The accreditation process for advanced education programs in pediatric dentistry: a look from the inside out

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It's likely that everyone in the audience today has experienced the American Dental Association (ADA) accreditation in some capacity. Many of you probably got your first experience as a dental student or resident when you served on a committee to prepare for accreditation. Most of you have experienced the accreditation process at the level of your specific program – you've completed a self-study, prepared for the site visit, or responded to recommendations that emanated from the accreditation process. Indeed, I suspect some of you have lived through the accreditation four or five times. And, there are a few unfortunate souls among you who have survived the accreditation process at more than one program – I salute you!

Several of you are past or present consultants who assist in the accreditation process. As consultants some of you have earned distinction as site visitors while others have served as consultants to the ADA's Advisory Committee for Pediatric Dentistry. Considering the collective experience of the accreditation veterans assembled today, I'll need to be careful not to preach to the choir. On the other hand, I have come to learn that the accreditation scene looks a little different when looking from the inside out. I want to share that perspective today, and then close my comments with a few recommendations.

Let's start by examining my source of *inside information*. As some of you may know, at any given time each specialty organization has two representatives who sit on the Commission on Dental Accreditation.[1] In 1992 it was apparent that our Academy's time would be 1993-95. Most of you know that I served as Academy President in 1990-91, an era characterized by an Academy-led initiative to redefine the specialty and revise and upgrade our specialty's education standards. Thankfully, we have completed the task of redefining ourselves and it appears we are near the end of this long and arduous sojourn of adopting new educational standards. In any case, during my years in the Academy officer chain I became one of several battered and bruised spokespersons for our definition as well as for our newly emerging standards. Because it was clear that these issues would be in the Commission's agenda sometime in 1993, the Academy Board of Trustees asked me to represent us on the Commission during the 1993-95 time-frame. This was an enlightening experience for me and today I'll share some insights I gained.

My goal today is not to talk about the Commission's policy development function. This is an intriguing process and one that is sometimes highly politically-charged. Furthermore, today I am deliberately avoiding a discussion of a myriad of other accreditation issues that are timely and hot, such as the Institute of Medicine's critique on the accreditation process,[2] not to speak of the sometimes shared and often not-so-shared concerns of the American Association of Dental Examiners, the American Association of Dental Schools and the ADA. These issues are important, but peripheral to my message today.

The inside view

I want to be careful not to put too fine a point on this, but while sitting on the Commission I saw the accreditation process for our program in a totally different perspective than I had previously. In most instances I was quite pleased with what I saw. I found the accreditation process to be fair at each step of the way. Most importantly, I saw a process I had understood poorly as an outsider. Accordingly, one of my major objectives is to help demystify this process for you. I believe that a better understanding of the accreditation process will help us improve our training programs. Some of you may find this a stretch, but first hear me out.

As a sitting Commissioner, I was assigned to one of a half dozen Commission committees. These committees are where the Commission's real work is done. It's not fair to say that the Commission is a rubber stamp for all committee reports, but for accreditation issues, this is a accurate assessment. During my two year tenure on the Commission we never overruled a committee recommendation for accreditation status and in fact, rarely was a committee recommendation discussed or questioned.

The real accreditation discussions and decisions are

made at the level the Commission's Committee B (Figure 1). Committee B is composed of ten members, eight of whom represent the specialties, plus two Commissioners who themselves are usually specialists or lay persons. Accreditation recommendations for the specialties are made by Committee B, while accreditation recommendations for schools of dentistry, advanced general dentistry, and general practice residency programs are made by the Commission's Committee A.[3] Similarly, accreditation recommendation for dental assisting, hygiene, and laboratory technology are assigned to other committees.

To review quickly then, accreditation decisions for our programs are made by Committee B–that's where the buck stops. This Committee is composed of ten members, eight of whom are appointed because they are specialists in one of the eight recognized specialties. These individuals are appointed by the Chairman of the Commission, not by the specialty groups. In some instances, as was my case, I served on Committee B because I was serving on the Commission. This was also the case for the periodontist with whom I served on the Commission and Committee B. But this is not usual and customary; in most cases the specialty groups are not asked to recommend the individuals who serve on the Commission.

So far I've been describing the process from the inside out, let's look back at the accreditation big picture and look from your perspective as a program director

Fig 1. The Accreditation Process

Application and Self-Study
↓
Site Visit
↓
Preliminary Draft Report
↓
Institutional Response
↓
PED DENT Advisory Committee
4 Members:
2 ABPD Reps
2 Academy Reps
↓
Advanced Specialty
Committee on Advanced Education (B)
10 Members:
8 Specialists
2 Commissioners
↓
Commission on Dental Accreditation (CODA)
20 Members:

4 ADA	1 ADHA
4 AADS	1 ADAA
4 AADE	1 NADL
2 Specialists	1 Student
2 Public	

↓
Transmission of Action to Institution

(Fig 1). Almost all of you know that the accreditation starts with a self-study undertaken by the program and most often under your leadership as a program director. This self-study is the foundation for the site visit and is used by the site visitor consultant to complete a checklist of 74 questions prior to the visit. The site visit becomes a focused opportunity to follow up on concerns and questions that the site visitor may have after reviewing the self-study. If the site visitor concludes that recommendations are needed, the recommendations are reviewed and confirmed by the Commission's Site Visit Committee.

Following the site visit, at the exit interview, the site visitor confers with the program director and other institutional officials and discusses any recommendations that are to be made. Shortly after the site visit, these are sent to the institutional program in a preliminary draft report. The institutional program then prepares a response, which is forwarded to the ADA. I suspect that many of you do not know what occurs next, so let's review the next step.

Advisory committee

Each specialty organization has an Advisory Committee to the Commission. This Committee is composed of four ADA consultants, two recommended by the specialty certifying board and two by the parent organization.[1] In our case these individuals are recommended two each by the American Board of Pediatric Dentistry and Academy respectively. The Advisory Committee meets prior to the meeting of the Commission, a total of two times per year. The Advisory Committee is the first group to review the site visitors' preliminary draft report of your site visit, but this report is reviewed in tandem with your institutionalal program response. After discussion, the Advisory Committee arrives at a consensus on accreditation status. It's important to emphasize that the Advisory Committee considers not only the preliminary draft report made by the site visitor consultant, but your response to the report as well.

As mentioned already, the Advisory Committee meets several weeks prior to the meeting of the Commission and Committee B. After its meeting, the Commission staff seals the Advisory Committee recommendations.

Committee B

When Committee B meets, it undertakes a similar review process as was undertaken by the Advisory Committee. Each site visit report is assigned to two reviewers who review each preliminary draft report in tandem with the institutional/program response. Except in cases of conflicts of interest, the primary reviewer is always of the same specialty as the program under review. For example, the endodontist on Committee B serves as the primary reviewer for endodontic programs, the orthodontist for orthodontic pro-

grams and so on. Each reviewer comes to his/her own decisions relative to whether the site visitor's recommendations were addressed adequately by the institutional/program response to the Commission. If the two Committee B reviewers are in conflict, both explain their justifications and Committee B as a whole derives a consensus on an accreditation status for the program under discussion.

When Committee B reaches this consensus, the Committee then reviews the report of the Advisory Committee for this specific program. If Committee B and the Advisory Committee are not in agreement, the floor is re-opened for discussion and Committee B has the prerogative to *change its mind.* In the final analysis, Committee B makes a final decision on the accreditation status. Technically, this decision is forwarded to the Commission as a recommendation, but as I noted previously, routinely these recommendations are endorsed by the Commission.

This overview brings the accreditation process full circle. Let's move on to examine more closely what I envision as opportunities for improving our programs within the context of this process as it's now structured.

Programs receiving less than full approval

Despite the frustration and rancor that the accreditation process often inspires, currently all 54 dental schools enjoy the highest level of accreditation status and none of our advanced training programs in pediatric dentistry has less than full approval. This is not always the case. It is my view that the single greatest barrier for programs' maintaining full approval is not related to faculty, facilities or resources, but rather a reluctance or unwillingness for a program to look beyond themselves for assistance. Although frequently Committee B and/or the Advisory Committee recommend that a program seek the assistance of an outside consultant, during my two year tenure I do not remember a single instance when this advice was heeded.

The Commission staff is helpful in assisting programs in suggesting ways for programs to meet their unmet recommendations, but in my opinion we need to look more to the expertise of consultants. And, we have a list of competent colleagues who can fulfill this consultantship role. This reliance upon consultants is common in other specialties; in fact, many programs in other specialties stage mock site visits with specialty consultants a year or so prior to their ADA Accreditation Site Visits. We have a talented pool of consultants to the ADA and as site visitors they know best the standards and how to meet them – I feel that we need to deploy these individuals more as special consultants *who come to assess our programs because we ask them to come, not because the ADA sends them as site visitors.*

New and emerging programs

A second arena for which I see opportunities for us to improve relates to new program development (Fig 2). The category of Preliminary Provisional Approval (PPA) is made on the basis of a paper assessment of a program's readiness to meet accreditation standards.[2] This designation does not require a site visit and the operative words here are that "the program is developing or has developed according to guidelines."

An important point to be made about this accreditation status is that a program can be initiated and ac-

Fig 2. COMMISSION ON DENTAL ACCREDITATION TERMINOLOGY FOR THE CLASSIFICATION OF ACCREDITATION STATUS

APPROVAL: An accreditation classification granted to an established educational program indicating that the program in general achieves or exceeds the basic standards for accreditation. This accreditation classification indicates that the program has no serious deficiencies or weaknesses. Recommendations or suggestions relating to program enhancement may, however, be included in the evaluation report.

CONDITIONAL APPROVAL: An accreditation classification granted to an established educational program indicating that specific deficiencies or weaknesses exist in one of more basic areas of the program. The deficiencies or weaknesses are considered to be of such a nature that they can be corrected in a reasonable length of time, which is usually defined as a period not to exceed two years. This accreditation classification indicates that the program is considered adequate to meet the eligibility requirements for licensure and certifying board examination.

PROVISIONAL APPROVAL: An accreditation classification granted to an established educational program indicating that the program has a number of major deficiencies or weaknesses in one or more specific areas. This accreditation classification signifies that program deficiencies or weaknesses are serious, but that the program is considered adequate to meet the eligibility requirements for licensure and certifying board examination. The deficiencies or weaknesses are considered to be of such magnitude, however, that if they are not corrected, withdrawal of the program's accreditation will result. Evidence of significant progress toward resolving program deficiencies must be demonstrated within one year.

PRELIMINARY PROVISIONAL APPROVAL: An accreditation classification granted to an educational program based on the review of a Commission application and survey manual. This classification is granted to assure the educational institution and other agencies that the program is developing or has developed according to the guidelines established by the Commission. This classification provides assurance of candidate eligibility for certification programs.

ACCREDITATION ELIGIBLE: N/A

cept students prior achieving PPA status. While it's a chancy proposition, it's not uncommon practice. Indeed, there have been circumstances in which students were well into their programs while the programs were still in the process of seeking to achieve PPA status. If a program does not achieve PPA prior to students' program completion, the students do not complete an accredited program. To my knowledge this has not occurred, but certainly it's a possible scenario.

It is my view that newly developing programs need to rely upon knowledgeable consultants during their process of program and curriculum planning. Based on my observations, this occurs infrequently. While it's not as likely that a newly emerging program will graduate students who cannot meet ADA requirements as specialists, it is possible that new programs can get off to a slower and perhaps more rocky beginning than otherwise may have been the case had consultant expertise been deployed in the planning stages.

We are living in an era when we need more new programs and I hope we'll have more new programs emerge, especially in conjunction with hospitals who see pediatric dentistry as an integral part of pediatric health care. It's my view that hospitals are also more likely to be able to muster the resources for new program start-up in the next millennium. In any case, in all cases of new program start-ups, it's important that the genesis of these new programs be thoughtful. Some of you will have an opportunity to start a new program – we need them badly – but in an era of expansion, I urge careful planning from the outset. In summary, in addition to relying upon the Commission staff, use outside consultants and I'd urge you to achieve PPA status prior to accepting your first students.

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1. The Commission on Dental Accreditation: Roles and Responsibilities. September, 1993.
2. Field MJ. *Dental Education at the Crossroads: Challenge and Change*. Washington, DC, National Academy Press, 1995.
3. Procedures and Reference Materials for Review Committees: Committee on Advanced Specialty Education. Commission on Dental Accreditation. January, 1995.

An Invitation to Participate

Readers have asked how they can become involved with *Pediatric Dentistry*. The most obvious way is to prepare and submit a manuscript to be considered for publication. However, there is also a great need for dedicated individuals to volunteer the hours needed to referee articles, to prepare abstracts of the scientific literature, or to serve on the Editorial Board. If you are interested in any of these activities, please contact Editor in Chief Elect Milton I. Houpt through the Headquarters Office or by e-mail (houpt@umdnj.edu) indicating your particular interest and/or area of expertise. There is no financial remuneration for these activities, but great personal satisfaction comes from contributing to the production of our well respected journal.