

11 As per the resolution, constituent societies would be eligible for up to $3,000 total, regardless of the number
12 of schools involved. The Board agrees with this approach. Although the current program reimburses
13 constituent societies with dental schools up to $3,000 for student outreach per school, it would not be
14 appropriate to apply the per school allowance to non-dental school states. Therefore to avoid confusion and
15 simplify the reimbursement process, the Board recommends a maximum reimbursement of $3,000 funding
16 per year for constituent societies without a dental school within their boundaries, regardless of the number of
17 schools included in outreach activities.

18 There are 16 states without a dental school so the potential budgetary impact to offer these constituent
19 societies $3,000 each in block grant funding would be $48,000 annually or a total of $201,000 for the Student
20 Block Grant Program. There is little historical data available on student activities in non-dental school states
21 so it is difficult to forecast to what extent these states will use the grant. However, approximately 85% of the
22 budgeted grant funding was reimbursed in 2007 (or $131,508.55). Also, considering that only six of the 16
23 constituent societies have schools nearby (within 200 miles) and accounting for a few more enthusiastic
24 efforts, it is possible that only eight of the 16 non-dental school constituent societies will take full advantage
25 of the funding.

26 In addition to building future memberships, another benefit of the Student Block Grant program could be to
27 "plant the seed" to alleviate dentist shortages in certain areas. For example, constituent societies could use
28 funding to help recruit fourth year students to practice in their states, which could be especially beneficial to
29 states that face shortages, like Alaska.
30
31 Regardless of the types of activities funded by the grant, state societies without dental schools must follow
32 current Student Block Program requirements, including a personal outreach component. States whose
33 activities do not include a personal interaction with students will not be eligible for reimbursement.

34 The Board anticipates moderate usage of the expanded grant program and supports the student outreach
35 efforts of constituent societies without dental schools in their states. Therefore, the Board recommends
36 adoption of the following substitute resolution in lieu of Resolution 54:

37 **54B. Resolved,** that the American Dental Association amend the Student Block Grant Program to allow a
38 constituent dental society that does not have a dental school within its state boundaries to be eligible for
39 total funding of up to $3,000 per year for the purpose of student outreach and recruitment activities,
40 provided that the society adheres to all the Student Block Grant Program criteria, including the
41 requirement of a personal outreach component within each activity.
42

1 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

2 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
3 **BOARD DISCUSSION)**

Resolution No. 71 New ■ Substitute ☐ Amendment ☐

Report: Board Report 20 Date Submitted: October 2008

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication:

Amount One-time $ 52,300 Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

1 **REPORT 20 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA**
2 **MEMBERSHIP PRACTICES AND PROPOSED NATIONAL SUMMIT ON DIVERSITY IN**
3 **DENTISTRY**

4 **Background:** The ADA's proposed 2009 budget includes a decision package for a National Summit on
5 Diversity in Dentistry. This forum would bring together representatives from the ADA, the National Dental
6 Association, the Hispanic Dental Association (HDA), the Society of American Indian Dentists (SAID), and
7 others to seek common ground on goals, plans and collaboration for advancing diversity. Budgeted costs are
8 $40,000, with half to be financed through corporate sponsorships.

9 Subsequent to the preparation of the ADA's proposed budget for 2009, correspondence with the National
10 Dental Association prompted the ADA Board to consider whether additional financial commitments are
11 merited for the proposed National Summit on Diversity in Dentistry.

12 The Board believes that the ADA can be proud of its many accomplishments and ongoing programs to foster
13 diversity in the profession and leadership, and access to care for all Americans. The proposed National
14 Summit on Diversity in Dentistry would build on these accomplishments. The Board recommends approval
15 of additional funding to reinforce the potential of the National Summit on Diversity in Dentistry to achieve its
16 aims in collaboration with other national associations.

17 **Additional Investment in the National Summit on Diversity in Dentistry**

18 *In-person Planning Meetings*. If approved by the House of Delegates, the National Summit is to be
19 developed in fully collaborative ways with the other organizations. The original decision package envisioned
20 each association funding the travel of its own representatives to the planning group. By funding travel for the
21 core planning group, ADA would underscore its commitment to the National Summit, strongly encourage
22 participation by other associations and earn goodwill. (Each association would still need to arrange travel
23 funding for its representatives to attend the actual Summit.) To cover expenses for representatives from
24 NDA, HDA, SAID, and the ADA Board's Diversity Committee to attend a planning meeting, $13,400 is
25 proposed.

26 Having met once in person, the core planning group could continue to work well through conference calls and
27 e-mail. However, in case another in-person meeting would prove necessary, the Board proposes that ADA
28 budget for two meetings ($26,800 total), with the second meeting only as a contingency.

1 *More Flexible Format.* The National Summit on Diversity in Dentistry was originally envisioned as a one-
2 day event, to conserve time away from both practices and home for volunteers from the various associations.
3 The Board proposes adding $5,500 to the budget to cover an opening speaker and additional meals if the
4 National Summit were to be a day-and-a-half event. This format could enhance group cohesion and
5 consensus, increasing the likelihood that the National Summit would achieve its aims. There would be no
6 increase in travel and lodging costs borne by attendees.

7 *Fail-safe Funding*. The 2009 decision package for the National Summit envisions $20,000 of the necessary
8 funding coming from corporate sponsors. At this point, two of the three sponsors of the ADA Institute for
9 Diversity in Leadership have given promising but preliminary indications of willingness to help support the
10 National Summit on Diversity in Dentistry. The Board recommends that $20,000 in additional ADA funding
11 be available for use only in the event that corporate sponsorship levels were to fall short of requirements.

12 *Financial Summary*.

National Summit on Diversity in Dentistry	
Funding included in the proposed 2009 ADA Budget	$20,000 (with another $20,000 assumed from corporate sponsors)
Additional Proposed Funding	
Finance travel and lodging for multi-organizational planning group	$13,400
Contingency A: To allow possible shift to 1.5 day format for the National Summit.	$5,500
Contingency B: To cover travel and lodging for a possible second in-person meeting of the planning group.	$13,400
Contingency C: To offset risk of not securing corporate sponsorships	$20,000

13 **Resolution**

14 **71. Resolved,** that up to an additional $52,300 be allocated in the 2009 ADA Budget for expansion of the
15 National Dental Diversity Symposium.

16 **BOARD RECOMMENDATION: Vote Yes.**

17 **BOARD VOTE: UNANIMOUS.**

REPORT OF THE PRESIDENT

1 Thank you. It's hard to believe that I am standing here after eight years of our working together about to
2 address you for the last time.

3 It's the culmination of 25 years of elected service in organized dentistry. And at this moment, I savor every
4 single minute of that service.

5 Make no mistake this year was one I could have never anticipated.

6 The challenges of serving as President while keeping the ADA on mission and moving forward were at times
7 overwhelming.

8 It would have been impossible without the support of most all in the room today including the Board of
9 Trustees, ADA staff, council chairs and all of you who sent me constant e-mail messages of encouragement—
10 I am indebted to you all.

11 And in the end I take comfort in the fact that we are still a strong remarkable organization and will remain
12 so—mission accomplished.

13 Through the trials of administering this great association there were the wonders afforded me as President that
14 I will never forget.

15 Carol and I got to travel across this great land and got to meet with many of you one on one.

16 From Hawaii to Portland Maine, from Puerto Rico to Alaska we covered it all and even got to represent
17 American dentists abroad.

18 Everywhere we went we were warmly greeted and had the opportunity to hear your concerns and bring them
19 back to the Board table.

20 Quite a few of our hosts and hostesses are in the room today and again my thanks for all you did.

21 As I traveled and listened, it rapidly became obvious to me that we all share the same goals.

22 We all went into this great profession with the same thoughts. We put our patients first in everything we do.

23 We stand behind a fee-for-service system that has created the best oral health care system in the world.

24 We believe in making sure that our ethical, caring profession works for the benefit of all—and that the public
25 has greater access to the highest level of care.

26 When it comes to talking about the volunteer leaders of the ADA—there is no "them" —there is only us and
27 this is an important point to remember throughout your time here this week.

28 I am proud that I am leaving my leadership position knowing that the ADA is a smarter, more responsive,
29 more transparent organization than I when took office.

1 I will be sad indeed if all that is undone. Mark my words, if we do not run this Association in a spirit of
2 mutual trust and respect, we will never be unified and the things that divide us will eventually defeat us.

3 Our members and our patients deserve better.

4 I firmly believe there is no American dentistry without the ADA.

5 This is our profession's public square—it's laboratory—it's megaphone—it's newspaper—it's scientific
6 journal—it's calm, clear voice to policymaker and patient alike.

7 Over 149 years, what a tremendous organization we have built. And because of our volunteer involvement,
8 there has never been a better time to be a dentist.

9 We have greater technology at our disposal than ever before.

10 We're learning more about how to reach every possible patient every day.

11 And we know exactly what it will take to strengthen our profession—we need to improve our schools—
12 uphold our ethics—and provide world class oral health care throughout the 21st century.

13 It's all within our reach. We simply need the will to stick to our values—articulate them consistently—and
14 have the courage to fight for them.

15 In 2008, the American Dental Association is 156,000 members strong—representing more than 70 percent of
16 our profession.

17 No other professional membership organization comes close to our broad reach.

18 To give you an idea of the importance and scale of our organization—consider this meeting.

19 For this year's ADA annual session, we're in the sixth biggest city in the U.S.—and we are the largest
20 citywide convention San Antonio has ever hosted.

21 We're expecting more than 30,000 attendees—and we've sold out the more than 1,700 exhibition booths.
22 More than 700 companies are represented.

23 So I stand before you today as your elected leader soon to be past.

24 Let's step back a little over a year ago as I stood on the stage in San Francisco. We spoke about the times
25 ahead and the challenges we would face—the problems facing our educational institutions and our needs.

26 The **need** to provide access to care for those who lack it.

27 The **need** to respond to the instant often inaccurate information our patients find all the time on the internet
28 and the **need** to provide oral health information in a way that is understood by all.

29 The **need** to understand how in this great country a 12-year old boy could die from untreated dental disease.

1 We concluded that this is not the time to maintain the status quo or, even worse, look to return to the
2 comforting times when we could all practice undisturbed within the four walls of our offices.

3 No the challenges of today will not allow us to seek refuge in the comforts of the past.

4 So where do we stand a year later?

5 Well above all else we are and will always be a science-based association that is often frustrated by the fact
6 that we live in a world run by public policy makers.

7 I recently heard a speech by former Surgeon General David Sacher who told a story that illustrates the
8 frustration often felt between the politician and the scientist.

9 He told of a hot air balloonist who was hopelessly lost floating around the countryside.

10 Finally seeing a man working in a field, he lowered the balloon to 30 feet and yelled down "can you tell me
11 where I am?"

12 The man stopped and looked up and said "you are 30 feet above the ground in a hot air balloon." The
13 balloonist yelled back, "you must be a scientist" and the man said "well yes but how did you know?"

14 The balloonist replied "because the information you gave me is technically correct but of no value to me."

15 Now the man in the field, not to be outdone, said "you must be a politician." The Balloonist replied "actually
16 I am a member of congress, but how did you know that?"

17 To which the scientist replied, "You are in the same position as when we met, you don't know where you are
18 or where you are going, and now you are blaming me."

19 So as this illustrates, we must always be sure our answers have meaning and are useful and we work hard to
20 achieve those results.

21 When the lead in crowns controversy burst onto the public stage this spring, we immediately created talking
22 points so that you could discuss this issue with your patients and ease their minds about the sensational news
23 reports they were seeing.

24 And our science team took immediate action.

25 We advocated that the Centers for Disease Control and the Food and Drug Administration take aggressive
26 action to ensure the safety of these materials.

27 Both agencies concluded that there does not appear to be a safety concern.

28 These actions constituted an important defensive action by the ADA—helping to quell a potential public
29 outcry while also defending the health of our patients.

30 This was the ADA at its very best.

1 Ensuring that dentists have the best and most up-to-date information about the profession is a cornerstone of
2 our association.

3 But certainly the greatest dilemma we face is in providing access to care for all.

4 It puts our science and knowledge directly in the path of the public policy makers.

5 We certainly see them floating 30 feet above the ground and not knowing where they are, and many of them
6 see us as being non-responsive to their needs.

7 We need to work on bold new solutions and not be afraid of going where we never were before.

8 As I'm sure all of you know by now, I am a firm believer that the profession needs to seriously consider
9 moving to a post-graduate year after dental school that focuses on hands-on clinical experience, ideally in
10 community health settings and I don't call it PGY-1.

11 This year, the ADA completed an opinion survey on the dental education experience and the potential need
12 for an additional year of education and/or experience.

13 I believe that this important work will lay the foundation for more thorough consideration of fifth-year
14 proposals in the years ahead.

15 I strongly believe that one of the best ways to address the access to care crisis—and make no mistake, it is a
16 real crisis—is to find a way to tie our need for more hands-on clinical experience to the widespread shortage
17 of dentists in underserved communities.

18 If we can come up with a clear, workable plan that lacked nothing more than a commitment of federal funds
19 to make it a reality, I think we will have a much stronger message that we are serious about addressing this
20 problem and have a solution that keeps dentists as the leaders of the dental team.

21 Which brings me to the Community Dental Health Coordinator…CDHC.

22 First I think it's important to point out that the funds you allocated last year for the development of a
23 comprehensive curriculum for the CDHC has been put to very good use and I am very grateful to Bob
24 Brandjord and his committee for their incredible work.

25 On paper it looks very good but as I said earlier now we have to prove it works and has use for our patients.

26 The debate will be yours to have but please remember, the CDHC is exactly as it was when you adopted it in
27 2006 and then funded further development in 2007.

28 The only long-term solution is to prevent dental disease from starting in the first place and that is what the
29 CDHC is all about.

30 But unlike other organizations, we will not promote the CDHC until we have demonstrated it works and has
31 value and that is what we are asking you to allow us to do at this meeting.

1 You have to decide, do we move forward or do we look to return to the days of old?

2 Let's also remember that the CDHC is just one small part of our access to care initiatives which includes the
3 Oral Preventive Assistant and expanded function dental assistants as detailed in the 2006 workforce report
4 adopted by the 2006 House of Delegates.

5 There are other important ways that the ADA is taking a leadership role on the access issue.

6 Our signature access to care program—Give Kids A Smile—has provided a moral platform from which
7 dentistry can credibly and effectively engage in the national debate on access.

8 If we speak—if we lead—if we act—America will listen. America will listen because organized dentistry
9 isn't just another interest group lobbying for our piece of the pie.

10 Sure, we have professional goals—we push for legislation that makes it easier to work as small business
11 people—we protect ourselves against excessive regulation of our workplaces—we do all we can to let the
12 dental profession police itself.

13 But at the heart of it all, we stand for our profession, our principles, but most of all, for our patients.

14 I'm sure all of you have noticed at this year's annual session the ADA's new logo ... and our new tagline:
15 America's leading advocate for oral health.

16 It's an aspirational description—a way of thinking about ourselves and describing the ADA to others.

17 And it encompasses everything we do at the ADA—not just advocating our political goals in Washington, but
18 also promoting stronger American oral health—world-class patient care—better science—effective dental
19 education—stronger ethics—a more diverse membership and patient base —and stronger, more cooperative
20 professional relationships.

21 And finally, no discussion of the ADA being the leading advocate for oral health would be complete without
22 talking about our public policy advocacy.

23 At your direction, we formed a Future of Health Care/Universal Coverage Task Force to ensure that the ADA
24 has the right goals, strategies and policies to guide our future advocacy efforts related to any effort to change
25 the dental care delivery system as part of health care reform at the federal level.

26 You have a resolution before you at this meeting to enact those policies—it is boldly, and properly, called:
27 Improving Oral Health in America.

28 And let's not forget the action we are taking at the state level on important issues like supporting community
29 water fluoridation, maintaining the continued availability of the full range of safe and effective dental
30 materials and improving access to care.

31 On all these issues—and others too numerous to mention—the ADA has played a vital leadership role for the
32 profession in 2008.

1 So let us begin—let's talk about the challenges that face the future of this great association, openly and
2 honestly. We all love this profession.

3 And we want the next generation to inherit an even greater profession than the one we entered.

4 We dental professionals have every right to be proud of what we've contributed to the American social fabric.

5 We say it often and we say it proudly—Americans have the best oral health care system in the world.

6 But that system cannot survive without an unwavering commitment on our part to make sure that everyone
7 who needs oral health care can get it—that is the challenge of our times.

8 I know we can meet it—that we will meet it—because we are a noble profession, a caring profession,
9 supported by a great association that protects our interests and preserves our ideals.

10 So what's ahead for me?

11 Many of you have asked what will life be like after the ADA. Perhaps it would be better for me to answer
12 that in a few months, but let's talk about priorities.

13 My first granddaughter Hope was born shortly before I became ADA President, I shared the news at last
14 year's House of Delegate—and she just celebrated her first birthday a few weeks ago.

15 I missed that birthday unfortunately—I was overseas at the FDI forum in Sweden.

16 As much as I love organized dentistry, I'm sure you'll appreciate that one missed birthday is one too many for
17 a proud, loving grandfather.

18 I told her I would never miss another and she told me she understood and forgave me—she's very bright for a
19 one-year old.

20 Soon, I will turn over both the Presidency and the day-to-day management of the ADA to the very capable
21 hands of my good friend John Findley.

22 As you know from meeting him, John has a history of great leadership and will continue to move us forward
23 as we celebrate our 150th birthday year.

24 It's been a great honor to be your President.

25 It could not have happened without your belief in my abilities and the support from all my friends in the
26 Second District who I'd ask to stand and please help me thank them.

27 Finally, as I said, Carol traveled almost everywhere with me. We did it together and she also represented you
28 all very well.

29 I would not have done it without her—please rise.

1 For eight years I have ended every speech to this House with the promise to do my job with integrity and
2 commitment, never forgetting who it is that I am working for.

3 I now sit down confident in the fact that I kept my promise.

4 Thank you very much.

Resolution No. 81 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 2008

Submitted By: Fourteenth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going

ADA Strategic Plan Goals: Attain Excellence in Operations (Required)

1 **MEMBERSHIP CATEGORY FOR DISABLED DENTISTS**

2 The following resolution was submitted by the Fourteenth Trustee District and transmitted on October 17,
3 2008, by Ms. Diane Bouzis, caucus secretary.

4 **Background:** Current membership categories may not be inclusive of member dentists that can no
5 longer practice due to a disability but who are very capable of serving the profession in organized
6 dentistry. Finding a way to allow these dentists to have full participation even though they are no longer
7 able to treat patients would be of value to our organization.

8 **Resolution**

9 **81. Resolved**, that the Council on Membership consider creation of a membership category for
10 disabled dentists that do not meet the criteria for other membership categories, and that allows full
11 participation as active members with a report to the 2009 House of Delegates.

12 **BOARD COMMENT: Received after this section had been reproduced for House distribution.**

13