



Consortium of Operative Dentistry Educators (CODE)

Annual National Report: Regions I - VI

Prepared by:

Gary L. Stafford DMD – National Director

staffoga@ohsu.edu

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National Director's Update

For the 2025 CODE Fall Regional Meetings, each of our six regions met in person at one of the six host schools. For the first time, I was able to attend each fall regional meeting thanks to generous support from Haleon (the former Glaxo Smith Kline), which has partnered with CODE and King's College London, UK, to conduct a prevalence study on Erosive Tooth Wear (ETW) in North America. It has been a longstanding goal of CODE to participate in a study suitable for publication, and thanks to this partnership, it is highly probable that we will be able to do so. Dr. Rebecca Moazzez from the University of the Pacific Arthur A. Dugoni School of Dentistry in San Francisco, CA, delivered a presentation related to ETW at each regional meeting, with the dual aim of increasing awareness about the third most common oral disease and encouraging each participating school to complete an initial survey. Both Rebecca and I were very impressed by the hospitality shown by the host schools and attendees, as well as the engagement of the CODE members during the discussions surrounding the national agenda.

Each host school invited sponsors to help defray the cost of hosting the fall meetings and I can't thank the sponsors enough for their generosity. Please visit the member section of the CODE website at www.operativedentistryeducators.com to see which sponsors participated at the fall meetings and be sure and thank them for their support when you see them.

The list below shows the regional directors, locations, and hosts of the 2025 fall meetings:

- Region I Director Dr. James Keddington and host, Dr. Terese Pulido at Midwestern University College of Dental Medicine - Arizona.
- Region II Director and host Dr. Christa Hopp at Southern Illinois University School of Dental Medicine.
- Region III Director Dr. Marilia Sly and host, Dr. A.C. Liles at Louisiana State University Health Science Center School of Dentistry.
- Region IV Director and host, Dr. Adriana Semprum-Clavier at the University of Illinois at Chicago College of Dentistry.
- Region V Director and host, Dr. Eileen Hoskin at Rutgers Health School of Dental Medicine.
- Region VI Director Dr. Martha Bracket and host, Dr. Jorgelin Rodriguez at Nova Southeastern University College of Dental Medicine.

Dr. R. James Keddington from the University of Utah School of Dentistry chose to step down as the Regional Director for Region I and by unanimous vote, the Region I representatives elected Dr. Rich Homer from the University of Utah School of Dentistry to serve in that role. On behalf of all the Region I school representatives and the national

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CODE membership, we thank James for his many years of leadership and dedicated service to CODE.

Barbara Nordquist, CEO and President of Nordquist Advisors, was chosen to serve as an at-large member of the CODE Advisory Council. Her experience and willingness to assist CODE will be of tremendous value to the organization. As the host schools seek sponsorship for their fall meetings, Barbara will be able to assist in that capacity.

The organization has many dedicated participants, and CODE could not effectively function without the work of the Advisory Committee and our Regional Directors. The Advisory Council will meet in January 2026 to discuss the 2025 Fall Regional Meetings and the 2026 National Agenda. Each region has proposed questions, and the final agenda will be set for distribution by the end of May 2026. Several regions have expressed continued concern about the number of schools that were no longer actively involved with CODE. Faculty turnover and lack of departmental funding for meeting attendance were the two most frequently cited causes. I would request that the ADEA Section on Operative Dentistry members continue their involvement with CODE and encourage new faculty to register. Feel free to reach out directly to me at staffoga@ohsu.edu should you have any questions.

The six regions of the Consortium of Operative Dentistry Educators reported that their fall meetings were not only successful but, as is typical with these meetings, enjoyable. The CODE Annual National Meeting was held during the 2025 Academy of Operative Dentistry's Annual Meeting at the Drake Hotel in Chicago, IL. The annual meeting included a presentation by Dr. Upoma Guha on the "*Utilization of Loupes and Contemporary Trends in Dental Education.*" Dr. Guha is an Associate Professor in the Department of Adult Restorative Dentistry at the University of Nebraska Medical Center College of Dentistry and represented Region II.

Given that our annual dues remain low, we are a lean and mean operation, and we must function in that regard. Our organization could not operate were it not for the diligent efforts of our six Regional Directors and each of the hosts/host schools for the fall meetings. Their willingness to devote the energy necessary to coordinate the meetings and garner financial support from their parent institutions and corporate sponsors is noteworthy. Their work helps to ensure that the meetings are as memorable as they are productive. Speaking on behalf of the membership, we thank each of them for their commitment to the Consortium.

I would also like to thank the Deans of each of the host schools for allowing us to visit their respective institutions and for providing us with meeting spaces, refreshments, and permission to tour their facilities. Similarly, I must thank our corporate sponsors who

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generously provide product demonstrations, presentations, and meals for those in attendance.

I would encourage all current members or Individuals who wish to join CODE, to visit our website at www.operativedentistryeducators.com. There you will find a list of current members, national agendas and reports, as well as a portal for our participating dental school CODE representatives to pay the annual dues. The site can accept dues payments electronically via Square, PayPal, Apple Pay, and Google Pay, as well as traditional credit cards. If you have not registered as a CODE member, I would ask that you complete the form on the home page and your profile will be added to the member directory. This is a great resource to find contact information for our colleagues across North America.

On May 1st, 2025, I sent the Annual Dues Statement to the Regional Directors for distribution to each school's representative. Meeting the stated goal of 100% active membership by U.S. Dental Schools remains a challenge, especially since institutional membership and support of CODE through annual dues payments have declined since 2019. As the Regional Directors understand, collecting our annual dues is one of the most difficult aspects of their volunteer position, and given the relatively small amount of our annual dues, payment can be easily overlooked by an institution's administration. Therefore, each member school must have a CODE Representative who will provide the appropriate follow-up and ensure that the payments are made to CODE in a timely fashion. The significant decline in dues-paying member schools in 2020 can certainly be attributed to COVID-19, but we remain well below pre-COVID levels of dues-paying membership. However, our goal remains to have 100% participation by the dental schools in the United States. While I am proud of the level of institutional participation, I would ask each CODE Representative that if your school is listed as one of those not being an active member (see the Schools and Regions section of the 2025 Annual National Report), please help facilitate payment by following up with the individual who is responsible for sending in the annual dues. You can also find the institutions that have paid their annual dues on the CODE website at www.operativedentistryeducators.com. Please contact me directly at staffoga@ohsu.edu with any questions you might have or assistance you might require.

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The tables below show the percentages of dues paying membership rates in the US and Canada.

Table 1: Dues AY 2022-23 thru AY 2025-26 (Post COVID-19)

Region	AY 2025-26 US Schools	AY 2025-26 Canadian Schools	AY 2024-25 US Schools	AY 2024-25 Canadian Schools	AY 2023-24 US Schools	AY 2023-24 Canadian Schools	AY 2022-23 US Schools	AY 2022-23 Canadian Schools
I – Pacific	9/15 = 60%	2/2 = 100%	9/14 = 64%	2/2 = 100%	10/14 = 71%	2/2 = 100%	12/14 = 86%	2/2 = 100%
II – Midwest	9/10 = 90%	0/2 = 0%	9/10 = 90%	2/2 = 100%	9/9 = 100%	2/2 = 100%	7/9 = 78%	0/2 = 0%
III – South Midwest	9/9 = 100%	N/A	7/8 = 88%	N/A	6/8 = 75%	N/A	5/7 = 71%	N/A
IV – Great Lakes	4/10 = 40%	0/1 = 0%	2/10 = 20%	1/1 = 100%	5/10 = 50%	1/1 = 100%	4/10 = 40%	1/1 = 100%
V – Northeast	12/14 = 86%	1/5 = 20%	11/14 = 79%	0/5 = 0%	9/14 = 64%	1/5 = 20%	9/14 = 64%	1/5 = 20%
VI – South	10/16 = 63%	N/A	6/15 = 40%	N/A	7/14 = 50%	N/A	9/13 = 69%	N/A
National Totals:	53/74 = 76%	3/10 = 30%	44/71 = 62%	5/10 = 50%	46/69 = 67%	6/10 = 60%	46/67 = 69%	4/10 = 40%

Table 2: Dues AY 2010-21 and AY 2021-22 (During COVID-19)

Region	*AY 2021-22 US Schools	*AY 2021-22 Canadian Schools	*AY 2020-21 US Schools	*AY 2020-21 Canadian Schools
I – Pacific	13/14 = 93%	1/2 = 50%	4/13 = 31%	0/2 = 0%

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II – Midwest	9/9 = 100%	0/2 = 0%	5/9 = 56%	1/2 = 50%
III – South Midwest	4/7 = 57%	N/A	0/7 = 0%	N/A
IV – Great Lakes	3/10 = 30%	1/1 = 100%	3/10 = 30%	0/1 = 0%
V – Northeast	12/14 = 86%	1/5 = 20%	9/14 = 64%	0/5 = 0%
VI – South	10/13 = 77%	N/A	7/13 = 54%	N/A
National Totals:	51/67 = 76%	3/10 = 30%	28/66 = 42%	1/10 = 10%

Table 3: Dues (Pre COVID-19)

Region	AY 2019-20 US Schools	AY 2019-20 Canadian Schools	AY 2018-19 US Schools	AY 2018-19 Canadian Schools	AY 2017-18 US Schools	AY 2017-18 Canadian Schools
I – Pacific	13/13 = 100%	2/2 = 100%	13/13 = 100%	2/2 = 100%	13/13 = 100%	2/2 = 100%
II – Midwest	8/9 = 89%	2/2 = 100%	8/9 = 89%	1/2 = 50%	8/9 = 89%	2/2 = 100%
III – South Midwest	6/7 = 86%	N/A	7/7 = 100%	N/A	7/7 = 100%	N/A
IV – Great Lakes	9/10 = 90%	1/1 = 100%	9/10 = 90%	1/1 = 100%	8/10 = 80%	1/1 = 100%
V – Northeast	13/14 = 93%	1/5 = 20%	11/14 = 79%	2/5 = 40%	13/14 = 93%	3/5 = 60%


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VI – South	9/13 = 69%	N/A	12/13 = 92%	N/A	11/13 = 85%	N/A
National Totals:	58/66 = 88%	6/10 = 60%	60/66 = 91%	6/10 = 60%	60/66 = 91%	8/10 = 80%

Lastly, the 2026 CODE Annual National Meeting will be held at 5:10 pm in the Parkside Room of the Drake Hotel in Chicago, IL, on Thursday, February 19th, 2026. Dr. Roopwant Kaur from East Carolina University School of Dental Medicine, representing Region VI, has volunteered to deliver a presentation on *“Why CODE Matters”: A Historical and Strategic Perspective on Collaboration and Calibration in Operative Dentistry*” to those in attendance. Any member who would like to present at the 2027 CODE Annual National Meeting or who has a suggestion for speakers should contact their Regional Director or the National Director for more information. The Academy of Operative Dentistry continues to graciously provide support for this annual event, so I hope that many of you will be able to join us during the AOD’s Annual Meeting, and I look forward to seeing you there.

Until then, you have...

All my best,



Gary L. Stafford DMD
National Director – Consortium of Operative Dentistry Educators (CODE)

Origins of CODE

Project ACORDE (A Consortium of Restorative Dentistry Education)

The date usually cited as the starting point for the development of Project ACORDE is 1966. That year, in Miami, the Operative Dentistry Section of AADS formed a committee charged to plan for the cooperative development of teaching dental materials.

In July of 1971, the Dental Health Center, San Francisco, invited faculty from 14 dental schools to explore the feasibility of reaching consensus of a series of operative dental procedures. The outcome of the meeting suggested that it was feasible to achieve broad-based agreement on basic procedures: task analyses could be developed in which consensus could be reached on essential details of methods and instrumentation. The Project ACORDE committee was charged with the responsibility for coordinating curriculum development efforts on a national level in November of that year. Prominent in this project development were Bill Ferguson, David Grainger and Bob Wolcott.

The Broad Goals and Functions of this committee were:

1. To gain agreement among all participating dental schools on the teaching of operative dentistry functions and gain acceptance by all schools.
2. To produce materials which can be universally accepted and utilized for teaching dental students and expanded function auxiliaries.

During 1974, a 15-module package entitled Restoration of Cavities with Amalgam and Tooth-colored Materials was presented. The preparation package entitled Cavity Preparations for Amalgam and Tooth-colored Materials became available for distribution in March of 1976.

Project ACORDE was found to have produced three major benefits for dental education:

1. It opened new channels of communication among dental educators.
2. It suggested uniform standards of quality for the performance of restorative skills.
3. It produced numerous lesson materials that were useful both for teaching students and as models of developers of other lessons.

The benefit, most frequently cited by dental school faculty, was communication. The primary example of the communication begun by Project ACORDE, which has lasted well beyond the initial project, is CODE (Consortium of Operative Dentistry Educators). CODE has as its goal, the continuation of meetings for the purpose of information exchange

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among teachers of operative dentistry. Regional CODE meetings are held annually with minutes of each session recorded and sent to the national director for distribution. This system is a direct spin-off of Project ACORDE.

The first annual session of CODE was held in 1974/75.

The Early Years (1974-1977)

As founding father of the concept, Robert B. Wolcott of UCLA assumed the role of national coordinator and appointed Frank J. Miranda of the University of Oklahoma as national secretary. A common agenda to be provided to all six regions was established at this time. The first regional meetings were held in the winter of 1974. During the first three years of operation, each region devised a system of rotation so that a different school hosted the regional meeting each year, thus providing a greater degree of motivation and bringing schools closer together in a spirit of fellowship and unity. Each region submitted suggestions for future agendas, thereby insuring a continued discussion of interesting and relevant topics. A collection of tests or a test bank was started in early 1976. This bank consisted of submitted written examination questions on specified topics that were compiled and redistributed to all schools.

The Transition Years (1977-1980)

The first indication that the future of CODE was in jeopardy came in 1977, the first year that a national report could not be compiled and distributed. As the result of the efforts of a committee chaired by Dr. Wolcott, the original concept was renewed in 1980. Its leadership had been transformed from the structure of a national coordinator and secretary to a standing subcommittee under the auspices and direction of the Section of Operative Dentistry of the AADS.

The Reaffirmation Years (1997 - 1998)

During the 1997 meetings of both the Operative Dentistry Section Executive Council and the Business meeting of the Section, interest was expressed about reorganizing CODE and aligning it more closely with the Section. During the following year, fact-finding and discussions occurred to formulate a reorganization plan.

The plan was submitted for public comment at the 1998 meeting of the Operative Dentistry Section Executive Council and the Business meeting of the Section. At the conclusion of the Business meeting the reorganization plan was approved and implemented.

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Reaffirmation of CODE official title (2003)

CODE changed its name from *Conference of Operative Dentistry Educators* to *Consortium of Operative Dentistry Educators* due to a ratification vote at the Fall 2003 Regional CODE meetings.

Establishment of Board of Directors and Articles of Incorporation

In 2013, Dr. Larry Haisch stepped down as National Director. The organization flourished under Larry's outstanding leadership and 15-year tenure as National Director. Bank accounts needed to be transferred to the new National Director's locale and name. In a post 9-11 society, bank accounts are not as easy to establish for non-profit organizations as they once were. The organization was compelled to establish a Board of Directors and write Articles of Incorporation in order to conduct regular organizational business. The Board of Directors consists of all Regional Directors as well as the At-Large Directors.

The Future of CODE

The official sponsorship by the Section of Operative Dentistry of ADEA (formerly ADDS) and the revised administrative structure of CODE are both designed to insure its continuance as a viable group. The original concepts, ideas and hopes for CODE remain unchanged and undiminished. Its philosophy continues to be based on the concept of dental educators talking with each other, working together, cooperating and standardizing, when applicable, their teaching efforts and generally socializing in ways to foster communication. There is every reason to believe that organizations such as CODE, and those developed in other fields of dentistry, will continue to crumble the barriers of provincialism and provide the profession with a fellowship that is truly national in scope.

This section was written by Larry D. Haisch, DDS – CODE National Director 1998 – 2012

Past and Current National Directors (Coordinators)

1974 - 1982	Robert B. Walcott DDS	University of California Los Angeles
1982 - 1986	Thomas A. Garmen DDS MS	University of Georgia
1986 - 1989	Frank J. Miranda DDS	University of Oklahoma
1989 - 1998	Marc A. Gale DMD M Ed	University of Florida
1998 - 2012	Larry D. Haisch DDS	University of Nebraska
2013 - 2015	Edward J. DeSchepper MA Ed DDS MSD	University of Tennessee
2016 - Present	Gary L. Stafford DMD	Oregon Health & Science University

Organizational Operation

The Section on Operative Dentistry and Biomaterials of the American Dental Education Association (ADEA) has “oversight” responsibility for sustaining and managing the activities of CODE.

- The Executive Council of the Operative and Biomaterials Section will appoint the National Director of CODE for a three-year renewable term.
- The National Director will be selected from a list of one or more individuals nominated for the position by the CODE Advisory Committee after input from the regions.
- The National Director will perform the functions and duties as set forth by the Council.
- The National Director will be a joint member of the Council and will be expected to attend a regional CODE meeting and the annual meeting of the Council and Section. The National Director may also serve as an elected officer of the Council.

A CODE Advisory Committee (and now also the Board of Directors) will assist the National Director with his/her duties.

- A CODE Advisory Committee will consist of the Regional Directors from each of the six regions, the National Director, and three at-large members.
- Each region will select its Regional Director. The National Director and/or the Executive Council may select the at-large member(s).
- The terms are three years, renewable, and not to exceed two consecutive terms.
- The National Director serves as Chair of the Advisory Committee.

The annual CODE Regional meetings will serve as the interim meeting of the section. Some section business may be conducted at each CODE Regional meeting as part of the National agenda.

Regional Directors:

- Will be a member of ADEA and the section of Operative Dentistry;
- Will oversee the conduct and operation of CODE in their respective regions, while working in concert with the national director;

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- Will have communication media capabilities including e-mail with the capability of transmitting attachments;
- Will attend the region's meeting;
- Ensure that meeting dates, host person, and school are identified for the following year;
- Do follow-up assistance on dues "nonpayment" by schools;
- Ensure that reports of regional meetings are submitted **within 30 days** of the meeting conclusion to the National Director;
- Ensure that individual school rosters (operative-based) are current for the region;
- Identify a contact person at each school;
- Assist in determining the national agenda; and,
- Other, as required.

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Advisory Committee

(Board of Directors)

Updated 12.31.25

	Region	Regional Directors	Phone/email	3 Year Term
I	Pacific	Richard W. Homer DMD Assistant Professor Section Head – Dental Conservation and Restoration University of Utah School of Dentistry 530 S Wakara Way Salt Lake City, UT 84108	O: 801.581.8951 richard.homer@hsc.utah.edu	2026 - 2029
II	Midwest	Christa Hopp DMD Associate Professor Restorative Department Southern Illinois University School of Dental Medicine 2800 College Ave Alton, IL 62002	O: 618.474.7052 chopp@siue.edu	2024 - 2027
III	South Midwest	Marilia M. Sly DDS, MSD Associate Professor Department of Restorative Dentistry and Prosthodontics University of Texas Health Science Center at Houston, School of Dentistry SOD-5442 Houston, TX 77030	O: 713.486.4362 Marilia.M.Sly@uth.tmc.edu	2026 - 2029
IV	Great Lakes	Adriana Semprum-Clavier DDS, MS Clinical Associate Professor Department of Restorative Dentistry University of Illinois at Chicago College of Dentistry 801 S Paulina St Chicago, IL 60612	O: asemprum@uic.edu	2023 - 2026
V	Northeast	Eileen Hoskin DMD, MA Associate Professor of Professional Practice Director of Operative Dentistry Rutgers Health School of Dental Medicine 100 Bergen St Newark, NJ 07103-1709	O: hoskiner@sdm.rutgers.edu	2023 - 2026
VI	South	Martha Brackett DDS, MSD Professor The Dental College of Georgia at Augusta 1120 15 th St Augusta, GA 30912	O: 706.721.7308 mbrackett@augusta.edu	2023 - 2026
		At-Large Members	Phone/email	3 Year Term
III	At-Large	Rosemary McPharlin DDS Chair and Professor-in-Residence of Clinical Sciences Department of Dental Medicine University of Nevada, Las Vegas School of Dental Medicine 4505 S Maryland Pkwy Las Vegas, NV 89154	O: 702.774.2711 rosemary.mcpharlin@unlv.edu	2023 - 2026
VI	At-Large	Roopwant Kaur BDS, MS	O: 252.737.7148	2023 - 2026

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		Clinical Associate Professor Division of Operative Dentistry East Carolina University School of Dental Medicine 1851 MacGregor Downs Rd Greenville, NC 27834-4354	kaurr@ecu.edu	
	At-Large	Barbara Nordquist CEO President, and Principal Advisor Academics & Professional Relations Medical & Dental Nordquist Advisors 7 Powder Horn Hill Rd Wilton, CT 06897	O: 201.286.4991 Barbara@nordquistadvisors.com	2026 - 2029
I	Web Master	Gary L. Stafford DMD	staffoga@ohsu.edu	No Term
I	National Director	Gary L. Stafford DMD Professor, Restorative Dentistry Senior Associate Dean for Academic Systems Oregon Health & Science University School of Dentistry MC: SD-AA 2800 S Moody Ave Portland, OR 97201	O: 503.494.8801 C: 708.261.1039 staffoga@ohsu.edu	2025-2028

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Regions and Schools

North American Dental Schools = 82 (10 Canada* and 74 United States)

Dues unpaid for AY 2025-26

Region I (Pacific) – 17 Dental Schools (2 Canada* and 15 United States)

Region	Dental School	2025/26 Member
I	University of Alberta*	✓
I	University of British Columbia*	✓
I	AT Still University of Health Sciences - Arizona	✓
I	California Northstate University	✓
I	Loma Linda University	
I	University of Southern California	✓
I	Midwestern University - Arizona	✓
I	Oregon Health & Sciences University	✓
I	Pacific Northwest University School of Dental Medicine	✓
I	Roseman University of Health Sciences	
I	University of California at Los Angeles	✓
I	University of California at San Francisco	
I	University of Nevada at Las Vegas	
I	University of the Pacific	✓
I	University of Utah	✓
I	University of Washington	✓
I	Western University of Health Sciences	✓

Region II (Midwest) – 12 Dental Schools (2 Canada* and 10 United States)

Region	Dental School	2025/26 Member
II	University of Manitoba*	
II	University of Saskatchewan*	
II	Creighton University	✓
II	Kansas City University College of Dental Medicine	✓
II	Marquette University	✓
II	Missouri School of Dentistry & Oral Health	✓
II	Southern Illinois University	✓
II	University of Colorado Health Sciences Center	✓
II	University of Iowa	✓
II	University of Minnesota	✓
II	University of Missouri at Kansas City	
II	University of Nebraska Medical Center	✓

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Region III (South Midwest) – 9 Dental Schools (9 United States)

Region	Dental School	2025/26 Member
III	Louisiana State University Health Sciences Center	✓
III	Lyon College	✓
III	Texas A & M University	✓
III	Texas Tech University Health Sciences Center El Paso	✓
III	University of Mississippi Medical Center	✓
III	University of Oklahoma Health Sciences Center	✓
III	University of Tennessee Health Sciences Center	✓
III	University of Texas Health Sciences Center at Houston	✓
III	University of Texas Health Sciences Center at San Antonio	✓

Region IV (Great Lakes) – 11 Dental Schools (1 Canada* and 10 United States)

Region	Dental School	2025/26 Member
IV	Western University Schulich*	
IV	Case Western University	
IV	Indiana University	✓
IV	Midwestern University - Illinois	
IV	The Ohio State University	
IV	University of Buffalo	
IV	University of Detroit Mercy	
IV	University of Illinois – Chicago	✓
IV	University of Michigan	✓
IV	University of Pittsburgh	
IV	West Virginia University	✓

Region V (Northeast) – 19 Dental Schools (5 Canada* and 14 United States)

Region	Dental School	2025/26 Member
V	Dalhousie University*	
V	McGill University*	✓
V	University of Toronto*	
V	Laval University*	
V	University of Montreal*	
V	Boston University	
V	Columbia University	✓
V	Harvard University	✓

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V	Howard University	✓
V	New York University	✓
V	Rutgers University	✓
V	Stony Brook University	✓
V	Temple University	
V	Touro	✓
V	Tufts University	✓
V	University of Connecticut	✓
V	University of Maryland	✓
V	University of New England	✓
V	University of Pennsylvania	✓

Region VI (South) – 16 Dental Schools (16 United States)

Region	Dental School	2025/26 Member
VI	East Carolina University	
VI	High Point University	✓
VI	Lake Erie College of Osteopathic Medicine	
VI	Lincoln Medical University	
VI	Medical University of South Carolina	✓
VI	Meharry Medical College	✓
VI	Nova Southeastern University	✓
VI	The Dental College of Georgia at Augusta University	✓
VI	University of Alabama	
VI	University of Florida	✓
VI	University of Kentucky	
VI	University of Louisville	✓
VI	University of North Carolina	✓
VI	University of Pikeville	✓
VI	University of Puerto Rico	
VI	Virginia Commonwealth University	✓

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2025 Regional Meeting Hosts

Region/Dates	University/Address	Host Name/Phone/email
I – October 23-24, 2025	Midwestern University College of Dental Medicine - Arizona 19555 N 59 th Ave Glendale, AZ 85308	Teresa Pulido DDS, MS O: 623-537-6000 tpulid@midwestern.edu
II – September 11-12, 2025	Southern Illinois University School of Dental Medicine 2800 College Ave Alton, IL 62002	Christa Hopp DMD O: 618-474-7186 chopp@siue.edu
III – November 12-14, 2025	Louisiana State University Health Science Center School of Dentistry 1100 Florida Ave New Orleans, LA 70119	A.C. Liles DDS Alile1@lsuhsc.edu
IV – October 2-3, 2025	University of Illinois at Chicago College of Dentistry 801 S Paulina St Chicago, IL 60612	Adriana Semprum-Clavier DDS, MS asemprum@uic.edu
V – September 22-23, 2025	Rutgers Health School of Dental Medicine 110 Bergen St Newark, NJ 07103	Eileen Hoskin DMD, MA hoskiner@sdm.rutgers.edu
VI – October 8-10, 2025	Nova Southeastern University College of Dental Medicine 3300 S University Dr Fort Lauderdale, FL 33328	Jorgelin Rodriguez DDS, DMD, MS, MSED jorgelin@nova.edu

Consortium of Operative Dentistry Educators (CODE)

2026 Regional Meeting Hosts

Region/Dates	University/Address	Host Name/Phone/email
I – TBD, 2026	Western University of Health Sciences College of Dental Medicine 309 E Second St Pomona, CA 91766-1854	Higrit Islamoglu DMD islamogluh@westernu.edu Brent Fung DDS bfung@westernu.edu
II – September 9-11, 2026	Kansas City University College of Dental Medicine 2901 St. John’s Blvd Joplin, MO 64804	Jacksie Short DMD jshort@kansascity.edu
III – TBD, 2026	Woody L. Hunt School of Dental Medicine Texas Tech University Health Sciences Center El Paso 5001 El Paso Dr. MS 24001 El Paso, TX 79905	Rosemary McPharlin DDS O: 915.215.4707 rosemary.mcpharlin@ttuhsc.edu
IV – TBD, 2026	University of Illinois at Chicago College of Dentistry 801 S Paulina St Chicago, IL 60612	Adriana Semprum-Clavier DDS, MS asemprum@uic.edu
V – TBD, 2026	University of Maryland School of Dentistry 650 W Baltimore St Baltimore, MD 21201	Mary Anne Melo DDS, MSc, PhD mmelo@umaryland.edu
VI – TBD, 2026	TBD	TBD

Regional Meeting Reporting/National Meeting Information

The 2025 National Agenda was established after a review of the suggestions contained in the reports of the 2024 Fall Regional meetings, National CODE Meeting, and from the Regional CODE Directors. Previous National agendas were reviewed to avoid topic duplication. Inclusion of a previous topic may occur for discussion from the aspect of what has changed, the response/action taken, and/or the outcome.

Thank you to the Regional CODE Directors and the membership for making recommendations to establish the National Agenda. Each Region is encouraged to also have a Regional Agenda.

Each school attending a Regional Meeting is requested to bring their responses to the National Agenda in written form AND electronic media. This information is vital to the timely publication of the National Annual Report.

Continue to invite your colleagues, Dental Licensure Board examiners, and your Military and Public Health Service colleagues who head/instruct dental education programs to your regional meetings. The strength of the organization lies in its membership.

Each Region should select next year's meeting site and date/tentative date during your Fall Regional CODE meeting so this information may be published in the Annual National Report and on the CODE website.

The Regional meeting reports are to be submitted to the National Director **in a publishable format** as an email attachment.

The required format and sequence will be:

- 1. CODE Regional Meeting Report Form***
- 2. CODE Regional Attendees form***
- 3. Summary of Responses to the National Agenda**
- 4. Individual School Responses to the National Agenda**
- 5. The Regional Agenda summary and responses**

*(copies may be obtained from the CODE website:
www.operativedentistryeducators.com or within this document)

Send an electronic copy of the final regional report via an email attachment to the National Director (staffoga@ohsu.edu) within thirty (30) days of the meeting's conclusion.

2026 Annual National CODE Meeting: The meeting will be held on Thursday, February 19th, 2026, from 5:30 – 6:30 pm in the Parkside Room at the Drake Hotel, 140 East Walton Place, in Chicago, IL. This meeting is held in conjunction with the Academy of Operative Dentistry's Annual Meeting.

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2026 ADEA Section on Operative Dentistry and Biomaterials Forum: The meeting will be held on Saturday, March 21st at 7:00 am during the ADEA Annual Session & Exhibition, March 21-24, 2026, in Montreal, Canada.

National Directory of Operative Dentistry Educators:

The CODE National Director maintains the National Directory of Operative Dentistry Educators as a resource for other dental professionals. It is critically important that this information be as current as possible. You may update your personal directory listing on the CODE website at www.operativedentistryeducators.com or by sending an email directly to the National Director at staffoga@ohsu.edu.

To keep the National Directory up to date, please have each school in your Region update the following information:

1. *Individual names: (F/T Faculty), phone number, and email address of F/T Faculty who teaches operative dentistry.*
 - a. This could be individuals who teach in a comprehensive care program, etc.... if there is no defined operative section of the department.

Your help and cooperation in accomplishing the above tasks help save time and effort in maintaining a complete National Directory and publishing the Annual National Report in a timely fashion.

All my best,



Gary L. Stafford DMD
Consortium of Operative Dentistry Educators (CODE)
National Director
staffoga@ohsu.edu

Professor, Restorative Dentistry
Senior Associate Dean for
Academic Systems
Oregon Health & Science University
School of Dentistry
MC: SD-AA
2800 S Moody Ave
Portland, OR 97201

2025 National Agenda

I. Curriculum

- a. How are your external rotations organized?
 - i. How many affiliation agreements/sites?
 - ii. How many rotations?
 - iii. How many total weeks?
 - iv. When are the students scheduled externally? (DS4, DS3, etc...)
 - v. How many weeks at a time?
 - vi. How are students supported?
 - vii. Who pays for accommodations?
 - viii. How are faculty/preceptors calibrated?
- b. How are patients managed after the completion of their comprehensive care?
 - i. Ongoing recall/hygiene by students?
- c. Describe challenges you are experiencing related to the Gen-Z student learner?
- d. What strategies are you using to more effectively teach the next generation of dentists?
 - i. Techniques?
 - ii. Delivery of student feedback?
 - iii. Videos for preparation/restoration?

II. Materials and Techniques

- a. What types of materials and strategies are used for vital/non-vital pulp therapy?
- b. Treatment planning
 - i. Describe the treatment planning process at your institution.
 - 1. Who “owns” the treatment plan?
 - 2. Who can modify it?
 - 3. What educational methods and resources are used to teach treatment planning?
 - 4. Are there individual courses dedicated to treatment planning or is treatment planning embedded throughout the curriculum (discipline based)?
- c. How is your institution addressing the fluoride “controversy”?

III. Student Assessment

- a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?
 - i. Classroom instruction related to the exam process?
 - ii. Mock boards?
- b. How are students assessed when scheduled on external rotations?
 - i. Do you count those procedures for meeting requirements?

IV. Administration

- a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?
- b. What assistance in terms of initiatives/support/strategies does your school/university provide?
- c. Calibration
 - i. How often does your operative faculty meet as a group and what are the objectives of those meetings?
 - ii. Are your calibration efforts discipline-based or across all disciplines?
- d. What are your policies for student absences?
- e. What are the demographics of your current classes and what are the trends?
 - i. Is student performance in courses declining?
 - ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...?
- f. Are you considering a switch from axiUm to EPIC as your Electronic Health Record?

V. CaMBRA Questions

This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.
 - i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?
 1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?
 2. If NO, why are lesions not documented?
- b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use and how granular is your documentation? For example, some schools may note lesions on a simply binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression (“incipient” vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?
- c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?
 - i. If YES, which diagnostic codes/descriptors for caries lesions do you use?
 - ii. If NO, why are diagnostic codes not used?

2026 Regional Meeting Report Form

Region:

Host University, Address, and Dates of 2026 Regional Meeting:

Host University	Address	Dates of Meeting

Chairperson and Contact Information for the 2026 Regional Meeting:

Chairperson	University/Address	Phone/email

List of Attendees: (Please complete the CODE Regional Meeting Attendees Form on the following page)

Contact Person, Host University, and Dates of 2027 Regional Meeting:

Contact Name Phone/email	Host University/Address	Dates of Meeting

Suggested Agenda Items for 2027:

Consortium of Operative Dentistry Educators (CODE)

2026 Regional Meeting Attendee's Form

Name	University	Phone	email

Consortium of Operative Dentistry Educators (CODE)

2026 Regional Meeting Attendee's Form

Name	University	Phone	email

Consortium of Operative Dentistry Educators (CODE)

Please return all completed enclosures to:

Gary L. Stafford DMD
Consortium of Operative Dentistry Educators (CODE)
National Director

Professor, Restorative Dentistry
Senior Associate Dean for Academic Systems
Oregon Health & Science University
School of Dentistry
MC: SD-AA
2800 SW Moody Ave
Portland, OR 97201

O: 503.494.8541
C: 708.261.1039
staffoga@ohsu.edu

Deadline for return: 30 days post-meeting

Please send the requested documents via email with attachments.

Regional Responses

Region I

2025 National Agenda – Region I

Response Color Key

(ASDOH) AT Still University Arizona School of Dentistry & Oral Health
(CNU) California Northstate University College of Dental Medicine
(USC) Herman Ostrow School of Dentistry of the University of Southern California
(LL) Loma Linda University School of Dentistry
(MU) Midwestern University College of Dental Medicine
(OHSU) Oregon Health and Science University School of Dentistry
(PNU) Pacific Northwest University School of Dental Medicine
(RU) Roseman University of Health Sciences College of Dental Medicine – (No Responses)
(*UA) University of Alberta Faculty of Medicine and Dentistry
(*UBC) University of British Columbia Faculty of Dentistry
(UCLA) University of California at Los Angeles School of Dentistry
(UCSF) University of California at San Francisco School of Dentistry – (No Responses)
(UNLV) University of Nevada Las Vegas School of Dental Medicine – (No Responses)
(UoP) University of the Pacific Arthur A. Dugoni School of Dentistry
(UU) University of Utah School of Dentistry
(UW) University of Washington School of Dentistry
(WU) Western University of Health Sciences College of Dental Medicine

I. Curriculum

a. How are your external rotations organized?

(ASDOH) – We have a department which include senior director, a director, and multiple admin assistants who help the student select and make a decision about the rotation.

(CNU) – Our students are sent on a 7 week external rotation at on of 4 sites. They will do this in their DS4 year. The students are supported by our director of community outreach. The sites are within commuting distance so there is no need to pay for accommodations. The preceptors are calibrated in a session that is held at CNU once a year.

(USC) – External rotations offered by various departments, and schedule coordination is provided by the Office of Academic Affairs.

(LL) – Every day, Monday-Thursday, sending 16 students for external rotation.

(MU) – Through RMS (Rotation Management System) which is a university made program, overseen by the Academic Dean.

(OHSU) – Through our Division of Dental Public Health.

(PNU) – Currently we are in our first year as a dental program and haven't finalized a plan on rotations (during their senior year). Our students will be assigned to one of 3 FQHC clinics (supervised by PNWU faculty) for the duration of their dental education.

(*UA) –

(*UBC) – Between UBC and the community directors and external sites legal counsel.

(UCLA) –

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(UoP) – There is a course that administers the extramural rotations. The clinic also oversees the rotations.

(UU) –

(UW) – During each of these four quarters, students rotate through community, tribal, or private practice clinics, delivering care to underserved patients under a preceptor's guidance; they gain exposure to real-world clinical practice and develop valuable community-based dental skills.

(WU) – All sites are year-round with a requirement to accept both junior and senior students; therefore, each site has six, 7-week externship rotations for a total of 42-weeks of externship students out of 52 weeks annually.

Exceptions include that sites do accept students during break for students who are completing make-up sessions or would like to extend their externship rotations, which is only noted as volunteering experience and does not replace any hours of their scheduled externship rotation.

i. How many affiliation agreements/sites?

(ASDOH) – We have 65 active rotation sites, and we have agreements with about 100 sites.

(CNU) –

(USC) – 27 rotations, a combination of internal and external (8). External rotations are in dental mobile vans and external affiliated sites. Local sites (Greater LA area, Westlake/Koreatown) and distant sites (Santa Barbara and multiple sites in the San Diego area). Rotations are mandatory. Externships are optional, additional experiences based on students' interest/future advanced program ambitions.

(LL) – One only, SAC Health Brier Clinic.

(MU) – 5 all local (pedo focus, geriatric focus, health center) (electives: military and special needs)

(OHSU) – There are currently 33 active affiliated sites that hold affiliation agreements with OHSU's Office of Learner Placement and Housing. From the 33 sites, there are 54 available locations for students to rotate through. 21 of these locations are within 40 miles of OHSU, 29 are locations 40 miles outside of Portland in the state of Oregon, and 4 are out-of-state sites. Students can provide all aspects of care from restorative, extractions, endodontics, periodontics, and removal prosthodontics. The variety of experiences offered ensure that the student will develop cultural competence in the provision of the full scope of dentistry. All student procedures completed daily are entered in axiUm to capture the full range of care that is being provided by each student.

(PNU) – We have 3 agreements with the FQHC's; there may be more.

(*UA) – 3 satellite clinics (McLennan, High Level/La Crete) - once in DDS 4, for 2 weeks; some DDS 3 can volunteer during intersession term (end of third year).

- 3 sites- Access for all- mobile clinics: 4 one-week trips per year 2025/26 with DDS 4 and DH 3/4.(Lac la Biche, Cold lake, Medicine hat)
- Elective courses- DDS4 one week per term and two in total for students
- Global oral health-two Dominican Republic trips

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- Glenrose Rehabilitation Hospital: DDS3 and DDS4. Every student attends a two-day rotation; some students end up attending twice in each year. DDS 3 assists/DDS4 care providers.
- DDS3 and DDS4 - Radius Wellness clinic. Every student attends a two-day rotation; some students end up attending twice in each year.

DDS3 and DDS4 - UAH Rotation. I'm not sure how many rotations each student has in Year 3 or Year 4.

DDS4 - Long Term Care clinics. I believe each DDS4 student attends one full-day session.

(*UBC) – 5 different sites in DMD.

(UCLA) – 26 affiliated sites.

(UoP) – 9 affiliation agreements, 11 sites (2 of the sites have 2 locations).

(UU) – We currently have 5.

(UW) – 10 active sites.

(WU) – We currently have a total of 15 partners which includes FQHCs, FQHC-look-alike, IHS sites, VA, and non-profit community clinic. Within the 15 partnerships, there may be multiple site locations within the partnerships ranging from one to ten.

ii. How many rotations?

(ASDOH) – Five external rotation. 4 in the D4 year and one in the summer of the D3 year.

(CNU) –

(USC) – 27 rotations, a combination of internal and external (8).

(LL) – One rotation every other week. (22 rotations a year).

(MU) – Each student participates in one mandatory external rotation.

(OHSU) – Three rotations. Two are at an external site, usually the same site but two different rotations, and then one rotation at Russell Street Clinic which is an OHSU-affiliated clinic.

(PNU) – Not finalized yet.

(*UA) – See [previous].

(*UBC) – If this is referring to external rotations only, then it would be 7 rotations over the four years.

(UCLA) – Two rotations.

(UoP) – 1 extramural rotation

(UU) – There are currently 5 external rotations: HMHI (Neurobehavior Home), Liberty, Rose Park, South Main, St. George.

(UW) – 10 sites host 1-2 students for 5 weeks for around 88 total rotations per year.

(WU) – Two.

iii. How many total weeks?

(ASDOH) – 20 weeks.

(CNU) –

(USC) – Varies; days up to 3 weeks.

(LL) – 44 weeks in a year, but only every other week (22 rotations a year).

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(MU) – Three weeks.

(OHSU) – Nine weeks.

(PNU) – Not finalized yet.

(*UA) – See [previous].

(*UBC) – In total, approximately one week.

(UCLA) – Eight weeks.

(UoP) – Two weeks.

(UU) – Students are assigned to external rotations every week (except for St. George when we close the student clinic for a few weeks because of holidays, etc.). For fall semester, D4's will spend about 5 weeks on external rotations, D3's and D2's spend about 10 weeks.

(UW) – 5 weeks are required by all students, and some students complete 10 weeks.

(WU) – 14 weeks.

iv. When are the students scheduled externally? (DS4, DS3, etc...)

(ASDOH) – Spring D3 year, Fall D4 year, and spring D4 year.

(CNU) –

(USC) – External rotations start in tri 8 (D3), but we are trying to move the start earlier.

(LL) – D4 only started this year in Summer Quarter, sending 16 students /day.

(MU) – DS4.

(OHSU) – DS4.

(PNU) – They begin their clinic experiences at the beginning of their D2 years.

(*UA) – Mainly DDS 4, DH 4. DDS 3 can volunteer for satellite rotations.

See [previous].

(Access for all: DDS 4, DH 3/4

Electives: DDS 4

Satellite: DDS 4, DH, end of DDS 3

(*UBC) – One rotation in year 2, two in year 3 and three rotations in year 4.

(UCLA) – DS4.

(UoP) – D3/ I2 (Senior year for Dugoni).

(UU) – Students are scheduled externally every week throughout each semester. They begin serving as providers at external clinics starting in the fall of their D2 year.

(UW) – DS4 only.

(WU) – One during D3 (junior) and one during D4 (senior) year.

v. How many weeks at a time?

(ASDOH) – 4 weeks.

(CNU) –

(USC) –

(LL) – The rotation started from day one throughout the quarter.

(MU) – 3 (2 for electives).

(OHSU) – Four weeks for a site rotation and one week for Russell Street.

(PNU) – They will be there for the entirety of their D2-D4 years.

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(*UA) – See [previous].

(*UBC) – None of them are for weeks, only 1/2 or full days.

(UCLA) – Four weeks.

(UoP) – Varies; some students rotate 2 consecutive days over a period of several weeks.

(UU) – Similar to one of my [previous] answers, for the Fall semester, D4's will spend about 5 weeks on external rotations, D3's and D2's spend about 10 weeks.

(UW) – 5 consecutive weeks.

(WU) – 7 weeks at a time.

vi. How are students supported?

(ASDOH) – We call it ICSP rotation. There is a department that has a director and staff working to organize the whole rotation cycle. They are always following up on the students' progress and receive detailed feedback about the students while they are on rotation.

(CNU) –

(USC) – Same resources as in school, calibrated faculty, staff.

(LL) – The site is within driving distance from the main campus (approx. 2 miles). We do not provide financial support for this rotation.

(MU) – Through the Dean's office.

(OHSU) – If they are placed locally, within 40 miles of Portland, then they can live at home and are able to use the same resources they would normally have. If students need anything from the school, they have Dr. Foster Page who is the Division Head of Dental Public Health and her team at OHSU. There is a preceptor at each site to support the student. If the site is more than 40 miles away from Portland, they are given the option to have housing. Some students opt out because they want to stay with family. OHSU reimburses the travel costs to and from the site from Portland.

(PNU) – I assume you mean financially—our students are moving to their respective FQHC sites at the beginning of their 2nd year.

(*UA) – Access for all: MNA signs the location lease and insurance agreements.

Sponsorship partners. School. Volunteering. Satellite clinics:

- Travel is provided to High Level/La Crete. As well as travel to the clinic and grocery store.

- Students going to McLennan receive 200 CAD (for travel cost).

(*UBC) – Access for all: MNA signs the location lease and insurance agreements.

Sponsorship partners. School. Volunteering. Satellite clinics:

- Travel is provided to High Level/La Crete. As well as travel to the clinic and grocery store.

- Students going to McLennan receive 200 CAD (for travel cost).

(UCLA) – CBCE is a mandatory rotation that is supported by the director of Community-Based Clinical Education.

(UoP) – Extramural rotations are part of a course in the Department of Diagnostic Sciences. There are assignments that need to be done. There is a course director

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as well as a dedicated administrative assistant who supports student activities in their rotations.

(UU) – All of our external sites are reasonable to get to within a half hour, if they need to switch rotations they can submit a request.

(UW) – Faculty and staff from the school and the students are enrolled in a course, and they receive a pre-rotation orientation one (1) month before rotation. Staff make all travel and housing arrangements for students, and weekly procedure tracking and monitoring by faculty and staff.

(WU) – Students are supported through multiple means:

1) financial aid (during D3 and D4 year, financial aid is increased to help support costs of externship rotation such as transportation and housing for externship sites not within a commutable distance from primary residence;

2) some non-commutable externship sites provide free housing for the dental students. These students would only need to cover cost of transportation;

3) some sites cover housing through reimbursable stipends following rotations;

4) grant and/or donations to support travel and/or housing (non-commutable externship sites) costs;

5) self-financial support; and

6) if students need additional financial aid support for housing (non-commutable externship sites), the Associate Dean for Community Partnerships and Access to Care can provide a Letter of Financial Aid Support, which will increase the funds allotted for the dental students.

vii. Who pays for accommodations?

(ASDOH) – It varies; sometimes the site will provide accommodations or give the student a stipend. Other sites, where students should pay for the accommodation.

(CNU) –

(USC) – State funding available for distant rotation sites to cover housing and mileage.

(LL) – No accommodations are needed.

(MU) – None needed.

(OHSU) – OHSU.

(PNU) – The students.

(*UA) – Access for all: Metis Nation of Alberta (MNA) funds accommodations right now, and hopefully the OHAF (Oral health access fund) grant going forward. student placement agreements at the college level for five years, and CAC agreements with faculty members attending

Satellite: accommodations are provided in all three locations. The school pays for the housing. We have long-term lease agreements with houses within the communities. We rent a side-by-side duplex in HL (one side for staff, one side for students, and a up-down duplex in McLennan (top floor students, main floor instructor, and two units in row housing (one for students, one for staff).

(*UBC) – All rotations are local so no accommodation expenses.

(UCLA) – UCLA from CBCE acquired grants.

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(UoP) – We have several grants that reimburse students for travel and accommodations at some of the distant sites.

(UU) – The University Students that require travel to our St George clinic receive a food and hotel accommodations for the week they are there.

(UW) – Clinic sites pay a per diem fee for rotations that covers all travel, housing, staff, and faculty costs.

(WU) – Students through financial aid/self, externship site, or through grants/donations.

viii. How are faculty/preceptors calibrated?

(ASDOH) – The receptors are invited and encouraged to attend annual calibration, and there are several recorded lectures and videos that they can watch. The director and the staff visit the site and calibrate them also.

(CNU) –

(USC) – Same standards as in the school, clinical protocols and materials are the same. In-person calibration or online calibration. Due to calibration reasons, and due to CODA, only daily experiences no competencies

(LL) – Through our departmental Calibration program, which is online, the same as other faculty.

(MU) – 2 sites have MWU faculty, other sites have MWU alumni as preceptors.

(OHSU) – The Division of Dental Public Health has a link to a collection of modules that were created by each department at OHSU's School of Dentistry, which are used to calibrate the preceptors. In order to become a preceptor, individuals must complete all of the modules as training.

(PNU) – Supervising faculty attend calibration sessions at the main campus before starting their teaching position.

(*UA) – Either existing faculty attend or on-boarded part time members (get a virtual orientation session: 2-3 months prior to the trips and satellite instructor manual is shared with all instructors)

(*UBC) – Varies from different sites.

(UCLA) – Once a year a calibration retreat where each section gives a lecture to calibrate the preceptors.

(UoP) – Via online modules.

(UU) – They are calibrated with the rest of the faculty through live teams presentations that are recorded so they can be watched asynchronously if they are unable to watch live.

(UW) – All new sites complete online calibration through presentations by faculty from each department in the school. Then ongoing annually at an in-person calibration session where school faculty present and rotation standards are reviewed.

(WU) – 1. Faculty preceptors all receive an online Onboarding Toolkit from our Community-Based Dental Education team upon receiving their certificate of becoming an Externship WesternU Clinical Assistant Professor Adjunct Faculty Preceptor.

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2. In addition, an annual in-person site visit occurs in which at times, some FQHCs prefer a full meeting session with all faculty, while others prefer the lead dentists to receive the training and utilize a "train the trainer" dissemination. Furthermore, an annual in-person and virtual full-day CE symposium is provided for all Externship preceptors which includes calibration review and updates.

3. On a more regular basis, all Dental Directors and lead dentists receive monthly calibration emails and updates and have access to a WesternU Adjunct Faculty website with all calibration materials and training courses available to them.

b. How are patients managed after the completion of their comprehensive care?

(ASDOH) – After completing the comprehensive exam Students will meet with their CCUU directors to develop a patient treatment plan following the sequence of phases taught in the Treatment Planning module. They will consult with specialty directors as needed.

(CNU) – The patients are managed with ongoing care by the group practice.

(USC) – Treatment outcome assessment exam. Discontinuation of dental hygiene program, patients are dismissed from the dental school after completion of their comprehensive care and are referred to local dentists for continuation of care/recall. Perio recall.

(LL) – Once a pt has completed their comprehensive care, they are transitioned into the maintenance phase of dental care. This involves: Recall Exams, Preventive Recall Appt, Urgent/Emergency Care Availability.

(MU) – Students completed case assessment and then faculty not involved with the case verifies the assessment.

(OHSU) –

(PNU) – Since our students are at the FQHC for 3 years, they will manage ongoing care.

(*UA) –

(*UBC) – Recall system for 2 years by DMD, if no more restorative.

(UCLA) –

(UoP) –

(UU) –

(UW) – End of treatment assessment exam.

(WU) –

i. Ongoing recall/hygiene by students?

(ASDOH) – The students in the same group will follow up on recalls. In addition, we have 3 Hygienists who will follow up on recalls.

(CNU) – Mainly DS3 students will be doing the recare appointments.

(USC) – Treatment outcome assessment exam. Discontinuation of dental hygiene program, patients are dismissed from the dental school after completion of their comprehensive care and are referred to local dentists for continuation of care/recall. Perio recall.

(LL) – Recall Exams; Pts are scheduled for POE at intervals determined by their individual risk level-typically every 3,6, or 12 months to assess for new caries, Perio status, etc.

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Preventive Recall Appt; These include prophylaxis, oral hygiene reinforcement, and review of home care practice.

Urgent/Emergency Care Availability; Pt are advised to contact the clinic if they experience any urgent dental needs between scheduled visits. Ex, pain of fractured restoration, lost filling, trauma or swelling.

(MU) – The hygiene is usually done by the hygienists or the hygiene students. Students do the periodic exam. PAs in the suite schedule those appointments.

(OHSU) – Yes. Patients are given an exam at the completion of treatment and then placed on recall status. Students have patients return every 6 months for a periodic exam and cleaning. This creates a burden for our students in that they do a lot of hygiene procedures. We do not have a hygiene school on site and are looking to partner with local hygiene schools.

(PNU) – Yes.

(*UA) – Scheduled for recall exam with DDS ¾ and hygiene with DH.

(*UBC) – When the patients are dismissed, they go to hygiene students.

(UCLA) – Yes, regular recalls and perio maintenance appointments are scheduled.

(UoP) – Students complete a form on Axium (Case completion), which confirms that all the comprehensive care has been completed. Patient is also monitored for their hygiene recall intervals through a pop up on Axium. If a case is transferred from a graduating senior to a junior, each patient gets an exam appointment even if they are mid-treatment

(UU) – Ongoing recall and hygiene are maintained by the students and GPL's. Recall is expected to be performed according to patient, if any have fallen through the cracks they are picked up during chart audits.

(UW) – a. Annual exams, b. Hygiene at the appropriate intervals, c. The recall system is currently being developed

(WU) – Ongoing recall/hygiene is completed by students after comprehensive care is completed. A lot of times these are done by new D3s entering clinic. We are exploring affiliations with local dental hygiene schools; however, space is an issue.

c. Describe challenges you are experiencing related to the Gen-Z student learner?

(ASDOH) – Entitlement. Attendance and tardiness are issues. Want to know what is on the exam. Happy with a minimum passing grade. Depend on technology for answers, a lack of critical thinking. Not patient, just needs to be done

(CNU) – Gen Z learners struggle with learning on their own. They want a video or be spoon fed material. They struggle with looking up information and finding their own answer to questions.

(USC) – They are easily stressed out, more support is needed and expected. They ask for visual and interactive content, hands-on demonstration, and have a short attention span. They are tech savvy, try to obtain information from alternative sources that teach things differently.

(LL) – Shortened Attention Spans and Digital Distractions: Gen-Z students are multitasking across devices. This leads to difficulty maintaining focus during lecture time. Preference for On-Demand Learning: They gravitate toward short, modular content (videos). High

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Expectations for immediate feedback: They expect rapid feedback and personalized guidance, which sometimes can be difficult to provide in large class sizes.

(MU) – Most all of the students are highly dedicated and motivated, but the more challenging students possess the following qualities:

- High expectations of faculty and administration regarding immediate feedback, email replies/requests...

- Different learning styles, strategies, and backgrounds (lecture attendance, presence in the clinic)

- They need more support and are motivated differently.

(OHSU) – We are experiencing challenges with late arrival to class, early departure from class, and overall issues with time management. We have seen a steady increase in students who need academic assistance and accommodations.

(PNU) – We are in our 8th week of teaching—we will get back to you.

(*UA) – We have a variety of students with different cultural backgrounds. Most common challenge: Short attention span when doing live demos. More dependent on technology. Increased number of accommodation requests (not sure if that is a gen z issue).

(*UBC) – They go for shortcuts, they are not very ambitious and want to do less. They prefer instructors to do. Some students are very entitled, demanding, and not so professional or polite.

(UCLA) – Keeping the students engaged during lecture. Challenges with attendance. Frequently asking for a reduction in requirements and always complaining about their patient pool.

(UoP) – Short attention span. Poor attendance (lecture recordings available). Everything must be laid out step by step. No critical thinking. Easy access to information created a sense of laziness and not appreciating the information they receive. Gen-Z students are digital natives, most confined to communicating and interacting through their digital devices

(UU) – Many students demonstrate strong digital fluency but can struggle with persistence and focus during longer, hands-on or self-directed skill development sessions. Additionally, their comfort with technology can sometimes outpace their interpersonal confidence, necessitating more emphasis on communication, professional judgment, and resilience in the clinical setting.

(UW) – Attached to electronics. AI use for written assignments. Less in-person participation.

(WU) – Not reading the posted material for sessions or not reading instructions beforehand when they know faculty help is available during a lab session. Differences in communication styles affect their ultimate ability to meet the expectations of other generations and gain trust.

d. What strategies are you using to more effectively teach the next generation of dentists?

(ASDOH) – Use interactive platforms (Kahoot, Poll Everywhere, Quizlet) for quick engagement.

- incorporate simulation tools, VR/AR, or digital case studies that mirror real-life practice.
- Provide digital study aids like podcasts or short video summaries.

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- Use flipped classrooms: assign pre-class videos or readings, and use class time for problem-solving, discussion, or hands-on work.
- Encourage peer teaching — students learn well by explaining concepts to each other. Share short patient stories or ethical dilemmas to spark curiosity and discussion.

Encourage critical thinking over memorization, Ask “why” and “what if” questions rather than only testing recall.

Provide frequent, constructive feedback, and short, timely feedback keeps them engaged and motivated.

(CNU) – Videos of preparations I find very helpful. Students of this generation are so used to YouTube and TikTok that they are trained to see things this way.

(USC) –

(LL) – To more effectively engage and prepare students, we are using student centered approach that incorporates both traditional rigor and modern learning as well as interactive learning.

(MU) –

(OHSU) –

(PNU) – Using teaching techniques derived from adult learning principles.

(*UA) –

(*UBC) – We emphasize the importance of being ethical and professional, as these values are fundamental to their future careers, beyond mastering specific techniques. Our approach focuses on creating a positive and supportive learning environment that actively engages students, encouraging reflection, critical thinking, and lifelong learning.

(UCLA) –

(UoP) – It is vital to understand the relationship of our students with technology and use these understandings and relations as a teaching and learning tool. Watching demos and tutorials ahead of time. Different modalities of teaching – lecture, videos, flipped classrooms, small group seminars. Helix model to where we present something basic, then review it in a future lecture, and expand on it and so on.

(UU) –

(UW) –

(WU) –

i. Techniques?

(ASDOH) –

(CNU) –

(USC) – More and more incorporation of digital dentistry, more and more videos, lecture quizzes to keep them engaged during live and recorded lecture, starting to introduce podcasts (Bites of dental wisdom)

(LL) – We embed hands-on activities to make learning more interactive and clinically relevant. Like working on DTX teeth -D2. Students are given real-world scenarios that require critical thinking and decision-making, which helps bridge theory and clinical application. We offer short videos, and quizzes that accommodate short attention spans. We foster a supportive, inclusive learning

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space that encourages questions, reflections, and growth. Clear expectations and transparency in grading.

(MU) – Case discussions and weekly emails, Pre-recorded lectures, Only selected lectures are mandatory, More 1 on 1 instruction and small groups.

(OHSU) – Our students have OHSU issued iPads. We utilize APPs to help with student learning. We have textbooks online. Some courses utilized the flipped classroom. We have DS4 TAs in our courses as a bridge between faculty and students.

(PNU) – Establish safe environment, describe relevance, embed formative quizzes, and describe take home points.

(*UA) – We use PPT for lectures. I try to include platforms like Mentimeter, Nearpod to make the lecture more interactive and incorporate learning activities.

(*UBC) – Active learning, technology, gamification, positive learning environment.

(UCLA) – Live demos; Animation to show preps and restorations; 3D-printed models of preps.

(UoP) –

(UU) – We are a small institution that allows faculty to try new things. Some have tried flipped classroom, short presentations/videos that the students make, some have continued to present slide decks. There is good collaboration between the faculty so others can implement these techniques if they choose.

(UW) – a. Interactive classroom presentations, b. Pre-recorded short lectures, followed by Interactive classroom seminars, c. Short videos to demonstrate procedures, d. Digital workflow in the clinics.

(WU) – Demonstrations of procedures before they do it on their own, some faculty do a follow-along type of instruction during the very first session of a new module.

ii. Delivery of student feedback?

(ASDOH) –

(CNU) – Feedback is delivered in a softer manner to help ensure that the student understands what is needed.

(USC) – Feedback on sign-off or grading sheet during preclinical sessions or on LMS on student submissions and pictures taken by students. or in Axiom during clinical session. Same rubrics in preclinic and clinic. Review of exam results on Examsoft. Meeting with faculty for feedback and separate form by faculty for students who had low performance, especially before sending students to SPPEC. Regular meetings with students for feedback ASB, dean, associate deans, and administration. Surveys by module directors to improve module content.

(LL) – We utilized formal and informal mechanism to provide students with timely constructive feedback that supports their growth. Immediate chairside or bench side feedback is provided during pt care or simulation exercises, which allows for correction of technique and development of critical thinking. We use standardized Rubrics aligned with preclinical competencies, ADEX style Criteria, to ensure consistency. At the end of each course, students provide anonymous feedback through course evaluations. We review these evaluations to identify teaching

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strengths and opportunities for course improvement. In turn, we make instructional adjustments.

(MU) – Student liaison, Town hall, Grading criteria same and conversation – discussion of grading only with directors

(OHSU) – We encourage our faculty to use the students’ iPads to take photos of their work and the mark up tool to help communicate during our classes.

(PNU) – We do a mid-course and end-of-course evaluation.

(*UA) – Verbal feedback, written formative assessments (electronically submitted). Use a dental microscope or take a photograph of prep/resto and outline areas that need improvement. Drawings on white board.

(*UBC) – We consistently use student feedback to enhance the quality and effectiveness of our teaching and course delivery.

(UCLA) – Class leadership meeting with course chairs; course evaluations at the end of each course.

(UoP) – Exam review sessions, allocated time in the course for feedback after practicals, in clinic feedback forms on Axium. Synchronized and calibrated feedback through new technologies.

(UU) – This hasn’t changed much. In the simulation clinic, direct feedback is given day to day and through grading rubrics (in PDF form) that they get signed off and upload to Canvas. In the clinic, we give feedback for each procedure through a daily MAPS assessment. The criteria used for formative feedback in MAPS assessments are generated from the rubrics using a 3-point system (3 Exceptional, 2 Acceptable, 1 Deficient). Summative assessments are performed independently, following the appointment a MAPS summative assessment is filled out with the same criteria, but a grade scale of Acceptable (Pass) or Deficient (Failed)

(UW) – a. Encouraging student participation during class including feedback, b. Quarterly student feedback about the course.

(WU) – 1. We have meetings with student reps for each class every two weeks, where we receive a lot of feedback on which methods students liked best and what they would like to see more of. We also have course evaluations where we receive feedback from students. 2. We try to provide feedback as quickly as possible; this closes the learning loop faster and provides the opportunity for the student to utilize the feedback with minimal wasted time.

iii. Videos for preparation/restoration?

(ASDOH) –

(CNU) –

(USC) – Videos about various procedures, created by faculty members, are posted on LMS and school’s intranet. Some videos created by students.

(LL) – Faculty performed ideal preps and restorations recordings, procedures-based videos, (Preparations & Restorations-YouTube), as well as fixed Prosthodontics.

(MU) – More videos and instruction that way for information and resources-Canvas.

(OHSU) – We have videos for operative procedures.

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(PNU) – Yes, we use videos.

(*UA) – Yes, we try to incorporate more demo videos in addition to live demos. We include students in video making progress as learning activity (graded assessment, they get to work in groups of 4 students).

(*UBC) – Yes, as many as possible.

(UCLA) – Digital library that contains step-by-step videos for common preparation/restoration.

(UoP) – Yes.

(UU) – These are available depending on the class. Some have more recorded videos, and some have less.

(UW) – a. Videos posted online, b. Use of independent educational platforms, such as Spear Education Online.

(WU) – A lot of our faculty have videos on prep/resto for direct restorations, we have videos on digital dentistry, periodontics, operative.

II. **Materials and Techniques**

a. What types of materials and strategies are used for vital/non-vital pulp therapy?

(ASDOH) – Vital pulp therapy: Deep caries lesion with reversible pulpitis, selective caries removal (Indirect pulp cap) using a Glass ionomer liner (Vitrebond) or Theralcal.

If caries exposure occurs, direct pulp cap. Dycal, Theralcal or Endosequence. If deep caries lesions with signs and symptoms or irreversible pulpitis, partial or full pulpotomy using Endosequence, then a glass ionomer liner and composite filling. Non-vital pulp therapy: Pulpotomy or pulpectomy.

(CNU) – For vital therapy we are using bioceramic materials like MTA or biodentin. For non-vital therapy it is non-surgical root canal therapy with bioceramic sealer and a single cone technique.

(USC) – Vital: Don't do indirect pulp capping. Advocate stepwise excavation. Rubber dam for deep cavities, scheduled in endo section in case of anticipated exposure. If mechanical pulp exposure with caries free surrounding tissue direct pulp capping with bioceramics (EndoSequence BC RRM or EndoSequence BC RRM Fast Set Putty). Liner: GC Fuji Liner LC. Restore. If caries still surrounding exposure site, then RCT.

Non-vital: files, irrigation with NaOCl, irrigation with EDTA, CaOH medication, epoxy-based sealer (Thermaseal Plus), bioceramic based sealer (EndoSequence BC Sealers), gutta percha with modified lateral condensation, blue orifice barrier (EndoSequence BC Liner)

(LL) – Vital Pulp Therapy

a. Indirect pulp cap for deep caries, no exposure. We use CaOH, Ultrablend, RMGIC

b. Direct pulp cap for small exposure, controlled bleeding. We use MTA, CaOH

Non-Vital Pulp Therapy

a. RCT - Irreversible pulpitis, pulp necrosis, symptomatic or asymptomatic apical periodontitis. Use NaOCl, EDTA, CaOH, GP with Sealer

b. Apexification – Close apex in non-vital immature teeth. Use MTA

Common Disinfectants and Sealers:

-Sodium Hypochlorite NaOCl for irrigation

-Calcium Hydroxide as a medicament in multi-visit cases

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-Gutta-percha with sealers like EndoSequence

(MU) – Vital non-mature apex: EDTA and NaHCl irrigation, rinse and MTA or Bioceramic, flowable at pulpal floor, cotton pellet and IRM

Vital mature apex: RCT

Necrotic non-mature apex: EDTA and NaHCl irrigation, CaOH in canal. Wait 2-3 weeks, access it, irrigate with EDTA, file used to stimulate bleeding in the apex or patient's blood inserted in the canal, collagen barrier and MTA or bioceramic putty, flowable on the pulpal floor, cotton pellet and IRM

(OHSU) – For vital pulp therapy we encourage both indirect and direct pulp capping procedures. The Restorative department maintains that an indirect pulp cap with selective caries removal is the treatment of choice for direct restorations. In this case we use CaOH (Life) sealed with glass ionomer (Vitrabond) and a definitive direct restoration. In the case of an inadvertent pulp exposure, we support the use of a direct pulp cap. Once hemostasis is achieved, we use a Bioceramic for the direct pulp cap sealed with Vitrabond and a direct restoration.

(PNU) – We haven't taught this topic to the students yet. It is planned for the second year.

(*UA) – We try to avoid direct pulp capping due to selective caries removal technique.

We do have Theracem. Used for indirect pulp capping, but rarely (we prefer bonding to tooth structure after selective caries removal)

Preferred for direct pulp capping is neo MTA and vitrebond as base.

We don't do liners under composite. Might do vitrebond base under deep amalgam restos. Gluma as desensitizer under Ag restos.

non-vital pulp therapy: Irrigation: NaOCl, Qmix; RC filling: Sealer and Guttapercha.

(*UBC) – At UBC vital and non-vital pulp therapy are performed following the principles outlined in the Canadian Academy of Endodontics Standards of Practice, with adaptations to align with evidence-based and minimally invasive approaches taught in the undergraduate curriculum.

For vital pulp therapy, strategies include protective bases, indirect and direct pulp capping, and partial pulpotomies, aimed at preserving pulpal vitality when the pulp is reversibly inflamed or exposed under controlled conditions. Materials used include calcium hydroxide and bioceramic materials such as Mineral Trioxide Aggregate (MTA) or Biodentine. All procedures are performed under rubber dam isolation, following aseptic protocols, and restored with materials that ensure a durable coronal seal to prevent microleakage.

For non-vital pulp therapy, or when the pulp is necrotic or irreversibly inflamed, UBC follows standard endodontic protocols emphasizing thorough chemo-mechanical debridement and disinfection of the root canal system using sodium hypochlorite, EDTA, and calcium hydroxide as intracanal medicament when indicated. The canals are obturated with gutta-percha and resin-based sealers using warm vertical or lateral condensation techniques. In immature permanent teeth, apexification with MTA or regenerative endodontic procedures may be indicated to promote continued root development. All treatments are completed under rubber dam isolation, with radiographic and clinical follow-up to ensure healing and long-term success.

(UCLA) – Vital and non-vital pulp therapy both are done with proper rubber dam isolation.

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Vital pulp therapy: Indirect pulp capping is indicated if the tooth is asymptomatic and the caries are in close proximity to the pulp. Caries has to be cleaned-out from all the walls around the pulpal floor and the DEJ must be clear of any caries. To avoid pulp exposure pulpal floor should be carefully cleaned out and minimal caries can be left out. Materials used are RMGI-based liners.

Direct pulp capping is indicated if the tooth is asymptomatic and either mechanical or pathological exposure has occurred. Bleeding has to be stopped by placing NaOCl-soaked cotton pellet over the exposure for 2 mins and no more than 10 mins. After hemostasis, 2% Chlorhexidine soaked cotton pellet is placed for 2 mins to disinfect the area. MTA-based material is later applied over the exposure. Following that, a RMGI-based liner is used before restoring the tooth.

Non-vital pulp therapy: RCT is recommended for necrotic and symptomatic teeth. Root canal therapy is done under the supervision of the Endo section in Endo clinic utilizing rotary instruments and GP obturation.

(UoP) – Vital pulp therapy (VPT) is done on teeth with vital pulps. If the apex is still immature, vital pulp therapy is always recommended by either pulp capping with a bioceramic material or pulpotomy and placement of a bioceramic material over the pulp stumps.

The bioceramics used at the school are Biodentine, MTA, and BC Putty.

For teeth with mature apices, VPT is considered when the procedure can be done aseptically, the pulp bleeding can be controlled within 5-10 minutes with a sodium hypochlorite-soaked cotton pellet, a bioceramic material is used, and the tooth can be restored immediately.

For non-vital (necrotic) pulps, if the apex is immature, the residents can perform regenerative endodontics which involves rubber dam, access, working length determination, irrigation with 20ml 1.5% NaOCl, and medication with calcium hydroxide. The second visit is done about a month later and the tooth is anesthetized with an anesthetic without epinephrine, reopened and irrigated with 20ml 17%EDTA. Bleeding is stimulated into the canal up to the CEJ level, a collagen barrier is placed on top of the blood clot, a bioceramic is placed on top of that and then the tooth restored. The patient is then monitored.

Alternatively, if the apex is immature, a collagen barrier can be placed at the open apex and a plug of bioceramic can be used for "instant apexification".

For mature teeth with a necrotic pulp, RCT is recommended. This includes anesthesia, rubber dam, access, electronic apex locator, WL determination, radiographs, creating a glide path to a loose #15 file followed by the use of a 25/0.06 Brasseler ESR reciprocating file, followed by a 30/0.04 ESR file. Calcium hydroxide is used as an intracanal medicament which is placed with a paper point or file. 2.5% NaOCl is used as an irrigant in the pre-doc clinic. Obturation is done with a single GP cone and Bioceramic (BC) Sealer. Temporization is done with a sponge and Fuji Triage.

(UU) – At the University of Utah School of Dentistry, vital pulp therapy utilizes calcium silicate-based materials such as MTA, Biodentine, and Endosequence Root Repair Material (ERRM) for their biocompatibility, antibacterial properties, and ability to promote

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predictable dentin bridge formation. All procedures are completed under rubber dam isolation with sodium hypochlorite disinfection and immediate placement of a bacteria-tight permanent restoration. Case selection emphasizes teeth with vital pulp responses, controlled bleeding, and no radiographic evidence of periapical disease.

(UW) – a. Dycal, Vitrabond, b. MTA.

(WU) – Dycal/Vitrebond (RMGI Liner), Bioceramic (putty and liner)

b. Treatment planning

i. Describe the treatment planning process at your institution.

(ASDOH) – Didactic module. We have a treatment planning module that is taught in the fall of D2 year and continues with case presentations during the spring Semester. In addition, each disciplines teach treatment planning in their specific modules too. Several sessions also presented during the D3 year in regards to Treatment planning after the student’s transition to the clinic.

(CNU) – Treatment planning is a hot topic at our university, we are still in the process of determining who “owns” the plan so that it won’t be modified by each faculty member. Right now the push is for our Group Practice Leaders to be the owner of the treatment plan and the ones to approve a change in the plan.

(USC) – In clinic: Patient who seek treatment in the dental student clinic are seen for a screening and data collection visit by any faculty member. Then a separate comprehensive treatment planning visit is scheduled with Group Practice Director (GPD).

(LL) – The treatment planning process at LLUSD is a comprehensive, patient-centered, and evidence-based approach that integrates diagnostic findings, and clinical judgment to deliver ethical and effective dental care.

a. Comprehensive Examination COE

- Full medical and dental history review
- Head and neck exam
- Intraoral exam
- Periodontal charting
- Occlusal assessment
- Diagnostic radiographs and clinical photographs
- Diagnostic impressions and digital scans if there are missing teeth to be replaced.

b. Problem List Development

- Based on exam findings
 - Includes disease conditions, missing or non-restorable teeth, esthetic concerns, etc.

c. Risk Assessment

- Caries risk, periodontal risk, and systemic risk are evaluated.

d. Diagnosis and Prognosis

e. Treatment Planning by Phases

- Phase I: Emergency and disease control
- Phase II: Restorative Care
- Phase III: maintenance and recall POE

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- Optional Phase: Orthodontics, Esthetic, etc.

f. Student-Generated Plan with Supervising Faculty

g. Patient Consent and Financial Planning

h. Once accepted, Plan is activated in Axium (electronic health record system).

Appointments are scheduled by phase.

i. Periodic Re-Evaluation

(MU) – The pair of students meet with the CCC and CCFs and present the treatment plan.

(OHSU) –

(PNU) – We plan on teach a phased treatment approach. We begin with developing a trusting patient relationship; understanding patient goals and expectations; a comprehensive exam; a problem list; and a treatment plan(s) discussion.

(*UA) – We have a Comprehensive Care (CC) model. Phase 3 Tx Options presentations are submitted by students to their respective CC Directors. If they are comfortable with managing the complexity of the case, the CC Director approves the tx options and ultimately the final tx plan; if the CC Director feels the case is complex and requires tx planning overseen by a prosthodontist, student forwards Phase 3 Tx Options presentation to prosthodontist where case is discussed in Grand Rounds. Prosthodontist then approves tx options and ultimately the final tx plan.

(*UBC) –

(UCLA) – Faculty in the Section of Interdisciplinary Dentistry are responsible of initial patient screening to determine if the patient can be seen by pre-doc or post-doc practitioner. Patients then will be assigned to group practices and the Group Practice Director will then assign each patient to the students in their group. Once the patient is assigned to a student, the patient will be scheduled in Patient Assessment clinic where a treatment plan will be developed under the supervision of either their GPD or GPL. Treatment plans are finalized during that appointment with the assistance of Endo, Prosth, Perio, or Resto consultations if needed with a faculty member from the respective section.

(UoP) – Individual disciplines teach the principles of treatment planning in their own preclinical courses. There is a central ICS course where Axium training for treatment planning is taught, but the concepts of treatment planning do not converge until the student is in clinic seeing patients. In the Main clinic, the student dentist acts as the general dentist and is responsible for a comprehensive treatment plan, after referrals and consultations with specialists and other disciplines.

(UU) – Comprehensive examinations happen with each patient including all necessary radiographs, head and neck exam, dental hard tissue and complete periodontal evaluation. Students and attending faculty members then review findings and develop appropriate treatment plan following the acute, disease control, definitive, and maintenance phase model.

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(UW) – The treatment plan is designed by the dental student with advice and approval from faculty advisors. It is then delivered by the dental student.

(WU) –

1. Who “owns” the treatment plan?

(ASDOH) – The Clinical Dean and the CCU directors.

(CNU) –

(USC) – Group practice directors (GPD).

(LL) – Group practice directors (GPD).

(MU) – CCC manages treatment plans.

(OHSU) – Nobody “owns” the treatment plan, although it is reviewed and approved by faculty.

(PNU) – Provider and Patient.

(*UA) – Ultimately, the CC Director owns the patient and their management.

(*UBC) – Institution owns. The students have access to it while working on it, and instructors need to see the patient and approve the plan.

(UCLA) – Group Practice Director (GPD) and Group Practice Leader (GPL).

(UoP) – The faculty member in the clinic who swiped the comprehensive treatment plan on Axiom, the GPL.

(UU) – Ultimate responsibility for the treatment plan falls to the Group Practice Leader (GPL) of each assigned row. Specialists for each discipline, as well as a complex treatment planning committee, are resources that are available and utilized by students and GPLs in the development of the treatment plan. If minor changes need to be made at an appointment (such as additional surfaces to be treated for a direct restoration), any attending faculty member can authorize those adjustments. If major treatment plan changes arise (such as changing from an implant to a fixed partial denture), GPLs must be consulted and authorize the change in treatment plan.

(UW) – Student and faculty advisor.

(WU) – The overseeing group faculty. If a student is being seen by a PT faculty, then the TP is (ideally) reviewed by overseeing faculty before approval. Specialist input has already been received before finalizing, and tx plan re-evals are commonly used as needed.

2. Who can modify it?

(ASDOH) – CCU directors and specialty Directors.

(CNU) –

(USC) – Modification by faculty members on floor only after consultation with and approval by GPD who helped develop the treatment plan

(LL) – Attending Faculty if needed or PCMs.

(MU) – CCC or CCF in consultation with CCC and student/patients.

(OHSU) – Anyone can modify it, although faculty are reminded that this is to be avoided and any disagreements should be discussed among faculty first, before modifying the original plan.

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(PNU) – Provider with faculty approval.

(*UA) – Once approved by instructors in axiUm, the treatment plan cannot be changed. Planned treatment, however, can be deleted and new treatment can be planned with appropriate instructor approval and patient consent.

(*UBC) – They can modify, but they need approval; they can transfer to another students.

(UCLA) – After obtaining a consult from a restorative faculty to change a treatment in the tx plan, the student will work with their Group Practice Director to change it the treatment plan.

(UoP) – Anyone at this point.

(UU) – Any attending can complete minor modifications. GPLs or clinic directors must be consulted to make major modifications.

(UW) – Advising faculty member.

(WU) – Overseeing faculty. Modifications to individual parts of a tx plan may happen based on daily presentation; however, major changes are discouraged. If multiple parts of a plan require review, a tx plan re-eval will be indicated (usually with group faculty).

3. What educational methods and resources are used to teach treatment planning?

(ASDOH) – Lectures, Cases presentations and seminars.

(CNU) –

(USC) – lecture and in-person seminars, content on LMS.

(LL) – Lectures and Clinical Case-based Scenario and OSCEs.

(MU) – D1 Basic sciences cases, D2 Clinical Cases course Simulation Clinic Cases, D3 and D4 Practice Management Curriculum (3 courses), QUADS, D4s have access to Spears courses.

(OHSU) – The textbook we use is Diagnosis and Treatment Planning in Dentistry, by S. Stefanac and S. Nesbit. We have Tx planning preclinical courses which are described below. We also share with students Tx planning guidelines in the form of checklists, to assist with the administrative part of the Tx planning process.

(PNU) – Use the Stefanac book as a guide; present case studies, treatment planning exercises.

(*UA) – Lectures

and seminars (grand rounds); use of standardized cases. And individual meetings with CC Director and/or Lead to present/discuss cases.

(*UBC) – Two made up patients, presentations, get more complex and by phases. Delivered IGP coordinators.

(UCLA) – Lectures that are taught throughout the 2nd and 3rd years. Students are evaluated using case assessments and case competencies in clinic.

(UoP) – Lectures, case based discussions, Seminars and case discussions.

(UU) –

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(UW) – a. Comprehensive course at the beginning of 3rd year of dental school, b. Textbook: Stefanac: Treatment planning in Dentistry.

(WU) – Largely practice and repetition through group treatment planning in seminar. Small group and large group review sessions on Virtual Patients. Students are asked to treatment plan for a variety of virtual patients, then defend their treatment decisions to faculty.

4. Are there individual courses dedicated to treatment planning or is treatment planning embedded throughout the curriculum (discipline based)?

(ASDOH) – There is one didactic module in D2 year fall and spring but it is also embedded in whole curriculum.

(CNU) –

(USC) – Didactically: treatment planning in preclinical modules of each discipline. Additionally, comprehensive treatment planning seminars in D2 with rotations and many cases and comprehensive patient-centered treatment planning seminar in D3/D4 with real cases.

(LL) – There are Mega courses for Diagnosis and Treatment planning, Patient Center Care (PCC):

- DENT 720 A & B: For D1

- DENT 770 A & B: For D2

(MU) – Clinical Case Courses in D2 year, then cases throughout curriculum.

(OHSU) –

(PNU) –

(*UA) –

(*UBC) –

(UCLA) –

(UoP) –

(UU) –

(UW) –

(WU) –

- c. How is your institution addressing the fluoride “controversy”?

(ASDOH) – The ADA recommendations and guidelines are presented.

(CNU) – Treatment planning is taught in a course. Students are given IOE/EOE exam information, perio charting and an FMX and go through the process of treatment planning patients. This is done in a didactic course. Further, treatment planning is integrated into courses throughout the curriculum.

(USC) – Students and patients are made aware of fluoride controversy, discussing arguments out there. Clear statement to students about the benefits of fluoride and its support by evidence-based science. Use of fluoride varnish and 5000 ppm fluoride toothpaste in the CAMBRA kits. All patients must adhere to CAMBRA, otherwise they are dismissed.

(LL) – LLUSD actively addresses the fluoride controversy through education, research, and community engagement, ensuring students and patients receive accurate and evidence-based information.

(MU) – We go by the ADA recommendations.

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(OHSU) –
(PNU) –
(*UA) –
(*UBC) –
(UCLA) –
(UoP) –
(UU) –
(UW) –
(WU) –

III. **Student Assessment**

- a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?
- (ASDOH) – Our students take the laboratory section of the exam early in the D3 year and the clinical portion in the spring of the D4 year. They are scheduled for several days of practice, during which we provide practice teeth and have faculty available to offer immediate feedback. A mock exam is scheduled at the beginning of the week before the actual exam, and feedback is provided within 24 hours after the mock exam is graded.
- (CNU) – For licensing exams there is a DS4 course that is present to help the students prepare for the ADEX exam. They also have a mock board that is graded by an examiner.
- (USC) –
- (LL) – At LLUSD, we take a comprehensive and structured approach to prepare students for the ADEX licensing exam. Our strategy includes a combination of didactic review, hands-on practice, and simulated board experiences, all designed to closely mirror the actual exam format and expectations.
- (MU) –
- (OHSU) –
- (PNU) – We will use rubrics that are aligned with the licensing organizations; have mock exams.
- (*UA) – NDEB equivalent. A lot of students take preparation courses that are offered by third party (prep doctors).
- (*UBC) – Fake OSCE in December to see how stations of the real exam.
- (UCLA) –
- (UoP) – Conventional class practices and practical, testing students on the rubrics, mock boards. We have a two quarter course for ADEX preparation.
- (UU) – We prepare our students for the ADEX exam.
- (UW) –
- (WU) –
- i. Classroom instruction related to the exam process?
- (ASDOH) – Yes
- (CNU) –
- (USC) – Classroom orientation session about the exam process. Additionally, SIM lab time given to D4 students for practicing in January and February. A teeth will be provided to the students to practice.

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(LL) – We developed a targeted course specifically for ADEX preparation for the D4/IDP4 students. It includes lecture reviews aligned with ADEX rubrics, emphasis on ideal prep designs, criteria-based grading, and procedural efficacy.

Also, hands-on practice sessions are scheduled for each component; Class III, Class II, Anterior Crown, Posterior 3-units Bridge, Endo anterior and posterior teeth, and Perio scaling. Faculty use ADEX- rubrics.

(MU) – Prep course in D3 summer (PEP) – 2 lectures for the restorative component (D4 year).

(OHSU) – Faculty in charge of the Mock exam have created power point presentations describing the exam format and with instructions for success on the exam. These are presented live on WebEx and distributed as recordings for students to review. The CDE department also hosts Q and A sessions for students who are considering taking ADEX. Out of each class (78 max graduates) around 40-50 students choose to take the ADEX. The rest of the students take the DLOSCE. Oregon and Washington state both accept the DLOSCE for licensure.

(PNU) – Yes.

(*UA) – Yes, review sessions are being offered for each discipline.

(*UBC) – Review lectures IGP IV.

(UCLA) – The restorative section has an ownership over both the Operative and Prosthodontics sections of the ADEX exam. We hold a classroom session for each exam section before the Mock exam and another classroom section for each section after the Mock exam.

(UoP) – Yes.

(UU) – There is a course that meets weekly called Clinical Challenges. We provide lectures and material for the students to prepare and allow for practice/feedback during the class session.

(UW) – Yes.

(WU) – There is dedicated classroom instruction and prep time on typodonts in year 4, especially going over examination protocols and techniques for ADEX and rubrics.

ii. Mock boards?

(ASDOH) – Yes

(CNU) –

(USC) – A mock board is administered close to the actual board exam date in February. Different sections take place at different dates.

(LL) – We hold a full 2 days mock board that replicates the structure, timing, and scoring of the actual ADEX exam. Students are evaluated under exam-like conditions:

- Accidental DTX teeth
- Self-assessment and faculty evaluation
- Use of the same instrumentation and infection control protocols as the live exam
- Students who require additional help, we have Remediation of the mock board with faculty mentorship and practice plans.

(MU) – Yes, competency mock board needed to pass to sit for exam (not for perio).

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(OHSU) – The Restorative Department holds a Mock board for the Pros section of the exam in the Fall approximately one month prior to the ADEX pros exam and a REST mock exam in the Spring one month prior to the ADEX restorative exam. The endo department holds a mock exam for the endo section of the exam.

(PNU) – Yes.

(*UA) – Yes.

(*UBC) –

(UCLA) – Yes, mock boards are usually held a couple months before the actual ADEX exam. The mock exam follows that format of the exam including using the same grading forms.

(UoP) – Yes.

(UU) – We try our hardest to mimic the board exam during our mock boards. We have 2 mock boards, the first relating to the Prosth, Endo, Perio exam. The second is for the Restorative exam. We have floor examiners for setup and to run the exam and in a separate lab we have graders ready to grade or look at modification requests. It is organized so we can get mod requests submitted the way they would do it on the exam and have the grading area organized to get mod requests out as soon as possible.

(UW) – Yes.

(WU) – A mock ADEX is facilitated in mid-February. Students receive detailed feedback and have dedicated sim practice times with faculty present for feedback between the mock and actual ADEX dates at the end of March.

b. How are students assessed when scheduled on external rotations?

(ASDOH) – External faculty will send a report about the students at the end of the rotation besides the open communication while students are in rotation.

(CNU) – The students are assessed by the preceptors at the end of their rotation.

(USC) – Students are assessed on procedures on external rotations according to the same criteria used in the internal student clinic.

(LL) – We are in the process of creating these assessments to mirror the ones we have on our main campus.

(MU) – Faculty completes an evaluation and the students submits a reflective report and evaluate the faculty. But grades are not considered.

(OHSU) – Student evaluation forms are completed by the Group Practice Leader (GPL) and the student prior to their first external rotation. The assessment has 13 experiential points with an overall assessment and considers not only if a student can manage the clinical care for patients in the community but also assesses a student's cultural sensitivity and humility to work in the community. This self-assessment with the Group Leader provides an opportunity for students to reflect on their expectations for the community-based experience and clinical experiences, and how the extramural experiences will contribute to the students' learning. This same assessment is then completed at 4 weeks (formative), and 8 weeks (summative) by the preceptor with the student. The preceptor evaluation is an integral part of the program. The assessment specifically addresses each student's experiential learning associated with the goals and objectives of the rotation. The

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preceptor's feedback is reviewed by the Course Director to establish if the student has passed the course.

(PNU) – We will use our established rubrics.

(*UA) – I believe they only receive verbal feedback, unless there is a violation or critical error or professionalism infraction.

(*UBC) – Written assessment and same assessment on Axium in geriatric rotation.

(UCLA) – Students' daily work is assessed by site preceptor. Some of the sites' dentists are qualified to cover a clinical skill assessments. In these sites, students are allowed to complete case assessment only, no case competencies are allowed in external rotations.

(UoP) – They are assessed through a formal online survey by the faculty at the site.

(UU) – We use the same MAPS assessment form that is used at the Wakara clinic.

(UW) – Grading forms completed by preceptors.

(WU) – We use e-value that tracks their procedures... and a weekly Formative Feedback form is completed by preceptors during their seven-week externship rotation. All Externship sites are considered Minor Educational Activity Site Reports, and no competency exams or assessments are completed at the sites. However, formative feedback is completed through daily self- and faculty assessments, which are completed through the use of an online platform. It is student-driven, the faculty preceptors receive an email notification once the student has completed the daily assessment, and the faculty preceptor completes the daily assessment of the student, which is based on both technical, professional, and other core skills. All data is cumulated into a live electronic platform in which the on-campus Community-Based Dental Education team can intervene if a faculty preceptor has requested an intervention or critical concern of a student. An electronic final evaluation is also completed at the end of the externship rotation both from the student of the site as well as of the student from all the faculty preceptors.

i. Do you count those procedures for meeting requirements?

(ASDOH) – Not at this time, we do not have minimum requirements.

(CNU) –

(USC) – Procedures count towards overall experiences, but only as daily evaluations. Competency exams must be performed in-house.

(LL) – Not Currently.

(MU) – No, except for SVDP (pedo) that is a major educational site, staffed by MWU faculty and, they can challenge pedo competency.

(OHSU) – Procedures completed at the Russell Street clinic count towards meeting requirements. Endodontic procedures at all sites are counted toward meeting requirements.

(PNU) – Since they are not at a rotation site, but part of a PNWU clinic within a FQHC, all completed work counts for meeting requirements.

(*UA) – Yes.

(*UBC) – No.

(UCLA) –

(UoP) – Not currently.

(UU) – We do count each step of a procedure they perform as far as requirements go, they also receive RVU's towards graduation requirements. Students are

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allowed to perform summative assessments (only for pediatrics) at two of the 5 rotations (south main and liberty clinics). We do not see pediatrics at the Wakara clinic so they are allowed to challenge them here.

(UW) – If a student completes two Service Learning Rotations, each of which is 5 weeks in duration, then some of the procedures may be counted towards clinical requirements.

(WU) – Yes, they do for overall accomplishments. Our preference would be to have their formative experiences to qualify for demonstration of competency to occur within our campus clinic to ensure their readiness by those who will be grading it.

IV. **Administration**

- a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?

(ASDOH) – We do our best not to bother each other while we are away. There is wellness program. If you are approved by your supervisor, you could have 30 minutes three times a week for wellness. The university schedules entertainment events for employees.

(CNU) – There really are not strategies for this. As a new program we are all trying to make this work.

(USC) – USC provides support through the WorkWell Center that is available for students, staff, and faculty. It coordinates mental health and wellness programs, offers counseling, coaching, and consulting.

(LL) – As part of LLUSD's Christian faith-based heritage, we have a strong emphasis on spirituality and wholeness. Our University's motto is "To make man whole." Thus, we focus on not just our physical needs, but also our mental and spiritual needs. We emphasize taking care of our physical bodies by abstaining from harmful habits and focusing on good nutrition (encouraging a more plant-based diet), we hope our people will live healthier and happier lives.

We also have policies that support work-life balance. One of the policies we hold is related to what we believe is the biblical Sabbath. Employees at LLUSD are highly encouraged NOT to engage in any work-related activities from sundown on Friday to sundown on Saturday. (the exception being service activities).

(MU) – University PTO and benefits are very good. HR in-services. WFH opportunity during student breaks. Offered 0.9 to clinical faculty.

(OHSU) – Healthy sleep, exercise, time in nature, and with family.

(PNU) – I practice Pilates and meditation.

(*UA) – None.

(*UBC) – Strategies encouraged at the institutional level include thoughtful workload planning, equitable distribution of teaching, research, and service responsibilities, and the promotion of clear boundaries between professional and personal time. Opportunities for flexible scheduling and the option to work remotely, where appropriate, also contribute to promoting a sustainable and balanced professional environment..

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(UCLA) – The section hold regular faculty group meetings to discuss workload and brainstorm how to improve teamwork in an effort to maintain a successful work/life balance.

(UoP) – There is a wellness committee that arranges activities. Taking time off during the weeks the students are away. Being respectful of faculty time outside of official working hours.

(UU) – I think when we talk about work/life balance, the thing we are referring to is time. The school tries to be reasonable with faculty time as they are developing and delivering content. There is admin time that is available for course development. Some may say that it is not enough, but at least there is time offered. Administration is usually sensitive to faculty needs (time) and tries to not over-burden. Dr. Keddington is working on evaluating faculty time and responsibilities.

(UW) – a. Students are provided with a day-long lecture and group exercise or work/life balance. b. Office of student services has support available for students who struggle to maintain a proper balance or request help.

(WU) – Benefits help. Use vacation and sick days as indicated. Recommended to use them between semesters, but groups do well to cover during absences.

Various development sessions with external speakers.

- b.** What assistance in terms of initiatives/support/strategies does your school/university provide?

(ASDOH) – Provides entertainment events.

(CNU) – N/A

(USC) – USC provides support through the WorkWell Center that is available for students, staff, and faculty. It coordinates mental health and wellness programs, offers counseling, coaching, and consulting.

(LL) – This important responsibility is shared between multiple entities within the University and the School. Being a faith based private institution, much of these efforts are based upon spiritual wholeness and well-being. Our department starts every day with a virtual huddle with all faculty and we begin with prayer and positive thoughts.

There are multiple committees for “Spiritual Life and Wholeness” that focus on creating opportunities for faculty. The Faculty Development Committee also is involved in supporting faculty in this area. On a quarterly basis, LLUSD holds a “Faculty Advance Seminar” that often has topics about wholeness and balance for faculty and staff.

(MU) – PTO and floaters to cover in clinic and preclinic. Webinars and wellness activities. HR resources: counseling/coaching/leave/tuition/childcare reimbursement

(OHSU) – OHSU has employee benefits aimed to support wellness. SPARK is one such initiate. After COVID there are more counseling services provided through Occupational Health.

(PNU) – Academic support, Research opportunities or scholarships, Support for teaching innovation, Faculty development training.

(*UA) – Online resources on UofA website available for staff and students. Sometimes there are workshops. There is a wellness retreat summit once a year, but I have yet to attend.

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(*UBC) – The University of British Columbia provides a broad range of supports and initiatives aimed at promoting work-life balance for faculty members. These include flexible work arrangements, comprehensive vacation and leave policies (such as parental, family, and personal leave) outlined in the UBC Faculty Collective Agreement, and access to wellness resources. The Employee and Family Assistance Program (EFAP) offers confidential counselling, mental health support, and resources for managing work-life challenges.

Within the Faculty of Dentistry, additional supports include access to an on-site counsellor, student services initiatives such as Puppy Day, social and community-building events, and opportunities for informal engagement such as Coffee with the Dean. The Faculty also fosters collegiality and well-being through mentorship opportunities and regular professional development activities, creating a supportive and sustainable work environment.

(UCLA) – Currently, the school is going a rough financial period. The resources are limited but there are some wellness and cultural initiatives.

(UoP) – See [previous].

(UU) – U Health and the University also have areas of support for faculty such as the Resiliency Center and other counseling benefits to aid in the development of strategies to gain better life-balance. Dean Hume and some other deans always attach links at the bottom of their email to remind people of the help that is there. You never know when someone may be struggling so I think it is a good reminder and support system.

(UW) – See [previous].

(WU) – Benefits. There are faculty intramural grants available for research, university resources for capital improvements and planning, project management.

c. Calibration

- i. How often does your operative faculty meet as a group and what are the objectives of those meetings?

(ASDOH) – We have one lead faculty member who teaches all the didactic content. This faculty member meets with the simulation-clinical instructors during the preclinical modules and also oversees the clinical sessions, ensuring calibration among the clinical faculty as well.

(CNU) – Calibration is done in individual course and during our break week session. The objectives are to get the clinical faculty on the same page as to what is being taught in the didactic courses. The calibration is across all disciplines to help ensure that everyone is on the same page.

(USC) – Meet regularly during the semester for updates in the school, university, and in the field. Smaller, focused groups also meet regularly.

(LL) – Operative faculty collaboration is essential for maintaining consistency, calibration, and alignment with educational goals and institutional policies. We hold a formal meeting at the beginning of the academic year for the D1. I provide course orientation, clear directions and expectations, updates on grading rubrics and procedural techniques, and recommendations on managing student performance.

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Beyond formal meetings, I maintain daily communication via group text messaging for real time update on lab sessions, student challenges, quick clarifications to ensure we are all aligned during sessions.

If I observe inconsistencies in instruction or deviation from LLUSD standards, I address it directly and professionally with the faculty member involved to help maintain quality assurance, faculty accountability, and a united message to students.

The objectives of our operative faculty coordination are ensuring calibration across all instructors, uphold LLUSD policies, provide timely support to students and faculty during pre-clinical activities, and promote clear and consistent communication within the teaching team.

(MU) – Preclinical faculty – daily sim huddles and scripts sent out ahead of time. Clinic calibration done one on one (scanners and lab restorations are reviewed by the Directors and addresses one on one. At clinical faculty meetings once a month – pictures presented and discussed.

(OHSU) – On average, once per month. The department of Restorative Dentistry has a quarterly department meeting. The objectives of these events are to update faculty on all relevant changes and initiatives. The department also meets monthly for a clinic huddle. These meetings center around clinical cases and topics with the goal of improving calibration in our clinical care.

(PNU) – We have huddles before and after each Operative Dentistry lab. We only run the lab one day a week, but we've conducted faculty calibration sessions to stay consistent.

(*UA) – Once a month, sometimes the meeting gets cancelled if there is no agenda. No clear objectives lately. We discuss changes we want to implement (like add materials, change typodonts) and concerns we have.

(*UBC) – Module coordinators give orientation related on how to follow UBC protocols, but not Restorative procedures per see. Restorative group organize annual retreats to discuss topics and alignment across the three modules.

(UCLA) – Once a quarter.

(UoP) – Faculty engage in a post lecture huddle before each sim lab session for calibration. The objective is for all the pods in the sim lab to be assessed using the criteria in a similar manner. For the clinic we have faculty orientation once every quarter, and specific in-person calibration modules run all week, and also mandatory online modules.

(UU) – We have monthly meetings where we meet in person, stream the live presentation and record the calibration for those unable to make it (maybe they work on a different day or at an external clinic). The objective is to support the faculty in their knowledge and grading skills to maintain consistent grading and feedback. Everyone has their own technique, but we recognize that the students must have to have a solid foundational knowledge before learning the technique each individual faculty member uses. Many times we will teach the clinical faculty what and how the students learn procedures so they may help them develop the foundational skills before branching off.

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(UW) – Monthly meetings to discuss departmental developments, updates in policies and procedures.

(WU) – Preclinical faculty meet once every week for calibration of assessments or projects coming up. Another weekly meeting is used to coordinate and collect any materials for faculty calibration – usually to prepare a few weeks in advance.

Clinical Group Faculty have meetings now monthly. Used to be every two weeks.

ii. Are your calibration efforts discipline-based or across all disciplines?

(ASDOH) –

(CNU) –

(USC) – Calibration events are usually offered through the school's CE department. Most of them are available for all disciplines. Some events might be limited to certain disciplines only.

(LL) – They are discipline-based: operative, fixed, medical emergencies, etc.

(MU) – Across all disciplines, during the faculty and clinic meetings.

(OHSU) – Both. When meeting as operative faculty, our main focus is on the restorative (including both fixed and removable prosthodontics) treatment we provide patients in our clinics. When a controversial topic is identified, vital pulp therapy and selective caries removal are two examples, we will invite members of other disciplines to come to our clinic huddles to discuss the topics. Additionally, this year, an entire morning was dedicated to an all-school calibration education event. During the event key educators from each department presented on topics that they felt needed to be addressed to promote intra-disciplinary calibration and collaboration.

(PNU) – All faculty who supervise in the clinic must be calibrated for all graded assessments.

(*UA) – Dentistry related discipline based. Twice a year we have calibration sessions for the entire faculty (DDS, DH, DA). Topics presented are AI or other topics relevant for every discipline.

(*UBC) – Discipline based, difficulty to align with community dentists.

(UCLA) – Discipline-based.

(UoP) – Both, some modules are discipline based and some are across disciplines, for the clinical faculty as we practice comprehensive care.

(UU) – We try to get a variety of disciplines to participate so we know how and when to incorporate specialists or those with more experience in a field. This makes for a better workflow and group collaboration to patient treatment.

(UW) – There are general calibrations and discipline-based calibrations.

(WU) – Our weekly calibrations are discipline or assessment/project based, but we also have meetings 2-3 times a semester for calibration between all disciplines and the curriculum in general.

d. What are your policies for student absences?

(ASDOH) – They must submit an absence request and will approved by the admin after consulting with module instructor, which must be approved. For exams, medical documentation is required. We are currently reviewing all related policies.

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For clinical courses, students may take up to five days off per semester for internship courses and interviews. During the first two years, students cannot miss more than 10% of sim-clinic sessions.

We do not take regular attendance in lectures; however, if a pop quiz is given and a student is absent, they will not receive credit unless they have an approved excused absence.

We are also reviewing the policy for the first two years to consider limiting the number of allowed absences.

(CNU) – Students are allowed 10 absences per academic year for whatever reason they choose. They are only allowed 5 in one semester.

(USC) – Excused absence only for:

- religious holidays (approved holidays by USC)
- sickness
- death of immediate family member

Only excused absence will allow make-up. All other reasons will count as unexcused.

(LL) – There are different policies for different situations:

A. Didactic Courses- Each course director has their own attendance policy. Officially, the School and the University state that attendance less than 85% of a course may result in a failing grade.

B. Clinics- Main restorative clinic does not have an attendance requirement. All clinical blocks do require attendance and these sessions must be made up if missed in their respective areas.

C. Medical/health leaves- may be granted based on health professionals assessments

D. Leave of absences- may be granted on a case by case basis

(MU) – Clinic: D3 (10 days) and D4 (15 days)

Preclinic: excused absence or make up the absence on finals week

(OHSU) – Attendance for all students enrolled in the DMD program is mandatory at all scheduled classes, pre-clinic, and clinic sessions unless stated otherwise by the course director(s) and/or course syllabus. Absences may be classified as either “excused” or “unexcused”. All absences are considered unexcused unless approved by the Office of Academic Systems. The SOD allows each student a set number of discretionary days for use during an academic year. Discretionary days are considered excused absences. There may be days that students cannot use discretionary days (assessments) and must plan accordingly. DS1 and DS2 students are granted 5 days per year with no carry over. DS3 and DS4 are given 8 days per year which may be carried over from the 3rd year to the fourth year.

(PNU) – Unexcused absences are followed by a meeting with the clinic director and result in a 1% grade deduction.

(*UA) –

DDS I and DDS II

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Students who are absent for more than 2 weeks in total of scheduled programming in a course block in DDS I or DDS II for any reason, will have their attendance and progress reviewed by the Course Director and the Associate Chair, Academic.

DDS III and DDS IV

Students must attend 95% of their total assigned clinical time in a given academic year, which means that students may be excused from no more than 5% of their clinical sessions. DDS III and DDS IV students have approximately 400 clinical sessions in total each year. Hence students that have missed more than 20 clinics in total during an academic year will be expected to make-up the number of missed clinics above the threshold before the end of the current academic year, or the end of the following academic year if applying for a leave that extends into the following academic year.

The Course Directors and Associate Chairs Academic and Clinical Education will determine if sufficient clinical experience and achievement of course requirements has been achieved for promotion/graduation.

(*UBC) – New system implemented, they cannot miss more than 5 IGP sessions.

Policy on student absences. It outlines issues related to absences. We are updating this section right now in the Policy and Procedure manual.

(UCLA) – To avoid low attendance rates, restorative courses usually have a weekly quizzes. In the event of an excused student absence for the first time, the quiz will be dropped for that student. If it is the second or third excused absence, a remediation is scheduled to retake the missing quizzes.

(UoP) – Course directors (or program directors of residency programs) determine a reasonable attendance policy specific to their course (or program), and must provide students or residents a written statement of such policy in the course syllabus.

Attendance policies may vary by course and department, and even by course within department, and it is the student's responsibility to be aware of and adhere to course attendance policies.

The student or resident is responsible for making up all work missed due to an absence. Faculty have sole discretion in determining whether and under what conditions missed work is to be made up.

A student or resident who will be absent for all or part of an instructional day must notify the Office of Academic Affairs in advance of the absence or by 9:00 am on the day of the absence. Absences must be communicated daily. In the event of an emergency, the student or resident must notify Academic Affairs as soon as reasonably possible. The Office of Academic Affairs will notify faculty promptly of the student's or resident's absence and will maintain a log of absences. The log will be circulated quarterly, or upon request, to course directors, program directors, and chairs.

(UU) – This is course-dependent at this point. This may change in the future.

(UW) – Students are permitted to have 5 excused absences, unless they have approved accommodation for personal reasons to take more time off.

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(WU) – Students must either make up a missed session, whether absence is excused or not, or they must use after-hours to catch up on projects if they miss the dedicated sim time assigned. If a missed session is a recorded lecture, then the student is expected to watch the recording and reach out to discipline experts with questions. We also allow a few personal days/leave without questions asked or any documentation, students tend to use these days for mental health. But they are not allowed to use these days for days with scheduled exams, SCEs, peer-to-peer sessions, etc.

e. What are the demographics of your current classes, and what are the trends?

(ASDOH) – More young students. Most have a dental background and community service. From Multiple states.

(CNU) – As for demographics I can not speak on that but we do have a lot of students that they are the first to do this in their families. We have an equal mix of male and female students.

(USC) – 144 members of Class of 2028; 53 female/47% male

Ethnicity/Race: Asian 63, Black 3, Hispanic 4, White 53, Mixed Race 12, Didn't Report Ethnicity/Race 9

Degrees: Six hold a master's degree, and all hold bachelor's degrees

GPA: 3.76 average total GPA; 3.70 average science GPA

DAT: 21 DAT academic average; 20 DAT PAT average; 21 DAT science average

AGE: Age range 19-37

21 U.S. States/Territories: In addition to California, enrolling students come from 20 other U.S. states/territories: Alaska, Arizona, Florida, Hawaii, Illinois, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Jersey, New York, North Carolina, Pennsylvania, Texas, Utah, Washington and Washington D.C.

36 Majors: Most popular majors were biology, biochemistry, chemistry, health, history, psychobiology, psychology, sociology, biomedical science, public health and natural science.

61 Undergraduate Universities: Top feeder schools: UCLA (22), UC San Diego (13), UC Irvine (12), USC (10), UC Riverside (6) and UC Santa Barbara (6)

(LL) – Traditional students (Class of 2029): 106 total

Male/Female: 52/54

Age: Mean- 22 Max-42 Min- 19

Race-

Hispanic: 11

Asian: 63

Black: 5

White: 33

(MU) – 52% female; 48% male;

40% non-white; 11% underrepresented minorities.

40% in state, rest from adjacent states.

Hygienist/dental assistants: About 10%.

We do not track. Estimation only.

5% non traditional students.

Majority are aged in 21-25 years

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(OHSU) – The class of 2029 is following National trends in terms of gender: 32 males and 42 females. 7% Hispanic, 34% Asian, 4% Black, 44% White, two or more races 7%, and 4% did not report. 38 Oregon residents and 36 out of state.

(PNU) – 23 females; 13 males; 15 Hispanic, 4 Native American, 6 Black, 2 Asian, 23 White (all self-reported).

(*UA) – DDS 1: 32 students. DDS 2: 52 students (20 advanced placement students join, they are usually older and have families). Variety of different cultural backgrounds and experiences.

(*UBC) – The two subsection (i and ii) are listed [previous answer].

UBC leadership team has reservations about answering this, considering privacy issues and suggested bringing this concern to the group.

(UCLA) – Class of 2028 is a 60 women and 28 men. The majority of the students are from California, with a few out of state. The International program class has students coming from 26 different countries.

(UoP) – We have a diverse class room population. Classes are getting younger (chronologically and/or maturity level). Significant number come from families of dentists. Very few have no dental background.

(UU) – As far as the current student body, we're about 200 students total; about 100 Utah residents and 100 out-of-state students; and we admitted close to 100 women & 100 men. We are at a pretty steady state as far as the student body makeup is concerned.

When you step back and look at applications, we are trending positively at a higher rate than the national average. A lot more applications from out-of-state students, from women, and from HURE students (HURE = Historically Underrepresented Racial and Ethnic students; this is an ADEA term). As a state, Utah is only so big, so our numbers over time out of Utah are very consistent and stable. Almost all of the growth we're seeing is coming from the other 49 states.

- Gender distribution The current student body is about 50/50 men:women. Although we don't have the same percentage of applicants who are women as other schools, it's trending in that direction, and we're closing the gap.
- Race/ethnicity breakdown Same general idea as above. We have a higher proportion of students who are white applying to our program, but over the last several years we're seeing a higher raw total and higher % of non-white students applying here.
- Age range or average age Each year, our average incoming class age is 24-25.
- Geographic background (in-state vs. out-of-state, rural vs. urban) For admitted students, it's half-and-half. As far as our applicant pool, it's more like ~20% in-state, 80% out-of-state.
- Educational background (number with advanced degrees, previous careers, etc.) Our students almost always come in with a bachelor's degree only. Very few have a master's or other degree.
- Other relevant categories (e.g., first-generation college students, socioeconomic diversity) We have a handful of first-gen and/or rural students in each class. We are looking for the best students, regardless of their background. We participate in the ADEA Fee Assistance Program (FAP). With FAP, students can apply for 3 schools for free, and

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we'll waive our \$100 application fee for all these students, as a way to help students from low-income households who need it.

(UW) – Balanced demographics with Gender and variable background.

(WU) –

i. Is student performance in courses declining?

(ASDOH) – We are pass/fail, so definitely they are not trying hard. Our passing rate is 75% with one remediation trial. Academic entitlement is a problem.

(CNU) – In certain courses we do see a decline in performance. This is mainly due to a lack of ability to learn on their own.

(USC) – No. Performance of students overall has been steady over the past years with minor annual variations.

(LL) – Yes, somewhat.

(MU) – No.

(OHSU) – Yes.

(PNU) – Too soon to assess.

(*UA) – No. There are always a few students that tend to struggle more.

(*UBC) – No, the distribution is comparable between students who perform successfully and those who experience difficulties compared to previous cohorts.

(UCLA) – We noticed a decline the years following COVID-19 during online admission and online instructions. Recently, the performance seems to be improved again with our prediction that class of 2026 will outperform class of 2025 at the time of their graduation.

(UoP) – Each year, each class has its own dynamic, ups and downs, at the end of the course, performances balance out, and it's hard to identify a trend either upward or downward. Yes, due to: Academic entitlement, student-centered education has its side effects. Biomedical sciences courses are taking up too much of the students' time.

(UU) – We have not seen this trend.

(UW) – It varies from year to year, but while performance had declined during the pandemic, it has consistently improved in the past 3 years.

(WU) – Anecdotally, yes. Less critical thinking, more adjacent tooth damage. More justification is needed for basic expectations. Students stop performing when requirements are finished – regardless of pt care.

ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...?

(ASDOH) – One remediation attempt, then they fail the module and are required to retake it at their own expense.

(CNU) – Students are allowed 1 chance to remediate a course.

(USC) – For restorative preclinical modules, remediation is built into the module (last two weeks reserved for remediation), divided into skill and knowledge remediation separately. Students must pass remediation to pass the module. If a student does not pass, the student is referred to the Students Performance, Professionalism, and Ethics Committee (SPPEC), which will decide if the student is remanded or dismissed.

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(LL) – Lab exams: switching from unlimited to a fixed number. Piloting in pre-clinical fixed pros and operative with 1 retake attempt.

Didactic exams: none.

Courses individualized per committee decision.

(MU) – One for didactic and for preclinic. Clinic competencies are changed to a regular appointment.

(OHSU) – Final written exams (summative) there is no remediation option, the student receives an NP and then needs to remediate the course. Remediation of courses is decided by the Student Performance Committee. Practical exams often have one remediation before the end of the course. Students must pass all Clinical Skills Assessments and are able to re-take if the first attempt is not successful.

(PNU) – 2 for procedural exams (sim lab).

(*UA) – Written exams (Midterm/final): 1 additional attempt, if that is failed then it

goes to academic standing. Skill assessments in the lab: Depends on the discipline.

For operative/fixed: Not more than twice the same assessment. If there are 6 assessments in total, then 3 remediation attempts.

(*UBC) – Must pass clinic and oral exam they have remediation for written.

(UCLA) – For written exams, 1 remediation is allowed. For clinical skill assessments, if the student fails their 2nd attempt, they will be given a practice projects to complete before they can challenge the exam again.

(UoP) – One time.

(UU) – This is course dependent, but I'd say that most allow for one remediation. If a trend continues they are reported to the Academic Professionalism Review Committee (APRC).

(UW) – Three attempts.

(WU) – We give students 3 official exam attempts for most SCEs, they must pass 2 attempts. If not, a Progress Improvement Plan (PIP) is initiated, usually involving a remediation project and re-taking of the SCE is involved. Remediations for written exams go into effect if they fail more than 1 exam a semester per course. If a student doesn't pass the PIP, they fail the course and are referred to Student Performance Committee (SPC), and the decision of that committee is followed for any further remediations or if additional measures need to occur, i.e., repeating the year or dismissal from the curriculum. Students basically remediate until they pass. Clinically, students who fail an independent demonstration of competence require remediation if there are large deficiencies noted. This doesn't happen very often, however.

f. Are you considering a switch from axiUm to EPIC as your Electronic Health Record?

(ASDOH) – We just switched to Axium we use to have axium ascent.

(CNU) – We are sticking with axiUm at this time.

(USC) – No.

(LL) – Not currently.

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We have recently begun using Epic in a limited capacity within an external rotation site. It's still a new experience for us, and we are currently in the evaluation and adaptation phase.

(MU) – We changed last year to EPIC.

(OHSU) – There has been talk.....but nothing is currently being planned.

(PNU) – Yes.

(*UA) – No.

(*UBC) – No.

(UCLA) – Yes, the school just formed a committee to work on the transition from axiUm to EPIC.

(UoP) – There have been some discussions, but it has not happened yet.

(UU) – We have worked our way through Epic the entire time at our school.

(UW) – Not aware of any pending changes.

(WU) – We've considered switching for many years. But we never have. At that time, there were concerns with their lack of a treatment planning module. This could easily have been remedied after all the years.

V. CaMBRA Questions

This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.
 - i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?
 1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?
 2. If NO, why are lesions not documented?
- b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use, and how granular is your documentation? For example, some schools may note lesions on a simple binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression (“incipient” vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?
- c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?
 - i. If YES, which diagnostic codes/descriptors for caries lesions do you use?
 - ii. If NO, why are diagnostic codes not used?

Region II

2025 National Agenda – Region II

Response Color Key

- (CU) Creighton University School of Dentistry – (No responses)
(KCU) Kansas City University College of Dental Medicine
(MU) Marquette University School of Dentistry – (No responses)
(MOSDOH) Missouri School of Dentistry & Oral Health
(SIU) Southern Illinois University School of Dental Medicine
(UC) University of Colorado School of Dental Medicine
(UI) University Of Iowa College of Dentistry
(UM) University of Minnesota School of Dentistry
(UMKC) University of Missouri – Kansas City School of Dentistry
(UNMC) University of Nebraska Medical Center College of Dentistry
(*UM) University of Manitoba Dr. Gerald Niznick College of Dentistry – (No Responses)
(*US) University of Saskatchewan College of Dentistry – (No Responses)

I. Curriculum

a. How are your external rotations organized?

(UC) – Student providers typically participate in alternating 3-week rotation blocks to outside practices (i.e., 3 weeks on rotation and three weeks back at the CUSDM). Students start Advanced Clinical Training and Service (ACTS) rotations from May of their third year.

(UNMC) – Generally, by Emily Gish, Office Associate II, College of Dentistry Administration.

i. How many affiliation agreements/sites?

(KCU) – 42 agreements, 91 sites.

(MOSDOH) – Currently, 79 affiliation agreements are in place. However, many remain inactive or have not been utilized in several years. In some cases, sites were initiated by students and only hosted a rotation once.

- For the 2025-2026 academic year, 37 active affiliation agreements will support a total of 49 rotation sites.

(SIU) – 5 in place, but only 3 are currently active.

(UC) – The ACTS Program currently has partnerships with over 22 partner organizations across Colorado and more than 45 community-based clinical sites across Colorado host students enrolled in the ACTS Program.

(UI) – 12 in Iowa and 4 out of Iowa.

(UM) – We currently have 21 active outreach partners.

(UMKC) – 30 organizations, 52 clinic locations.

(UNMC) – We have recently reduced the number of sites from 30 to 15.

ii. How many rotations?

(KCU) – 2.

(MOSDOH) – 3.

(SIU) – usually 2, but this year only 1.

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(UC) – Six rotation blocks are required.

(UI) – 1 extramural rotation.

(UM) – Pediatric Dentistry and Oral Surgery.

(UMKC) – 1 (with optional D4 Spring Semester extended rotation if SOD clinic requirements are met).

(UNMC) – The D-3 students do one day at the Monroe Meyer Institute (The Munroe-Meyer Institute's mission is to be world leaders in transforming the lives of all individuals with disabilities and complex health care needs, their families and the community through outreach, engagement, premier educational programs, innovative research and extraordinary patient care.)

iii. How many total weeks?

(KCU) – 14.

(MOSDOH) – 10 weeks per student.

(SIU) – 2 weeks.

(UC) – Typically, 18 weeks total.

(UI) – 5 weeks.

(UM) – Required to graduate is 10-12 wks for DDS, 6-8 wks for DT, & 4-6 wks for DH students.

(UMKC) – 3 consecutive weeks.

(UNMC) – The D-4 students rotate for one week (down from 2 weeks) at one of our 15 sites. Most are FQACs (Indian Health and correctional institutions) or at one of several private sites.

iv. When are the students scheduled externally? (DS4, DS3, etc...)

(KCU) – DS4 year.

(MOSDOH) – DS3 year.

(SIU) – DS4 year.

(UC) – May of the D3 year through March/April of the D4 year.

(UI) – DS4 year.

(UM) – DS3 & DS4 years.

(UMKC) – D4 beginning fall semester.

(UNMC) – The D-3s are for 1 day at any time during the year. D-4s for 1 week again during the year.

v. How many weeks at a time?

(KCU) – 7 weeks.

(MOSDOH) – Two 3-week blocks and one 4-week block.

(SIU) – 2 weeks.

(UC) – Each rotation block is typically three weeks in duration.

(UI) – 5 weeks

(UM) – Between 1 to 6 weeks at a time. Most typically 4 wks.

(UMKC) – 3 weeks.

(UNMC) – See above.

vi. How are students supported?

(KCU) –

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(MOSDOH) – The program prioritizes student support by working closely with sites to minimize financial and logistical barriers to participation.

-Financial Considerations: Students are advised to budget approximately \$1,500 per semester to cover living and travel expenses associated with rotations.

(SIU) – Hotel paid for, but not food or transportation.

(UC) – By the ACTS Program (orientation; site-specific onboarding; Canvas preparation portal; ACTS Eval. Portal; access to previous Canvas shells for students to prepare for each rotation block, access to the ACTS coordinator; access to Dr. Owens via email/personal phone after hours; preceptor calibration);
By each organization's: IT team; compliance team; clinical sites' clinical/patient coordinators; clinical sites' compliance officers; CUSDM appointed faculty preceptors; most sites hire dedicated dental assistants for the students; etc.
By the CUSDM clinical faculty and staff (Dr. Lampe, Agueda Garcia Paredes, SDM IT, Marisela Melendez, CUSDM clinical coordinators, etc.)

(UI) – Students have to pay for accommodation and logistics.

(UM) – All providers overseeing our students across these 21 partner sites are either onboarded Volunteer Adjunct Faculty or are paid Clinical Assistant Professors through the outreach department (different models used for different sites, such as Hibbing - we own the clinic, so all staff and faculty are paid employees). These providers are required to attend our annual calibration sessions (the Annual Outreach Dental Review) and always have access to our policies, such as bloodborne pathogen protocols. All students, staff, and providers have the Outreach Division team's contact information for any additional support. All sites send students a Welcome Letter ahead of their rotation to set expectations/provide logistical information and then are given orientation on site on day one. We require all sites to provide our DDS and DT students a dedicated assistant, so they feel safe and supported within the rooms to increase their efficiency utilizing 4-handed dentistry

(UMKC) – There are weekly Zoom sessions to share the experience with classmates/course director and consider various topics of communication, intra- and inter- professional collaboration, the health center setting; students receive written feedback from the supervising dentist(s) weekly; sites are required to provide the student with an assistant during patient care. School covers the cost of lodging and a place to stay, pays mileage where applicable.

(UNMC) – The college pays for lodging. It doesn't pay for meals or mileage.

vii. Who pays for accommodations?

(KCU) – Dependent upon site - included in cost of attendance.

(MOSDOH) – Many sites provide housing at no cost to students. If a site does not provide housing, students are not required to rotate there.

(SIU) – School.

(UC) – Colorado AHEC provides housing for sites that are ≥ 40 miles from campus.

(UI) – Students have to pay for accommodation and logistics.

(UM) – Typically we require the clinical partner to provide accommodations such as hotel rooms.

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(UMKC) – Some sites (<30%) provide accommodation, most do not. Attempt to schedule rotations around student preferences whenever possible- some students stay local; some are placed in hometowns and stay with friends/family or pay for housing themselves. The school pays for 1 round trip drive to the site, if it is >50 miles from the school.

(UNMC) – See above.

viii. How are faculty/preceptors calibrated?

(KCU) – Annual onsite training and follow-up asynchronous training in Canvas.

(MOSDOH) – Initial Training: All preceptors receive onboarding training through MOSDOH before hosting students. Ongoing Calibration: Training and calibration are updated regularly to align with CODA accreditation requirements and ensure uniform evaluation of student performance across sites.

(SIU) – Annual Zoom session by the director.

(UC) – CUSDM calibration sessions. ECHO preceptor training.

(UI) – Online self-paced clinical vignettes and quiz once a year.

(UM) – Annual meeting required but not always attended.

(UMKC) – Canvas (LMS) quizzes required by adjunct faculty at participating sites.

All dentists supervising students must have Courtesy Faculty status with UMKC SOD.

(UNMC) – Through a long series of online calibration modules on our Canvas system. The same modules are used for the in-house faculty as well as rotation faculty.

b. How are patients managed after the completion of their comprehensive care?

i. Ongoing recall/hygiene by students?

(KCU) – Goes into a recall system and is seen by the student.

(MOSDOH) – After completion of comprehensive care, a dummy code (9930) is placed in the patient's chart. Patients are then added to a recall list. The Clinical Care Manager (CCM) pulls the 9930 codes from NextGen and keeps track of the recall due dates. Students are responsible for managing their patients' recall appointments until they graduate. After graduation, the patients are transferred to incoming D3 students. Issue:

Tracking is not always accurate if students fail to enter the 9930 code. This gap affects our ability to maintain consistent follow-up and patient care.

Each semester, we have four dental hygiene students who rotate through the clinic once a week. D4 students have the option to schedule hygiene appointments with them.

(SIU) – Transferred to our hygiene recall after all treatment completed. Recall perio done by hygienists, exams done by faculty

(UC) – If all the patient has left is recalls for perio maintenance and prophys, there are a few different things that can happen:

- Perio maintenance patients we generally keep and continue to see because they are Portfolio B patients for students (which is a requirement) and are also good for the new DS2/ISP1 students in perio lab.
- Prophy patients will generally get referred to the hygiene school BUT –

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- If they are a good patient, we may keep them at the school to be perio lab patients for the new DS2/ISP1 classes to do their first cleanings on.
- Sometimes if they continually get caries, we keep them to monitor and take care of those things as they come up.

(UI) – They receive the prophy and recall exams by dental students in preventive dentistry, and by dental hygiene students in hygiene clinic.

(UM) – After completion of all planned restorative treatment, the patient remains with the assigned student for recalls; at the end of the year or at patient-transfer, recalls can be switched to hygiene.

(UMKC) – An “Exit Exam” is completed, then sent to the Team Leader, who puts the patient on recall. Usually into a team bank to keep faculty consistent.

(UNMC) – The completed patients are assigned either to dental students (or the same student if available) or dental hygiene students.

c. Describe challenges you are experiencing related to the Gen-Z student learner?

(KCU) – Anxiety and mental health challenges. Professionalism and academic dishonesty.

(MOSDOH) – Students do use social media (e.g., TikTok, Instagram) to learn procedures. - They prefer to ask each other for advice and learning rather than asking a faculty (while the faculty is standing there) -The growing use of generative AI poses challenges for students, such as limited engagement, exposure to misinformation, originality concerns, and ethical issues like plagiarism.

(SIU) – Information technology skills can vary. This leads to difficulties with some students effectively utilizing the systems in place. We often "assume" ability with their generation.

(UC) – Our Gen-Z learners have shared the following as to how they learn best:

- Hands-on learning, showing rather than telling
- Working one-on-one
- Group work
- Peer teaching
- Office hours; open-door policy; approachability of faculty
- Establishing expectations early.

(UI) – Shorter attention span, reading textbooks, visual learners.

(UM) –

d. (UMKC) – We have good academic support staff and faculty training. They have reframed this in a way that has helped me better communicate. Especially changing the wording- these students are big “self-advocates.”

Our academic support staff person handles accommodations, but we require the student to reach out to faculty as well.

Trying to make more videos for lab exercises (challenging with gutted communications department) and provide more feedback as well as more encouragement of self-agency. The students seem to want more hand holding, so encouraging them to read the lab manual, for example, before asking for a one-on-one demonstration.

(UNMC) – Officially no particular challenges.

e. What strategies are you using to more effectively teach the next generation of dentists?

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i. Techniques?

(KCU) – Active learning in the classroom, learning enhancement strategies, uniform Canvas course sites, peer-reviewed resources (My Dental Key), Recordings of all teachings (didactic and simulation), standardized patients, and wellness activities.

(MOSDOH) – Teaching Methods: Blend of lectures, self-directed study (videos, readings), Zoom sessions, and active learning (case discussions, group work, interdisciplinary cases). -Skill Development: Hands-on lab work, simulation technology (SIM to CARE, haptics), clinical rotations, and community outreach (e.g., Give Kids a Smile, Jamaica Mission). -Communication Training: Didactic content, Standardized Patient encounters, and practical exercises. Digital Dentistry: Students learn intraoral scanning, digital impressions, chairside design/milling, and cementation for indirect restorations. Technology in Learning: Intraoral cameras for teledentistry, AI Simulated Patient (implemented in Spring 2025), online course management (Canvas), and secure digital exams (ExamSoft).

(SIU) – Poll everywhere, Microsoft Teams communication, more integration between clinical and bioscience.

(UC) – Hands-on learning, showing rather than telling.

(UI) – Digital dentistry, Flip classroom for small group, 50-minute lectures: 10-minute break.

(UM) – Digital Dentistry, Canvas course-sites, Powerpoint slide digital handouts, Mediasite lecture recordings (only provided for excused absences).

(UMKC) – Trying to use technology to provide more lab demonstrations, create videos.

(UNMC) – We have been into digital dentistry and education before many schools. It has been developed a great deal since then.

ii. Delivery of student feedback?

(KCU) – Scorpion and 1:1 feedback after summative experiences, B-Line.

(MOSDOH) – Feedback is integrated into simulation clinic and lab sessions through real-time guidance and performance tracking. Clinical settings offer direct, formative feedback from faculty. Feedback is delivered in a timely and respectful manner. Private Feedback for Behavior: More critical feedback or feedback specifically directed toward student behavior is provided one-on-one in a private area. Digital platforms (Canvas and ExamSoft) support feedback delivery through quizzes, assignments, and exam reviews.

(SIU) – Practice practicals before each one.

(UC) – Daily project feedback is done during the given session by the covering faculty. The course evaluations are looked at after the course is over, and changes are integrated in the next class as needed.

(UI) – Chair-side verbal feedback.

(UM) – Heliocampus (formerly AEFIS).

iii. (UMKC) – TO student: provide feedback on exam questions that they questioned, create study guide to help streamline information, lab faculty write feedback on

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grade sheets, one-on-one feedback during lab, and when they bring projects to the clinic.

FROM student: semester feedback with comments. Try to take constructive feedback into consideration for the next semester. Will include requests for feedback in canvas homework assignment (for no credit or bonus points).

(UNMC) – Students receive feedback at all steps of pre-clinical projects and are required to self-evaluate all steps. Clinically, the faculty will give feedback during all procedures. This may vary between the different faculty.

iv. Videos for preparation/restoration?

(KCU) – My Dental Key, Live Demos, 1:1 tutoring.

(MOSDOH) – Instructional videos are provided to support preparation and restoration techniques, allowing students to review procedures before hands-on sessions. These videos enhance self-study and improve procedural understanding ahead of labs and clinical practice.

(SIU) – Yes, preparations videos, restoration videos, and evaluation of preparation videos.

(UC) – We started to have more videos during COVID and have those available for our students.

(UI) – We have videos of preparations/restorations. We also do in-person demonstrations that the students seem to like.

(UM) – Yes. Caries removal, composite placement, etc.

(UMKC) – Trying to create videos. Mine don't hold a candle to Stevenson.

(UNMC) – Many faculty create their own videos. Some faculty will use something as simple as a smart phone to shoot a video. We do have professional help available from the medical center to help with content or the actual creation of the videos.

Some faculty will use outside videos, like YouTube, or others if they are deemed to be of a high enough quality.

II. Materials and Techniques

a. What types of materials and strategies are used for vital/non-vital pulp therapy?

(KCU) – MTA, Limelight, RMGI.

(MOSDOH) – In the Simulation Clinic: Calcium hydroxide (Dycal) – used for indirect pulp capping. Glass Ionomer Cement (Fuji Lining LC Paste) – applied as a liner or base. MTA – placed directly over simulated pulp exposures on extracted or plastic teeth for direct pulp capping. IRM or Glass Ionomer – used as provisional restorations. In the Clinic: MTA for vital pulp therapy in clinics. MTA for mechanical pulp exposures. Dycal mostly for indirect pulp cap. Non-vital cases – managed with endodontic therapy.

(SIU) – Indirect pulp therapy performed with calcium hydroxide, MTA, or plans to add Limelight to availability in the future. Capped with RMGI if being restored with amalgam or if direct pulp exposure.

(UC) – For teeth with extensive carious lesions and preserved vitality, we follow the Deep Caries Lesion Protocol (DCLP) established for our clinics. The protocol includes:

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- Pulp vitality testing to confirm diagnosis. If the pulp is vital or presents with reversible pulpitis, the protocol is initiated.
- Isolation of the operative field, preferably with rubber dam placement.
- Cavity preparation, establishing a 1–2 mm margin of sound dentin along the DEJ and ensuring a clean, non-discolored DEJ with healthy enamel at the cavosurface margin.
- Selective caries removal, retaining affected dentin on the axial wall or pulpal floor when indicated to preserve pulp vitality.
- Placement of a liner/base, using either a glass ionomer (Fuji Triage, Equia Forte) or a resin-modified glass ionomer (Vitrebond, Fuji II LC).
- Definitive restoration placement, whenever feasible, to ensure long-term tooth stability.
- Follow-up evaluation, scheduled to reassess pulp vitality. As part of our workflow, the Axium template includes the DCLP code, which automatically triggers a re-evaluation recall appointment planned within 6–12 months.

Additionally, Biodentine™ XP is available as a bioactive dentin substitute, specifically indicated for pulp capping, vital pulp therapy, and root perforation repair. Within the Deep Caries Lesion Protocol, Biodentine™ XP is most often recommended as a temporary restoration in cases with uncertain pulpal diagnosis.

For primary root canal therapy (non-vital pulp therapy) in the pre-doctoral program we utilize the following materials and techniques:

- 3% Sodium Hypochlorite and 17% EDTA for irrigation. We use side-vented needles only, in an oscillating motion
- We also use *Endo Activator* before obturation
- BC Sealer (regular and hi-flow) for obturation. We use hydraulic, or warm vertical compaction – depending on the case.
- *Calciject* calcium hydroxide paste (single use packaging) for intracanal medication
- Gutta percha cones (*WaveOne Gold*) and matching paper points
- *Templt* calcium sulfate material for temporizing teeth with circumferential remaining tooth structure and conservative access
- *GC Fuji Triage* (pink), or composite for interim restoration of all other teeth

(UI) – Theracal and RMGI.

(UM) – Indirect pulp therapy (≤ 0.5 mm remaining dentin thickness) or non-carious exposure: calcium hydroxide (Dycal) or MTA (difficult handling, slow setting, expensive), then RMGI. Direct pulp therapy (pulp exposure on immature permanent teeth): Dycal, MTA, or Biodentine, then RMGI. Pulpotomy (pulp exposure mature permanent tooth of primary tooth with vital pulp).

- b. (UMKC) – Vital: Discrepancy between endo and restorative department. Restorative teaches that it is acceptable to leave small amount of Affected dentin to avoid pulp exposure.

Dycal covered by vitrebond is our standard indirect and direct material protocol.

Direct: achieve hemostasis with sodium hypochlorite first.

Nonvital: endo/TE.

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(UNMC) – At UNMC, vital pulp therapy is performed using indirect pulp capping, direct pulp capping, pulpotomy (especially in pediatrics), with materials including calcium hydroxide, mineral trioxide aggregate (MTA) for direct pulp capping, glass ionomer or resin-modified glass ionomer for indirect. In operative, the students learn about the different materials available, but only handle calcium hydroxide and glass ionomer in the pre-clinical lab. MTA is only available in the endodontic clinic, so if it is needed in the restorative clinic the students should go to endo and request it. The use of MTA is limited because of the price. The students learn and are encouraged to use selective caries removal and to vitality test teeth before restorative procedures to avoid unnecessary pulpal exposure. For non-vital pulp therapy, endodontic treatment is performed, using calcium hydroxide as medication, bio-ceramic sealers for obturation and MTA in case of perforations.

c. Treatment planning

i. Describe the treatment planning process at your institution.

1. Who “owns” the treatment plan?

(KCU) – Group Practice Leader.

(MOSDOH) – Students are responsible for their patients' comprehensive care. Students and the CCU directors own the plan.

(SIU) – Created by a student with a Team leader, no ownership.

(UC) – Comprehensive care teams. The student and the patient, along with the approving faculty. Covering faculty assigned to the team approves the tx plan before patient can accept and sign.

(UI) – For clerkship treatment planning is done in the oral diagnosis clinic for comprehensive exams and then treatment is in various departments. They have a student advocate that follows-up the completion of treatment. For D4 year, senior students do treatment planning and treatment.

(UM) – It is a permanent part of the record, so the patient "owns" the treatment plan.

(UMKC) – Team Leader and student.

(UNMC) – The current student assigned to the patient would be the one who "owns" the treatment plan for clinical care to be delivered. But for legal purpose, the team leader of the respective team is the person who is responsible for ultimate supervision and moderation of the patient care. That said, the treatment plan must be current and renewed each year, with patient consent given and uploaded into the electronic dental record. This helps navigate any changes that arise from periods of time of not seeing the patient and validating that the treatment plan still aligns with the patient's oral health condition and presentation.

2. Who can modify it?

(KCU) – Proctoring faculty, AGPL.

(MOSDOH) – Only the CCU director who formulated the plan.

(SIU) – Proctoring faculty.

(UC) – Any covering faculty assigned to the team can modify the treatment plan. That will require a faculty swipe to reopen the tx plan and patient

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needs to sign it again. Complex cases are followed up with prosthodontic faculty and team leaders. Simple modifications such as changing on materials, surfaces of restorations are done by covering faculty as needed. (UI) – Students can modify the plan if the supervising faculty sees the need for it.

(UM) – The plan cannot be modified once signed by the patient. However, supervising faculty may modify it, if necessary, e.g., to add a surface if not treatment planned, or remove a surface if deemed unnecessary. What is charged out is just changed on the day of preparation.

(UMKC) – Any faculty at the time of treatment.

(UNMC) – It is usually agreed upon that the group leads can review and modify a treatment plan with the student, or the original faculty that developed the treatment plan. If a change is being considered outside of that scope, there is communication with the group leads/original faculty overseeing the treatment plan to decide on change of treatment. The student cannot modify the treatment plan without faculty oversight.

3. What educational methods and resources are used to teach treatment planning?

(KCU) – In the Foundations of Patient Care Series and Clinical Dentistry courses, students learn treatment planning didactically and through case-based learning.

(MOSDOH) – Students learn treatment planning through a variety of educational methods, including lectures, case-based learning, simulation exercises, and direct clinical experiences with faculty. They develop and defend treatment plans in patient-based cases and presentations while also completing written assignments and research projects. Resources such as course syllabi, Canvas materials, and standard dental textbooks (e.g., Pathways of the Pulp, Sturdevant's Operative Dentistry, Summitt's Fundamentals) further support the integration of biomedical knowledge with clinical decision-making

(SIU) – Each discipline teaches to their treatment planning, and an overall treatment planning course bring information together.

(UC) – The Treatment Planning and Case Presentation courses (listed below) are delivered in the Flipped Classroom format as the students present their cases and introduce the learning activities.

(UI) – Clinical vignettes along with radiographs and photographs are used for teaching. Some departments also use an online simulated case for the same.

(UM) – Course: Treatment Planning and Introduction to Clinic (DDS 6314) directed by Dr. Hatch to D2's in spring semester. They follow the Book "Treatment Planning in Dentistry" by Stefanac and Nesbit. 11-13 cases are developed over the course of the semester.

(UMKC) – Treatment planning course in D2 fall semester.

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(UNMC) – Clinical scenario questions and examples are given to teach and practice treatment planning and phasing and sequencing. Then patient case presentations and treatment plan write-ups are used to further students' understanding and comprehensive knowledge of treatment planning. Students are given a patient's presenting conditions and history and are asked to write up a treatment plan that includes diagnoses, prognoses, and phased and sequenced treatment plans that include EBD articles to support their reasoning. Students are then asked to give case presentations on actual patients their D2, D3, and D4 year to their fellow students and faculty. These case presentations help the student own the process of patient assessment, diagnosis, treatment planning, and case presentation, as well as case outcomes. They also help other students and faculty learn by seeing treatment examples and discussion on what can be done differently.

4. Are there individual courses dedicated to treatment planning or is treatment planning embedded throughout the curriculum (discipline based)?

(KCU) – Integrated throughout the courses.

(MOSDOH) – Treatment planning is embedded across the curriculum rather than confined to a single course. In the D1 and D2 years, foundational principles are introduced through courses such as Scientific Practice and Biomedical and Dental Sciences, emphasizing patient-centered and comprehensive approaches. As students' progress, treatment planning is applied in preclinical and clinical courses across all disciplines, with opportunities to develop and refine plans for a wide range of patients. Integrated seminars and case presentations, including EBD-based justifications, reinforce critical thinking and referral decisions. By the D3 and D4 years, students present and defend treatment plans to peers and faculty, demonstrating assessment, diagnosis, treatment options, and risk-benefit considerations. Competency-based assessments ensure students achieve proficiency in formulating phased treatment plans as a core skill throughout their dental education.

(SIU) – Both.

(UC) – Below are the classes in the Restorative Department that directly address treatment planning:

DSRE 5520 – Intro to Clinical Dentistry – DS1 Fall

DSRE 5521 – Intro to Clinical Dentistry 2 – DS1 Spring

DSRE 6600 – Transition Clinic – DS2 Fall

DSRE 6601 – Transition Clinic 2 – DS2 Spring

DSRE 7718 – Critical Thinking and Patient Care – DS3 Fall

DSRE 7935 – Tx Planning and Case Presentation 1 – DS3 Fall

DSRE 7936 – Tx Planning and Case Presentation 2 – DS3 Spring

DSRE 8945 – Tx planning and Case Presentation 3 – DS4 Fall (40 hours)

DSRE 8946 – Tx Planning and Case Presentation 4 – DS4 Spring (40 hours)

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(UI) – Treatment planning is a separate course. Some disciplines also have added case presentations and OSCE to assess students' treatment planning as it relates to the discipline.

(UM) – Yes, Dr. Hatches course. Each Division also teaches treatment planning topics specific to their particular area.

(UMKC) – see above, as well as in discipline (primarily perio).

(UNMC) – Both. Treatment planning is embedded throughout the curriculum as they learn the individual treatment options: operative, prosthodontics, periodontics, etc.

There are also two individual treatment planning courses. The first occurs during the fall of their D2 year: Physical Assessment and Diagnosis and Treatment Planning. This course teaches the students the systematic process of taking a patient from the lobby to right before you are ready to start treatment. They learn all the details of taking in-depth medical histories, vitals, consents, medical consults, head and neck exams, intraoral exams, entering in diagnostic info into the EDR, treatment planning, phasing and sequencing, and presenting the treatment to the patient.

The second course is in the spring of D2 year: Advanced Treatment Planning. This first half of this course brings in guest lecturers who present slightly more complex cases and how they treated it, who they referred to, and things they learned along the way. The second half of the course is focused on the students' gathering data in the clinic on a patient and compiling it into their first case presentation based on the rubric they have to follow as D3s and D4s for their case presentation requirements. This gives the students a lower stress introduction into this style of presentations and exposure to multiple patient scenarios right before they enter "full-time" clinic as a D2 in the summer.

d. How is your institution addressing the fluoride "controversy"?

(KCU) – Had a panel in the public health courses that discussed decades of evidence on Fluoride. Continuing to support fluoride use in dentistry.

(MOSDOH) – No changes. We continue teaching about fluoride as we have been.

(SIU) – No changes.

(UC) – We still teach the benefit of Fluoride and prescribe as needed. Fluoride has always been controversial to an extent and in Cariology course they still teach as before.

(UI) – We have had an online conference presented by Dr. Levy (Iowa Fluoride study) and other speakers on dietary fluoride, community water fluoridation, toothpastes/varnish/mouthrinse.

Shared the ADA's fluoride facts 2025 pdf with college.

(UM) – At this point, nothing new. We continue teaching about fluoride as we have been.

(UMKC) – We still teach it and bring up evidence. Discuss that our job is to educate patients, but never to shame them or to force them into anything. We have an anti-fluoride faculty member, as well, and I give a lecture in her class to counter that side.

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(UNMC) – The students are taught evidence-based dentistry, with an emphasis on understanding levels of evidence and evaluating the quality of studies. As part of this, they learn about the well-documented benefits of fluoride, including community water fluoridation. The controversy surrounding fluoride is also addressed in the cariology/operative course, where students are presented with common arguments against fluoride and guided in identifying which of these are supported by evidence and which are not. In addition, they learn how caries risk assessment and access to fluoride influence oral health outcomes. Alternatives such as hydroxyapatite toothpaste are also introduced, so that students are prepared to recommend options for patients who prefer to avoid fluoride in either water or toothpaste.

III. Student Assessment

a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?

i. Classroom instruction related to the exam process.

(KCU) – Didactic experiences and mock exams.

(MOSDOH) – Curriculum Alignment: Didactic and clinical courses are designed to build the knowledge and skills required for licensure exams. Skills Acquisition Courses (MDOH series): Focused on restorative procedures, these courses include hands-on practice, live demos, and personalized feedback aligned with board standards

(SIU) – Classroom instruction is provided leading up to the mock boards, but not beyond, and has been reduced since moving to simulation rather than live patient.

(UC) – CU dental school hosts ADEX only. Students receive 4 hours of lecture on Pros, Endo, and Restorative. ADEX criteria are introduced in the international program Restorative Lab. Students receive Feedback sessions on their practice. We also have an ADEX shell on Canvas.

(UI) – Students get brief information the senior year regarding the ADEX board exams. They have manikins available for them to practice.

(UM) – Yes, preparatory seminar before Mock Boards and debriefing afterward.

(UMKC) – Added simulation teeth with ADEX grade sheets to Operative II lab, 4 clinical requirements with simulation teeth and ADEX grade sheets.

(UNMC) – Students participate in a structured mock boards instruction session for both ADEX and CRDTS exams. Following the mock boards, a debriefing session is held to address challenges, clarify expectations, and provide targeted feedback. In addition, students attend lunch-and-learn sessions with representatives from each board, which gives them the opportunity to ask questions directly and learn about the logistics and requirements of the exams.

ii. Mock boards?

(KCU) – Yes.

(MOSDOH) – Yes. Simulated ADEX practice and practical progress exams are embedded in the Skills Acquisition curriculum, such as the Operative Dentistry Mock Progress Exam (Class II Composite), which replicates the ADEX format by grading preparation, caries removal, and final restoration. OSCEs are conducted each semester in the D1 and D2 years (eight total) and continue in the D3 and D4

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years for specific competencies and skills integration, providing standardized assessment across disciplines.

(SIU) – Yes, 2 for operative, 1 for perio, 3 for fixed, 3 for endo.

(UC) – We don't have mock boards at this stage.

(UI) – There is a mock board for the senior students.

(UM) – Yes.

(UMKC) – Longstanding excellent operative Mock (Trial) Board exam that is very well received using simulation teeth and ADEX grade sheets.

(UNMC) – Mock board examinations are administered in prosthodontics, operative dentistry, endodontics, and periodontics. These are tailored to the specific exam the students will take (ADEX or CRDTS). The mock boards are integrated into the fourth-year curriculum as Competency assessments, making participation and successful completion mandatory.

b. How are students assessed when scheduled on external rotations?

(KCU) – In process.

(MOSDOH) – We continue to use the same grading rubric and Qualtrics evaluation system that is implemented in the main clinic. One ongoing challenge is that many preceptors are not consistently completing the Qualtrics evaluations for students. For essential experience tracking, we currently count only one crown completed during the rotation.

(SIU) – Evaluation forms are filled out by the external site proctoring faculty, considering promptness, professionalism, and motivation.

(UC) – Student assessment by faculty preceptor(s) completing an evaluation for each student they provided faculty coverage for during each rotation block. Student assessment by submitting two required assignments in Canvas after each rotation block.

(UI) –

(UM) –

(UMKC) – Adjunct faculty oversees their work and delivers weekly feedback.

(UNMC) – Dentists at external sites are calibrated through online videos and quizzes to ensure they follow the same protocols as the school. In some locations, UNMC faculty are also present to directly oversee student performance. The external site faculty provide feedback on the students' behavior, but also on their dental knowledge and skills.

i. Do you count those procedures for meeting requirements?

(KCU) – Yes, for essential experiences, but not competency assessment.

(MOSDOH) – For essential experience tracking, we currently count only one crown completed during the rotation. They have to show us the Pre and post op pictures and x-ray to get the credit in case the preceptor did not do the qualtrics. Only one endo is counted toward essential experiences. We do count extractions and operative procedures toward the essential experience. Students have plenty of opportunities to perform these procedures in-house, so if preceptors don't complete the evaluations, it doesn't significantly impact their overall experience

(SIU) – No competencies are allowed at external sites.

(UC) – No, because all ACTS Program clinical sites are designated as CODA minor sites.

(UI) – No.

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(UM) – No, due to CODA regulations.

(UMKC) – No.

(UNMC) – For clinical requirement purposes, only periodontal procedures performed at designated external sites are counted, since a faculty member is always available to grade them. Operative procedures were previously included (with a limit of 10 restorations), but due to disparities between sites and lack of standardized evaluation, they are being phased out and will not be counted for future classes.

IV. Administration

- a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?

(KCU) – Encourage use of PTO, limit email responsiveness during off hours, team-based activities (brunch, TeeTime).

(MOSDOH) – The institution promotes work-life balance through supportive policies, including protected administrative time for clinical faculty, open communication with leadership to address workload and professional development. Preclinical faculty and course directors do not receive dedicated administrative time and instead utilize non-teaching hours for academic and research responsibilities. Despite supportive structures, maintaining balance remains challenging due to heavy workloads and faculty shortages, which often require significant preparation and grading outside regular hours.

(SIU) – Scheduled non-work activities.

(UC) – We have Intentional student scheduling for didactic, pre-clinical and clinical:

- Includes Study Time
- Protected time in schedule for specific courses
 - Teamwork
 - Recorded presentations
- Minimize required activities beyond 8:00-5:00
- Access to Simulation and Technique Labs, 24/7

(UI) –

(UM) –

(UMKC) – New Dean! Improving culture immediately. I don't struggle with balance EXCEPT during extremely busy times- finals/ multiple lab exam retakes.

(UNMC) –

Support for students:

Students can meet faculty members during everyday office hours 8-9 am to help them with any issues they are having academically or just to provide some guidance.

Support for faculty and staff members:

Faculty members are good with planning their time off periods ahead of time and utilize medical leaves when needed.

- b. What assistance in terms of initiatives/support/strategies does your school/university provide?

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(KCU) – 30 days PTO, Week of Christmas to New Years (paid leave - do not have to use PTO), professional development stipend, educational support (\$10k/year), YMCA Membership.

(MOSDOH) – The university provides supportive policies such as paid vacation days and structured leave. For professional development, full-time faculty receive an annual \$2,500 allowance to support continuing education, resources, conference attendance, and travel. Additional support includes faculty development workshops, TLC training programs, and mentorship opportunities that promote professional growth. (SIU) – Full-time employment allows for 5 weeks of paid vacation time, which is encouraged for use during student breaks, and main campus workshops are promoted by email.

(UC) – ADEA Peer Tutoring, DS2-DS1 Big-Little pairing, Office of Disability, Access and Inclusion for students requiring accommodations, Case Manager with Anschutz Office of Student Outreach and Support.

(UI) – “Teach and thrive” lecture series by office of education with invited speakers on various aspects of teaching and assessment.

(UM) – The Office of Human Resources (University level) offers a wellness program which includes resources, activities, and events on the Wellbeing Program portal, with nearly all of them free for you to use. E.g., On-demand video fitness classes (yoga, high intensity interval training or HIIT, kickboxing, cycling, and more); Mindfulness and meditation practices; An event calendar with upcoming webinars; Recipes and nutrition resources.

(UMKC) – They have had yoga in the past. New dean implemented Donuts with the Dean to open discussions and increase feelings of value among faculty and staff. Excellent work hours.

(UNMC) –

Support for students:

At UNMC we have Director of Student Wellness, a faculty member who is appointed to ensure students’ concerns are heard and addressed. Students can bring their issues to the Director of Students Wellness whether those are issues from personal life that is effective their academic experiences or challenges from dental classes etc.

There are many events when students, faculty, staff meet outside school hours for music programs, game days, golf tournaments etc. We have four clinic groups, and every group has group leaders who is mentoring the students in that group. The group leaders have events arranged for groups as well.

Students and faculty enjoy BBQ event in the beginning of fall semester, ice-cream social from UNMC Dairy stores on different times as well.

At the end of each semester, students get one-week time off before the next semester starts. During Christmas, the students get 2 weeks break. During summer semester. There is a well-structured plan for students’ maternity and paternity time off. That way they can maintain family needs when time comes.

Support for faculty and staff members:

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Full time faculty members and staff members can utilize their vacation time or sick days for personal and health reasons. At UNMC the sick leave is quite generous in case someone gets sick or a family member gets sick.

The Dean invites all faculty and staff members for annual Christmas dinner at the end of the fall semester.

We have employee support service in the main campus where faculty members can seek mental health support like therapy sessions.

Our institution provides educational support for faculty members if any faculty is interested to pursue a degree (MBA, PhD, Internationally Educated Faculty Dental Program - IEFDP) as part of the professional development with a tuition stipend.

The Adult Restorative Dentistry provides \$1500 professional growth funding for faculty members to present at the conferences to help them financially.

c. Calibration

- i. How often does your operative faculty meet as a group and what are the objectives of those meetings?

(KCU) – Formally, once a year. Informally, every lab session (via email or short huddle prior to the session)

(MOSDOH) – 15-minute calibration sessions are embedded throughout the Skills Acquisition courses, led by content experts. Preclinical faculty meetings occur periodically. Monthly clinical faculty calibration meetings are held at the St. Louis Dental Center for all clinical instructors.

(SIU) – Formally as a department each semester or year, informally weekly at each operative lecture/lab.

(UC) – We started to meet every month with our new department chair. When operative courses are in progress (Spring and Summer semesters), we meet every week as needed.

(UI) – Once a year. Calibrate faculty using examples, clinical vignettes. Try to get a 100% agreement or discuss if there is not 100% agreement.

(UM) – Monthly Department Meetings.

(UMKC) – Operative meets before each semester and then again before each lab practical. The Restorative Department meets monthly, often with calibration sessions, but not every time.

(UNMC) – Operative dentistry falls under Adult Restorative Dentistry department at UNMC. The department arranges monthly meetings to meet all faculty members. These meetings are aimed to calibrate the faculty members, keep everyone informed with the ongoing updates and progress of the department and clinics. In addition, all ARD faculty members are calibrated annually with all specialties (such as Prosthodontics, implant dentistry etc.) including Operative dentistry. The annual calibration is mandatory for all full time and part time faculty members in order to teach in the clinic floor.

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At the beginning of fall semester, UNMC arranges 2-3 day long calibration/orientation session for all students and faculty members for clinical information. This calibration/orientation is mandatory for all D3 and D4 students in order to treat patients in the clinic floor.

ii. Are your calibration efforts discipline-based or across all disciplines?

(KCU) – Discipline-based.

(MOSDOH) – The institution employs both discipline-specific and cross-disciplinary calibration strategies to ensure consistency and integration: 1-Discipline-Based Calibration: -Focused sessions on specific topics like Class II operative procedures, fixed and removable prosthodontics, pediatric competencies, radiology, and oral diagnosis. -Led by faculty with content expertise in the relevant field. 2-Institution-Wide Calibration: -Involves all full-time and adjunct faculty (preclinical, clinical, and biomedical sciences). -Conducted through faculty onboarding, biannual faculty advances, and curriculum committee reviews to ensure curriculum integration and consistency. Kirksville–St. Louis calibration days align multi-campus instructional practices. -Monthly COPC (The Clinical Operations, Policy, and Compliance Committee meetings) and QA/CQI (Quality Assurance/Continuous Quality Improvement) sessions address clinical policy, compliance, and operational issues across all disciplines. -Faculty Journal Club promotes evidence-based discussions applicable to patient care and teaching. -Annual training for external faculty at ICSP sites ensures consistent standards across all clinical settings

(SIU) – Formal calibration occurs through a section head presentation to all faculty that teach within each discipline, yearly. The lecture is recorded and requires review if not attended. Informal calibration occurs by encouraging faculty to attend each lecture and through the multiple faculty evaluation that occurs on all practicals (3 faculty graders) and all competencies (2 faculty graders) that must come to a consensus to grade.

(UC) – Our calibrations are across all disciplines, about once a month and also discipline-based.

(UI) – Calibration is discipline-based. We calibrate the faculty for various courses in operative dentistry once a year. The comprehensive care clinic (d4 year) faculty meet every quarter and calibrate their faculty, including faculty from different disciplines.

(UM) – Operative Standardization occurs in three ways. First, faculty in the preclinical simulation courses are standardized before each lab period. Many of these faculty also teach in the clinic. We strongly recommend that new hires teach first in preclinic for this reason. Second, there is an annual Saturday In-Service put on by the Operative Dentistry Division for all clinical and preclinical faculty (regardless of Division/Department). During this meeting, there is a standardization component. This usually involves an exercise in the weeks leading up to the meeting, a presentation at the meeting to increase standardization, and a follow-up exercise to measure the effect of the meeting. Third, extramural

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faculty have an additional annual meeting, which is aimed at standardization across all clinical disciplines—Operative Dentistry is included.

(UMKC) – Both- often other departments speak to Restorative to calibrate with their expectations.

(UNMC) – At UNMC, the annual faculty calibration is done across all disciplines (Operative Dentistry, Prosthodontics, Periodontics, Endodontics, Oral Pathology, Implant Dentistry, Oral Surgery, Pediatric Dentistry, Practice Management and Finances.

d. What are your policies for student absences?

(KCU) – All absences must be excused. Form submitted online before absence. Do not have a set number of days.

(MOSDOH) – MOSDOH enforces mandatory attendance for all required curriculum components—such as flipped classrooms, assessments, SimClinic, labs, clinics, and rotations—as a condition for passing. Students must arrive on time and stay for the full session. -Excused absences are required to make up missed assessments or activities and must follow official request procedures. -Unexcused Absences may result in a failing grade at the Course Director’s discretion. -While attendance at standard lectures without follow-up activities is not mandatory, it is strongly encouraged. -Recorded lectures are provided, when possible, but students remain responsible for all presented content, even if recordings are unavailable.

(SIU) – Absences require a form submitted with each course director's signature of approval, defining how the lost time will be accounted for.

(UC) – Attendance is mandatory in clinic.

- Advanced Standing DDS: Up to 18 full days (equivalent to 36 clinical sessions)- Semesters 2-6
- 4-year DDS: Up to 20 full days (equivalent to 40 clinical sessions)- Semesters 6–11

Attendance is expected in didactic (classroom) and pre-clinical (lab). Based on learning objectives, course directors’ expectations to achieve learning outcomes.

(UI) – Attendance at all assigned course activities, including lectures, labs, and clinic sessions, is mandatory for all students. Students must attend all scheduled clinic sessions regardless of whether a patient is assigned and/or all course requirements have already been fulfilled by the student. Students cannot be absent from or leave the clinic area during assigned times without instructor permission. Falsifying attendance is strictly prohibited. Students shall follow appropriate absence protocol as outlined in the College of Dentistry Attendance Policy.

(UM) – Didactic courses: Absences must be excused. There is additionally a Parental Leave Policy. Instructors are not required to offer make-up work to students who do not attend preclinical and didactic courses and do not have excused absences. Clinic courses: Students must be present in the clinic a minimum of 90% of available sessions. Students who are absent from clinic without an approved absence will have a PTO session deducted from their balance.

(UMKC) – Robust policy! Attendance is required. Excused absences have paperwork that must be completed prior to the event or as soon as possible in case of

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illness/unforeseeable event. Faculty signatures, including clinic dean or the dean of student affairs required.

(UNMC) – Students are required to submit absence requests to the Office of Academic Affairs prior to the date of absence. The excused absences are then notified to the related Course Directors and or Clinical Group Leaders. Without completing the student absence request, the students are required to attend all classes.

e. What are the demographics of your current classes and what are the trends?

(KCU) – About 50/50 male and female, trending more females than males. 40% are from the 4-state region. Increasing HUG across classes.

(MOSDOH) – AT Still University – MOSDOH is committed to fostering diversity within its student body, particularly through the inclusion of Historically Underrepresented Groups (HUGs) and international students. Gender Trends: Female enrollment remains consistently strong across all classes.

(SIU) – All four classes are mostly from in-state. Less than 10% are out-of-state. Generally half male and half female, though trending towards a higher percentage of females. The majority of ethnic background has consistently been Caucasian, though over the past four years, there has been a trend towards increased diversity.

(UC) –

	Age		Highest Degree prior to matriculating at CUSDM			
	Age Range	Average Age	No degree	Bachelor's Degree	Master's degree	Doctorate Degree
DS 2028	21-37	24	2	75	3	0
DS 2029	21-38	24	0	75	5	0

(UI) –

(UM) –

(UMKC) – Class of 2029- 71 female/38 male, 57 from MO/35 KS (3 HI, 3 Kuwait, 3 Ark)

- Hispanic- 8, White- 77, Black- 1, Asian- 15, Biracial- 5, non-US- 3

Trends

- Female students have been edging out males as slightly over half over the past several years, but this year is significant- 65% of class
- Increased number of total applicants than in past 5 years
- Increased number of MO applicants than in past 5 years

*admissions office especially interested because we're nearing the HS graduate cliff

Academic markers- DAT and GPA increasing significantly among applicants (national trend).

(UNMC) – Our class size is relatively small. We have 52 students in DDS program and 6 students in Advanced Standing Program in each class cohort.

i. Is student performance in courses declining?

(CU) –

(KCU) – No, increasing (curricular improvements).

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(MOSDOH) – Student performance initially declined during the 2021 transition to a new integrated curriculum, particularly among D1 students, due to changes in course structure and assessment methods. -Early Impact: Several students from the Classes of 2023–2027 failed the Biomedical Sciences and Dental Sciences course and had to repeat the year with the following cohort. -Pass Rates: While the 2021 pass rate for one course fell below the 90% benchmark, pass rates for 2022, 2023, and 2024 consistently met or exceeded the 90% goal for all didactic courses. -Response Measures: The institution reviews assessments, updates course content, and provides academic support to help students succeed. The performance issues are attributed to initial adjustment challenges rather than long-term decline.

(SIU) – From an anecdotal perspective, didactic performance may have declined over the past couple of years.

(UC) – Not clear what this question is assessing.

(UI) – No.

(UM) – No. Each class has a distribution of abilities, and the number of exceptional and concerning students in each class has remained fairly consistent.

(UMKC) – Not declining, but the trend seems to be more students (or more vocal students) requesting additional one-on-one help rather than working independently. This may reflect differences in faculty numbers.

(UNMC) – No. There is always a bell curve in the classes. The current trend shows students like to use artificial intelligence in their education a lot, therefore the exams are now more critical thinking based, where cases are presented and students need to use their clinical judgment.

- ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...

(KCU) – Students are allowed one retest on a practical exam and one attempt for remediation.

(MOSDOH) – Students are provided structured remediation opportunities depending on the assessment type. For course failures, one remediation attempt may be permitted with APC approval, with a maximum of two course retakes allowed during the program. Knowledge assessments below 70% require a makeup assignment or exam. Critical and competency assessments allow one retake, with a study plan required for a second attempt; failure results in course failure. Skills Acquisition exams (practicals, OSCE/OSPE) permit up to two retakes, with capped scores (75% on first retake, 70% on second). Integrated Block Exams allow up to three remediation attempts, while INBDE failures require a study plan reviewed by APC. Incomplete grades may be issued for extenuating circumstances, with resolution required within four weeks or by the next semester.

(SIU) – Exam remediation policies differ by course. Some do not allow exam remediations, some only allow one, and some allow multiple. Only one attempt is allowed for a course remediation. Failure of a course remediation results in repeating the year or dismissal, based on a recommendation by the committee to the dean. Passing a course remediation results in a course grade of D. Practicals

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and competencies allow only one remediation, graded on a pass/fail basis. If passed, the student is allowed to progress and the original grade stands; if failed, it results in a course failure.

(UC) – All remediation plans will be **customized** to address the specific course deficiencies identified by the course director. Remediation is a process which helps students re-engage with course content, receive additional assistance, and achieve knowledge, skills, and/or attitudes to bring an individual to the level expected of students at the conclusion of a course for program progression in a timely manner. Remediation plans are reviewed for approval by the Student Performance Committee, comprising representatives from all disciplines.

(UI) – Two attempts for each skill assessment/practical. There is no retake for didactic exams.

(UM) – Retaking exams or skill assessments will depend on the course director in each course. For course failure, the Progression Sub-Committee will decide the feasibility of remediation after reviewing the learner's academic record. If the learner does not successfully complete remediation, the Progression Sub-Committee will determine the learner's options.

- iii. (UMKC) – This varies by course, but Operative Lab allows two remediation attempts for Practical 1 and 2, and one remediation attempt for Practical 3. A remediated "A" grade is worth less than a first attempt "A" grade. Course remediation occurs over the winter or summer semester. One remediation attempt. Skills-sharpening open lab offered over the summer. Operative Lecture- no remediation of exams, failure of course would require remediation (haven't encountered this independent of a student failing the entire semester and having to repeat the semester.)

(UNMC) – It depends on the course directors. For each failed course, the course director arranges a remediation plan for the students. The number of retake options depends on each course as well.

In the clinical setting, if a student fails a competency exam, but have successfully completed the pre-requisite requirements for that competency, they have to re-do the pre-requisite as well in addition to the competency exam.

- f. Are you considering a switch from axiUm to EPIC as your Electronic Health Record?

(KCU) – No, we use ECW (same software as local FQHCs).

(MOSDOH) – Not at this time.

(SIU) – No, we have invested further into additional axiUm modules.

(UC) – Not under consideration.

(UI) – No.

(UM) – Yes.

(UMKC) – Not at this time- undergoing accreditation.

(UNMC) – Yes. Currently we use Salud. We have a plan to move to Epic within approximately 2 years.

V. CaMBRA Questions

This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.
- i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?

1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?

(KCU) – Yes, in an odontogram (as a condition).

(MOSDOH) – YES – In our student clinics, tooth-level caries lesions are documented in the electronic NEXTGEN health record (EHR). In NextGen EHR, tooth-level caries lesions are charted in the odontogram and associated with the patient’s overall caries risk category determined through CaMBRA.

(SIU) – Yes, odontogram as red (clinical) and green (radiographic)

(UI) – Yes. We have codes in Axiom under findings for caries lesions documentation.

(UM) – Yes. Odontogram (manually).

(UMKC) – Yes. Odontogram.

(UNMC) – Yes. At UNMC COD, the tooth level caries lesions are documented in the Odontogram in Salud EHR system. In Salud, students can document if the caries is limited to enamel or has extended to dentin already or even progressed further. Salud also documents the NCCL like attrition, abfraction, abrasion etc.

Students are also welcome to write their progress notes in detail with proper clinical findings, such as caries and correct diagnosis in their progress notes.

(UC) – Yes. We document on AxiUm, on Odontogram. Those are under “dental findings”.

2. If NO, why are lesions not documented?

- b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use, and how granular is your documentation? For example, some schools may note lesions on a simple binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression (“incipient” vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?

(KCU) – Simple binary, moving toward ICDAS; we also track incipient lesions (Curadont/SDF used).

(MOSDOH) – Lesions are recorded in association with caries risk categories determined by CAMBRA (Caries Management by Risk Assessment). Documentation includes whether the

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lesion is primary or secondary and is tied to the patient's overall risk status. CDT procedure codes are used for documentation of lesions and treatments. No use of ICDAS or ADA CCS; the system is based on the university's CAMBRA and APA (American Pediatric Association) -guideline-driven model. This shows that the documentation is granular enough to classify patients into low, moderate, or high caries risk categories based on various factors such as diet, oral hygiene, and fluoride exposure. The curriculum also covers the pathogenesis, progression, and clinical/histological manifestations of dental caries, which implies a detailed understanding beyond a simple binary classification (SIU) – Simple binary basis of lesion or no lesion.

(UI) – Initial, moderate, extensive caries + active/inactive, recurrent caries, root caries.

(UM) – Tooth surfaces involved; incipient vs. cavitated.

(UMKC) – On odontogram- initial/moderate/advanced. In some coursework, ICDAS is taught and assessed, but not on an odontogram.

(UNMC) – We document tooth-level caries lesions in the Salud electronic health record in a quite detailed manner. We document the general terminology referring to location (primary and secondary). The odontogram provides options such as surfaces of the restorations that is failing due to secondary caries, and students can select specific surfaces. Also, Salud provides options to add the level of progression (lesion into enamel only, lesion into dentin). Salud does not provide us with ICDAS/ADA CCS documentation. However, the ICDAS system is taught in great detail in operative dentistry and cariology courses in the first and second year. Students go through critical thinking process in cariology course in the second year when they have clinical cases to present with conservative treatment plans based on ICDAS caries detection system. Students are expected to utilize that knowledge in clinic floor while treatment planning for lesions (specially for enamel lesions) with remineralization treatment or surgical procedures (restorations). Their findings are required to be documented in detail in their daily progress notes.

(UC) – We teach ICDAS in Cariology course. For Clinical use on AxiUm we chart caries as: Active Incipient, Inactive Incipient, Moderate, Severe, and Root Caries.

c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?

i. If YES, which diagnostic codes/descriptors for caries lesions do you use?

(KCU) – Yes. CDT and ICD-10.

(UM) – Yes. ICD-10 Dental Diagnostic Codes.

(UMKC) – Yes. Used when treatment planning- must select ICD-10 code before treatment planning restoration, etc. Dental Caries, unspecified, Dental Root Caries, Cracked Tooth, (Enamel Caries, Dental caries extending into dentine, Arrested dental caries, At high risk for dental caries, Caries involving multiple surfaces of tooth, Caries of infancy, Caries of infancy associated with bottle feeding).

(UC) – Yes. For the periodic examinations and new patient examinations we use the following diagnostic codes after filling out CU caries risk assessment for the patient. The codes are:

- Caries risk assessment & documentation, low -Risk – Tx Code D0601
- Caries risk assessment & documentation, Moderate -Risk – Tx Code D0602

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- Caries risk assessment & documentation, High-Risk – Tx Code D0603.
- ii. If NO, why are diagnostic codes not used?
- (MOSDOH) – No. CDT codes are not used for diagnostic purposes. However, we do have the option to select the type of caries from a dropdown menu. The available options include: -Enamel caries, Root caries, Caries involving one-third of dentin - Caries involving two-thirds of dentin, Caries invading the pulp etc. Diagnostic codes are used, but not specific CDT codes. CAMBRA risk assessment levels of extremely high, high, moderate and low are used for assessments. -A Z code (diagnosis code) is applied for caries risk classification; this code is provided free of charge to the patient. CDT codes are applied for procedures related to lesion management (e.g., restorations, preventive care).
- (SIU) – No. Difficulty in implementation.
- (UI) – No. We use CDT codes for documenting caries risk level (low, medium, high) but not diagnostic codes.
- (UNMC) – No. CDT codes are used for caries risk assessments (extreme vs high vs moderate vs low) and restorations. It was not used historically at UNMC. This is something we can explore how other schools are documenting and see how we can implement at UNMC.

Region III

2025 National Agenda – Region III

Response Color Key

(LSU) Louisiana State University Health Sciences Center School of Dentistry

(LC) Lyon College School of Dental Medicine – (No Responses)

(AM) Texas A&M University School of Dentistry

(TT) Texas Tech University Health Sciences Center El Paso – Hunt School of Dentistry

(UM) University of Mississippi Medical Center School of Dentistry

(UO) University of Oklahoma College of Dentistry

(UT) University of Tennessee Health Science Center College of Dentistry

(UTH) University of Texas School of Dentistry at Houston

(UTSA) UT Health San Antonio School of Dentistry

I. Curriculum

a. How are your external rotations organized?

(LSU) – External rotations are assigned at random, based on each community site. The academic success coordinator enters all rotation details into our scheduling software, including the number of days per week, total weeks, and the list of students. The program then generates student assignments.

(AM) –

(TT) –

(UM) – We have community rotations to private practice locations throughout the state for senior students for six-week rotations.

(UO) –

(UT) – Before scheduling external rotations, an email is sent to all students assigned to participate in the upcoming semester. In this communication, students are asked to provide any dates that may conflict with their availability (e.g., travel, personal obligations) and to list their preferred rotation sites, with the understanding that not all requests can be accommodated. All responses are reviewed carefully, and rotations are then scheduled based on student preferences, site availability, and program needs. This process ensures fairness, maximizes participation, and minimizes scheduling conflicts while maintaining a balanced distribution of students across all external sites.

(UTH) – The external rotations are randomly assigned to students according to the availability of each community. We use a software program to enter all the rotations, including how many days per week, how many weeks, and the names of students, etc., and the program assigns the students.

(UTSA) –

i. How many affiliation agreements/sites?

(LSU) – Six total: Chabert Medical Center in Houma, OMFS Rotation at University Medical Center in New Orleans, GPR rotation in Baton Rouge, University Medical Center ID Clinic Rotation, Baton Rouge OMFS at Our Lady of the Lake Medical Center in Baton Rouge, Oral Oncology at Touro Hospital Oncology Center in New Orleans.

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(AM) – 4 Locations are associated sites. They are called Los Barrios, Healing Hands, Outside Special Care, & Now Forward.

(TT) – 9 with 2 in development; some sites have 2-3 offices.

(UM) – N/A.

(UO) – We have 16 active sites in Oklahoma (up to 37 total sites in and out of active status, mainly Tribal or Indian Health Service) for the Fall 2025 Semester.

(UT) – There are four active affiliation agreements encompassing a total of six rotation sites. Two of these sites are UT-owned. The current locations include Union City, Bristol, Chattanooga, Crossville, Knoxville, and Kingsport.

(UTH) – DS4- 8 external rotations/ internal rotation.

(UTSA) – External

- Haven for Hope
- DSO partner clinics
- South Texas Health Care System
- Other approved community rotation sites

Internal

- Geriatric Dentistry
- Pediatric Dentistry
- Periodontics
- Oral Surgery

(All internal rotations receive discipline points except for Pediatric Dentistry. Geriatric Dentistry is the only course in which students may complete competencies (seniors only).)

ii. How many rotations?

(LSU) – (1) D3 rotation at OMFS Rotation at University Medical Center in New Orleans, and (5-6) D4 rotations at Chabert Medical Center in Houma, OMFS Rotation at University Medical Center in New Orleans, GPR rotation in Baton Rouge, University Medical Center ID Clinic Rotation, Baton Rouge OMFS at Our Lady of the Lake Medical Center in Baton Rouge, Oral Oncology at Touro Hospital Oncology Center in New Orleans.

(AM) – 12-14.

(TT) – 9 with 2 in development; some sites have 2-3 offices.

(UM) – N/A.

(UO) – The students are required to attend 2 rotations, 1 in Fall and 1 in Spring.

(UT) – There are four active affiliation agreements encompassing a total of six rotation sites. Two of these sites are UT-owned. The current locations include Union City, Bristol, Chattanooga, Crossville, Knoxville, and Kingsport.

(UTH) – DS4- 8 external rotations/ internal rotation.

(UTSA) – External

- Haven for Hope
- DSO partner clinics
- South Texas Health Care System
- Other approved community rotation sites

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Internal

- Geriatric Dentistry
- Pediatric Dentistry
- Periodontics
- Oral Surgery

(All internal rotations receive discipline points except for Pediatric Dentistry. Geriatric Dentistry is the only course in which students may complete competencies (seniors only).)

iii. How many total weeks?

(LSU) – At LSUSD these external rotations are spread throughout the students' D3 and D4 years.

(AM) – 6-8 weeks during the academic year.

(TT) – 1 week for DS3; 2 weeks for DS4.

(UM) – N/A.

(UO) – 4 weeks total.

(UT) – Four weeks.

(UTH) – 2-3 weeks for each external rotation.

(UTSA) – Differs for third and fourth year-school has changed the number of weeks in the past year, is planning to add more rotations in the coming year.

iv. When are the students scheduled externally? (DS4, DS3, etc...)

(LSU) – Students from D3 and D4 will start in summer, fall and spring semester. At LSUSD these rotations are spread out through the student's D3 and D4 years.

(AM) – Students from D3 and D4 will start in summer, fall and spring semester.

(TT) – DS4 are scheduled in Fall term; DS3 are scheduled in Spring term.

(UM) – N/A.

(UO) – The students rotate externally as DS4s. They go in pairs.

(UT) – Students are assigned to external rotations during the D4 year.

(UTH) – both DS3 and DS4.

(UTSA) – External rotations are completed by third-year (DS3) and fourth-year (DS4) students only.

v. How many weeks at a time?

(LSU) – One week per semester. At LSUSD these rotations are spread out through the students' D3 and D4 years.

(AM) – One week per semester.

(TT) – 1 week in Spring for DS3; 2 weeks in Fall for DS4.

(UM) – Six-week rotation.

(UO) – 2 weeks each Semester.

(UT) – Two consecutive weeks each semester.

(UTH) – 2 weeks at a time.

(UTSA) – Rotation duration varies by site and curriculum needs, typically one to several consecutive weeks per assignment.

vi. How are students supported?

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(LSU) – Students are assigned to teams to assist one another. External clinics also have dental assistants present to help with appointment flow and patient management.

(AM) – Students are assigned in teams to assist one another. External clinics also have dental assistants present to help with appointment flow and patient management.

(TT) – Remote (>25 miles) rotations are paid for from a grant. This includes per diem for food, mileage, and hotel.

(UM) – Self-supported.

(UO) – Financially, we pay per diem for food and reimburse mileage.

(UT) – The College ensures support by arranging **housing and transportation** for students assigned to off-campus sites.

(UTH) – If a student goes for a rotation outside Houston, the school will pay for accommodations and food. If any exam is missed, the course director arranges a makeup day. If any assignments are missed, this is also coordinated with the course director to ensure students do not fall behind in their academic path.

(UTSA) – Students receive on-site supervision and evaluation from faculty preceptors in collaboration with UT Health San Antonio faculty. Continuous oversight ensures clinical expectations and patient care standards remain consistent across locations.

vii. Who pays for accommodations?

(LSU) – There are no accommodations that are paid for students to go to their rotation.

(AM) – There are no accommodations that are paid for students to go to their rotation.

(TT) – We applied for grants from local foundations; AHEC grants were not available for our area.

(UM) – N/A.

(UO) – We pay for hotel accommodations.

(UT) – The College covers the cost of lodging (for the duration of the external rotation).

(UTH) – Some community outreach grants will pay for food and accommodations when students go to out-of-town rotations.

(UTSA) – The School of Dentistry covers the cost of accommodations for students and provides gas reimbursement when students carpool to off-site rotations.

viii. How are faculty/preceptors calibrated?

(LSU) – LSUHSC-Health New Orleans' Compliance Officer and the LSUSD Dean of Clinical Affairs provide Quality Assurance/Control, Infection Control calibration, Patient Safety calibration, etc. through LSUHSC bridgeapp.com emails. Academic/program/curricular calibrations are also provided as needed by the academic dept responsible for the rotation.

(AM) – Clinical Affairs provides Quality Assurance/Control, Infection Control calibration, Patient Safety calibration, etc. through CQIRM annual meeting, and through TrainTraq trainings for all employees and students. Preceptors and

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Adjunct Faculty who are never on campus would be calibrated via their home department. Academic/program/curricular calibration (not operations) should be provided by the academic dept. responsible for the rotation (peds, OMS, perio, grad pros, public health, etc.).

(TT) – In house calibration event yearly; via module access; and site visit by faculty in charge of rotations.

(UM) – Via correspondence.

(UO) – Our Director of External Rotations gives a ZOOM PowerPoint lecture on expectations and requirements for 30 minutes with a Question/Answer session afterwards. Students can receive credit for completed procedures such as Operative and extractions. If it is a multi-appointment procedure, they receive credit for a portion of the procedure.

(UT) – Preceptors complete onboarding through the General Dentistry Department and participate in ongoing calibration via departmental meetings, continuous communication, feedback, and direct coordination with the Associate Dean for Extramural Clinical Education.

(UTH) – The adjunct faculty located in the community outreach programs follow the same standards for calibration. Yearly summer/fall calibrations, standard of care webinars are offered monthly during the year. Also, there is a Canvas site for all faculty to check and review the school's policies and protocols. This Canvas site, "The UTSD way," is a live source where the faculty can visit at any time to update or review a topic of interest.

(UTSA) – Dr. Meiners, English, Pineda

- The institution maintains an interdisciplinary calibration committee that collaborates with satellite clinics to ensure consistency in instruction, grading, and adherence to evidence-based best practices.

- Faculty calibration is reinforced through Canvas-based training modules that include instructional videos, rubrics, and best practice guidelines.

- Course-level calibration occurs through grading of practical exams, dental anatomy standardization, and ongoing departmental meetings.

b. How are patients managed after the completion of their comprehensive care?

i. Ongoing recall/hygiene by students?

(LSU) – No, patients are given a prophylaxis by their assigned hygiene student and a final exit exam by their assigned D4 student. If any caries or defective restoration is noted, then the D4 student will re-treatment plan and treat the patient. If the patient has no further treatment needed, then the patient is given an exit letter which informs them that their dental treatment is completed, and they are to find a private practice dentist going forward. Ultimately, they are inactivated from the system.

(AM) – At the completion of their comprehensive care, patients are entered into a recall pool managed by the comprehensive care program. This recall pool is separate from the hygiene program's recall system, as each program has unique procedural and curricular needs. Dental students are responsible for seeing their own patients for recall appointments until they graduate. After graduation, the

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patient is placed into the recall pool, where students assigned to recall rotation will see them for subsequent visits. If a student on recall rotation diagnoses a patient as needing further treatment, that patient is reassigned to another student for comprehensive care.

For external rotation: Dr. M.C. Cooper Clinic is the only clinic we own, and the only one where the patients belong to TAMCOD. Comp Care is provided at Cooper. We have a recall system where DH students rotate through and provide periodic care. In addition, DDS students provide preventive care in conjunction with other ongoing dental care. Once patient care is completed, patients receive a completion letter just as on the main campus. Patients can return for care if they still live in the accepted zip codes, but due to patient volume, the clinic does not provide routine recare once treatment is completed.

(TT) – Currently, DS's manage their recall patients in their practices for 2 cycles; in development is cooperation with the hygiene school in which we would refer the recall patients to them, and they would return patients to us if they had findings during their examinations.

(UM) – Recall by dental hygiene program
Ongoing recall/hygiene by students? Both

(UO) – Our patients are placed in our hygiene recall pool, and if additional caries is identified, then the assigned student will treatment plan again and treat. If the patient's dental student has graduated, then a new student will be assigned and re-treatment planned and treated.

(UT) – Patients in the predoctoral program receive a recall designation after initial periodontal treatment is completed. Patients are required to stay within the predoctoral perio recall system until their case is completed and the student has become a 4th-year student. After this occurs, patients are allowed to be transferred to the hygiene department. Once in the hygiene department, patients receive annual examinations from a licensed dentist. If an issue requiring dental treatment is found, the patient is then referred back to the predoctoral clinics.

(UTH) – Once patients finish their comprehensive care, they will be placed on a program called "OMP"- Oral Maintenance and Prevention. According to their risk level, they will return to school every 4-6 months for a periodic exam and prophylaxis or periodontal maintenance.

(UTSA) – Patients are scheduled for an "Outcomes of Care" appointment approximately six months after treatment completion. This visit includes a prophylaxis or periodontal maintenance and evaluation of prior treatment outcomes before the patient transitions into recall status.

The Recall Clinic introduces second-year students to patient management under the guidance of third- and fourth-year students and faculty.

c. Describe challenges you are experiencing related to the Gen-Z student learner?

(LSU) – Lack of critical thinking, shorter attention spans, variable communication skills, anxiety and fear of failure, difficulty managing time, and expectations and reliance on technology are just some of the challenges with the Gen-Z student learner.

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(AM) – Generation Z dental students present several challenges in the educational setting. They often have shorter attention spans and prefer quick, visually engaging content, which can make traditional lecture formats less effective. This generation relies heavily on technology and expects instant access to information and rapid feedback on their performance. They place a high value on well-being and work-life balance, sometimes finding it difficult to align with the rigorous demands of dental programs. Additionally, professionalism in the digital age poses new challenges, including managing social media use, maintaining appropriate online boundaries, and understanding the long-term impact of their digital footprints.

(TT) – Work/life balance is paramount to them, so we don't see as much after hours' participation from the majority. Always, a few are motivated and they put in extra effort. Technology assists in attendance taking, but the Gen Zs try to capitalize on their right to privacy. Perception and negotiation among Gen Z differ markedly from that of teachers.

(UM) – Lack of critical thinking skills, motivation.

(UO) – Technology-focused. Wanting pre-recorded lectures to reference, not as easily able to adapt to different situations, or able to come up with creative solutions.

(UT) – The Gen-Z dental student population brings both strengths and challenges to the learning environment. Many students demonstrate strong digital literacy but can also appear easily distracted, often watching videos or multitasking on their phones and computers during lectures. Additionally, some students require more frequent and personalized feedback to stay engaged and confident in their performance. Faculty have also observed a few professionalism concerns, such as inappropriate comments in patient care areas, as well as occasional academic integrity issues, including increased reliance on shared materials or unauthorized collaboration. Language barriers can further complicate communication and assessment. Collectively, these challenges highlight the need for consistent expectations, professionalism reinforcement, and adaptive teaching methods that resonate with this generation's learning style.

(UTH) – As educators, the main challenges in teaching Generation Z dental students include keeping their attention in traditional lecture formats, meeting their high expectations for updated technology and interactive learning, and addressing the stress and anxiety many experience in competitive academic environments. Balancing their need for flexibility and innovation with the discipline and rigor of dental education requires thoughtful adaptation of teaching methods and strong support systems.

(UTSA) – Students often struggle with accepting constructive or critical feedback. Many require frequent positive reinforcement and express discomfort when feedback is not affirming. Coaching can be challenging due to a general sensitivity to critique and perceived lack of resilience when facing correction.

d. What strategies are you using to more effectively teach the next generation of dentists?

i. Techniques?

(LSU) – Incorporating more pre-recorded videos into the courses, more interactive lectures, and more hands-on repetition are just a few techniques. Break lectures or demonstrations into brief segments and incorporating more technology are a few strategies.

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(AM) – To more effectively teach the next generation of dentists, all preclinical courses at Texas A&M College of Dentistry use a variety of active learning strategies. These include problem-based and case-based learning, hands-on simulation, and the integration of digital dental technologies such as CAD/CAM. Courses incorporate patient-based scenarios to help students develop both technical and clinical reasoning skills. Skill development is reinforced through stepwise laboratory assessments, the provision of high-definition photos of sample preparations and restorations prior to lab activities, and clear, detailed grading rubrics. Instruction occurs in small groups, maintaining a 1:8 faculty-to-student ratio in laboratory sessions, which promotes individualized feedback and mentorship throughout the learning process.

(TT) – AI was employed to convert PowerPoint into interview conversation. Faculty are gradually being taught EPAs to employ as a method of assessment/progression.

(UM) – Multiple (?)

(UO) – Pre-recording lectures, verbal quizzes prior to lab sessions over lecture material, PowerPoint presentations of lab projects on loop at each student's lab desk, consistent message of expectations, and USE of printed rubric for every graded procedure.

(UT) – To better teach the next generation of dentists, faculty use resources from the UTHSC Teaching and Learning Center (TLC) to make learning more interactive and relevant. Using TLC tools, we've added flipped-classroom methods, short instructional videos, and digital assessments that give students immediate feedback. TLC guidance also supports effective feedback delivery, promotes academic integrity, and helps faculty adapt lessons to fit Gen-Z learning styles. These strategies make classes more engaging, hands-on, and aligned with how today's students learn best.

Faculty have integrated technology-enhanced learning strategies, including curated YouTube and instructional videos, digital simulations, and interactive modules that align with students' visual learning preferences. Demonstrations are supplemented with self-paced review materials, and real-time digital feedback tools are used to maintain engagement.

(UTH) – We listen to students' needs and incorporate interactive, hands-on, and tech-based learning methods.

(UTSA) – Frequent institution-provided continuing education on generational learning psychology, motivation, and communication strategies.

ii. Delivery of student feedback?

(LSU) – Generally, verbal and written feedback is typically provided in a timely, constructive, and positive manner.

(AM) – Most feedback is provided to students through one-on-one conversations between faculty instructors and the student, allowing them to assess progress collaboratively. For assessments, feedback is delivered in the form of a detailed

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grading rubric, which includes specific comments made by instructors to highlight strengths or weaknesses and areas for improvement.

(TT) – Verbal mostly, written (inconsistent) in daily grade card; tailored clinic improvement plan when student has grievous or repeated deficiencies.

(UM) – One on one and as a class.

(UO) – Verbal and written (pre-clinic), verbal and digital (axiUm).

(UT) – While one-on-one feedback remains the most effective approach, students often struggle with critical thinking and tend to seek direct answers rather than guided reasoning.

(UTH) – We provide timely, constructive, and personalized feedback that encourages growth and confidence.

(UTSA) – When negative feedback is necessary, it is typically provided in private settings to maintain professionalism and student comfort.

iii. Videos for preparation/restoration?

(LSU) – Yes, we provide videos that are accessible 24-7. In Sim Lab, the video or set of videos for that session plays on a continuous loop so each student can view them at their workstation.

(AM) – We have found photos are a better medium for our purposes.

(TT) – A small # of instructors make videos; students consult You Tube, online videos.

(UM) – Yes.

(UO) – We should probably do some of these. And not have the students rely on unsanctioned online videos.

(UT) – Yes. Instructional videos for cavity preparation and restoration techniques are incorporated throughout the curriculum. These visual demonstrations have proven highly effective in improving student comprehension and performance consistency. Students can review them before, during, and after lab sessions to reinforce learning, visualize proper ergonomics, and replicate ideal outcomes.

(UTH) – We have created many instructional videos across all disciplines. These short, clear instructional videos are housed in Canvas so students can access them immediately when needed. These videos demonstrate clinical procedures step by step and support independent practice.

(UTSA) – In the simulation lab, students receive demonstration videos and live demonstrations for each project. Course content is distributed in advance to allow for pre-lab preparation and review.

II. **Materials and Techniques**

a. What types of materials and strategies are used for vital/non-vital pulp therapy?

(LSU) – Vital Pulp Therapy: (Direct Pulp Cap \leq 1mm) We utilize CaOH covered with a layer of Vitrebond LC before placing the restoration. (Indirect Pulp Cap) We utilize Vitrebond LC prior to placing the restoration.

Non-vital Pulp Therapy: Root canal therapy

(AM) – Students are required to use SOAP notes to document their assessment of the *pulpal status of the tooth*, establish a diagnosis, and evaluate the tooth for restorability. If

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the pulp is vital and the tooth requires either direct or indirect pulp capping, TheraCal is available in the clinic for use as a pulp-capping agent. If the pulp is determined to be non-vital, root canal therapy should be performed on the tooth.

(TT) – MTA for direct exposures ≤ 1 mm; Glass Ionomer for affected dentin; endo treatment SIP/SAP.

(UM) – CAO₂H.

(UO) – FOR VITAL TEETH: We utilize CaOH as a direct pulp cap and Vitrebond LC for indirect pulp caps. If CaOH is used, then it will be covered with a vitrebond liner before placing the restoration.

FOR NONVITAL TEETH: Pulp and infected tooth structure is removed, the canals are irrigated with NACOH, and then gutta-percha is condensed into the canals with sealer. A core build-up will then be placed, followed by a crown, usually.

(UT) – At this time, we do not have a simulation exercise for vital pulp therapy within the undergraduate Endodontics curriculum, nor are vital pulp therapy procedures currently performed in the predoctoral Endodontics clinic. Students may receive limited exposure to the concept and clinical indications of vital pulp therapy during Pediatric Dentistry, although they do not typically perform the procedure in the undergraduate pediatric clinic. It is possible that residents in the Graduate Pediatric Dentistry program gain hands-on experience with these procedures. The Graduate Endodontics program has incorporated vital pulp therapy cases in selected situations.

(UTH) – For vital teeth pulp therapy, the traditional approach used is to remove all infected/affected dentin on the external walls; if needed, some affected dentin may be left on the internal walls to prevent pulpal exposure. Calcium-based material, such as TheraCal, is placed on the deepest part of the preparation. The tooth is placed on a 6-month follow-up recall to check for vitality.

UTSD has recently implemented the Vital Pulp Therapy (VPT) technique, a conservative treatment aimed at preserving pulp vitality after carious or traumatic exposure. Using bioceramic materials and strict isolation and disinfection protocols, this approach allows healing of the pulp and continued root development, reducing the need for full root canal treatment.

For non-vital pulp, the patient is referred to the Endo Clinic for RCT.

(UTSA) – Vital: Dycal, Vitrebond, TheraCal, MTA, and selective caries removal techniques are utilized. Non-vital: Pulpotomies are completed the same day when the patient presents with pain, for both anterior and posterior teeth (protocols may vary slightly among groups).

b. Treatment planning

i. Describe the treatment planning process at your institution.

(TT) – Based on models by Bricker and Stefanac: Phased and sequenced treatments starting with Urgent/emergent, then disease control, then assessment, then definitive treatments. Developing a plan wherein the students need to get a sanity check via prosthetic analysis/design at the treatment.

(UM) – Done in the admissions process.

(UT) – All treatment provided to emergency or comprehensive care patients begins with an **initial screening appointment** to determine if the case is appropriate for

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undergraduate care. During this visit, the patient receives a **panoramic radiograph** to assist in case evaluation. If deemed suitable for undergraduate assignment, the patient is scheduled in **Oral Diagnosis** for a comprehensive examination, additional radiographs as needed, and documentation of initial findings. Following the diagnostic phase, the patient proceeds to the **fourth floor**, where the **group leader (team leader)** collaborates with the student to develop a comprehensive **faculty-authorized and patient-consented treatment plan** that includes current fees. Using the **Treatment Plan Module in axiUm**, students systematically review all clinical data to establish diagnoses, prognoses, and a phased sequence of care, entering the appropriate **CDT codes** in order of priority. The plan is presented to and approved by the supervising faculty before being reviewed with the patient. Once accepted, the plan is finalized in the **electronic dental record (EDR)**, digitally signed by the patient, and a printed copy is provided. Any modifications to an existing plan must be **approved by faculty, documented in the EDR, and re-consented by the patient**, ensuring all treatment is properly authorized, sequenced, and recorded.

1. Who “owns” the treatment plan?

(LSU) – Students are responsible for developing a phased, sequenced treatment plan for their patients. Each treatment plan is checked by faculty and reviewed and signed by the patient.

(AM) – Clinical Affairs manages patients’ records and treatment plans. According to institutional standards, patient records are made available to patients, parents, or legal guardians upon proper written requests. The Release of Patient Record Information form must be signed in the electronic patient record system for such access.

(TT) –

(UM) – Only the student that creates it.

(UO) – Students are responsible for managing and developing the treatment plan under the supervision of division faculty. DS2: (Oral diagnosis, Perio, operative) needs beyond the scope of DS2 will be managed by DS3/4 through Group practice director. DS3: (all divisions involved), group practice director usually approves the treatment plan. DS4: Primarily group practice director, with the input of specialists.

(UT) – The group leaders – licensed dentists overseeing the predoctoral students assigned to their individual group. Each group has 2 group leaders managing 36-40 students.

(UTH) – The student will develop a treatment plan for their patients and is encouraged to perform all the planned treatments and complete comprehensive care for them.

(UTSA) – The faculty member who signs the treatment plan maintains responsibility for its content and approval. With the transition from axiUm to EPIC, treatment plan signatures are easier to modify, occasionally leading to tracking challenges when plans are unsigned or altered post-approval.

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2. Who can modify it?

(LSU) – The treatment plan can be modified by a “Team Leader” or faculty if necessary.

(AM) – Only faculty who hold a valid dental license in the State of Texas and are credentialed with the Department of Comprehensive Dentistry are permitted to modify treatment plans with their students.

(TT) – Ideally, if there is a dispute on the plan, the faculty member questioning it would consult with the original doctor who planned the treatment. In the absence of that, the next person would be the lead mentor, who is most often around. Sometimes, the faculty will ask the student to perform some other procedure that is treatment planned, that the covering doctor is in agreement with, and leave the controversial procedure for later. Ultimately, the lead mentor or the Clinical Education Dean can make a decision.

(UM) – Faculty.

(UO) – It can't be modified, but we can suspend the Tx plan.

(UT) – Group Leaders.

(UTH) – The treatment plan is approved by the Group Practice leader or First/Second Attending Faculty. They can also modify it if needed.

(UTSA) – Any faculty supervising the student may unsign and revise an existing treatment plan when clinically indicated.

3. What educational methods and resources are used to teach treatment planning?

(LSU) – Lectures, case-based learning, simulation, and clinical experiences are methods used to teach treatment planning.

(AM) – The College of Dentistry (COD) employs a model of six group practices, where treatment planning is taught chairside through direct faculty-student interaction during patient visits. Although each group practice may have unique approaches, the general protocol requires faculty to review the patient's medical history and radiographs with students. Faculty lead the initial oral examinations and guide students through the treatment planning process in the clinic. After dismissing the patient, leadership faculty review all relevant documentation—including radiographs and study casts—and collaborate with the student to phase and sequence the proposed treatment plan.

(TT) – A block of lectures on treatment planning is part of a didactic course. Based on Stefanac and Bricker's texts. This is a calibration challenge, as everyone does what is right in their eyes.

(UM) – Mostly faculty experience.

(UO) – Lecture, clinical photos are taken of a student's patient then a written essay is presented on the proposed Tx plan and any other questions the faculty have addressed. (Diagnosis and Treatment Planning in Dentistry, Elsevier 4th edition).

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(UT) – An advanced treatment planning course is given to fourth year students during the fall semester utilizing small groups and specific, live case studies. Additionally, other classes utilize treatment planning concepts throughout the curriculum. Group leader-led exercises are also conducted prior to clinical responsibilities commencing during the fall of the third year. Group leaders, in the clinic, reinforce treatment planning concepts on a regular basis during the Evidence Based Dentistry course during the third and fourth years.

(UTH) – The Diagnosis and Treatment Planning Clinics (CLIN 3017 and CLIN 4012) at UTHealth School of Dentistry use a combination of didactic instruction, case-based learning, simulations, and clinical experiences to teach treatment planning. Students begin with lectures covering diagnostic methods, treatment sequencing, and interdisciplinary care, supported by online resources and reference materials such as the *UTSD Clinic Manual* and *Treatment Planning in Dentistry* text. Learning is reinforced through case scenario presentations, written reflections on simulated patient cases, and faculty-observed clinical competency exams. These methods emphasize critical thinking, evidence-based decision-making, ethical considerations, and collaboration across dental specialties, preparing students to create and execute comprehensive treatment plans for patients.

(UTSA) – First-year students are introduced to treatment planning within their EMR training modules. Second-year students complete a formal Treatment Planning course, culminating in an Objective Structured Clinical Examination (OSCE). Third- and fourth-year students develop treatment plans within their Group Practice Groups (GPGs), where juniors collect diagnostic data and propose preliminary plans for review. Faculty then guide students through a detailed evaluation of existing restorations and problem lists, working together toward a definitive treatment plan.

4. Are there individual courses dedicated to treatment planning, or is treatment planning embedded throughout the curriculum (discipline-based)?

(LSU) – Dedicated treatment planning courses in D2, D3, and D4 years.

(AM) – Treatment planning is included in several courses, with the primary focus in DDDS 721—Preclinical Diagnostic Sciences. While key foundational principles are taught in dedicated coursework, treatment planning skills are reinforced throughout the curriculum via integrated discipline-based learning and clinical practice.

(TT) – Embedded in the curriculum.

(UM) – Both, but never enough!

(UO) – OD 8105 Treatment Planning (.5 hours) Summer DS3. Discipline-specific treatment planning is embedded in the pre-clinic classes.

(UT) – Treatment planning is introduced early and reinforced throughout the curriculum. While there's a dedicated Advanced Treatment Planning

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course in the D4 fall semester (GENP 409), the concepts are also integrated across clinical and didactic courses – including DSOM 203A and 203B (Patient Evaluation Didactic and Lab). Students also complete a treatment planning exercise when they first start their D3 year.

(UTH) – CLIN 3005 - Prosthodontics Clinic, CLIN 3017 - Diagnosis and Treatment Planning Clinic, CLIN 4012 - Diagnosis and Treatment Planning Clinic, CLIN 4008 - Periodontics Clinic.

(UTSA) – Treatment planning is embedded throughout the curriculum, especially in “Introduction to Patient Care” courses. Historically, a dedicated elective treatment planning course was offered between the second and third years.

c. How is your institution addressing the fluoride “controversy”?

(LSU) – We have a task force to monitor and address any community concerns. We have not changed our curriculum or policies regarding fluoride.

(AM) – Education and Training: We incorporate the topic of fluoride and the surrounding public discussions into our curriculum and faculty development. Students learn both the science behind fluoride’s preventive benefits and the communication skills to engage patients who may have concerns. We emphasize evidence-based practice, cultural sensitivity, and informed consent.

(TT) – As an institution, we have not addressed it. We recommend/prescribe fluoride to high caries risk patients but have not gotten involved in any regional politics regarding whether the community water should or should not be fluoridated.

(UM) – No changes at present.

(UO) – We have not changed the preventive treatment options indicated in comprehensive care for our patients (primarily topical application). A local bottling company fluoridates bottled water, which can be recommended if patients have concerns. Faculty have been asked to voice concerns as an individual Dentist and can make no comments on behalf of the university.

(UT) – Our institution aligns with ADA and CDC evidence-based recommendations supporting community water fluoridation as a safe and effective public health measure. Students are taught to address patient concerns through evidence-based communication – reviewing scientific literature, discussing myths vs. facts, and emphasizing caries prevention benefits.

(UTH) – Our institution formed a task force to monitor and deliberate over the issue. At this time, we continue to teach and advocate for EBD.

(UTSA) – Alternative remineralization approaches have not been formally introduced at this time. Faculty including Dr. Amaechi and Dr. Dossett are involved in the exploration of caries management products such as ICON and other resin infiltration systems.

III. **Student Assessment**

a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?

i. Classroom instruction related to the exam process?

(LSU) – Our competency-based exams use criteria similar to the ADEX exam.

Students are given an instructional session covering all aspects of the ADEX exam.

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(AM) – Students complete D3 and D4 Competency Exams as part of their clinical training, using criteria very similar to those of the ADEX licensing exams. While the competence exams follow ADEX clinical criteria, they utilize a school-specific grading rubric for assessment. Before the licensure exam, all D4 students participate in a mock board exam scheduled several months prior, designed to closely replicate the format and rigor of the ADEX clinical exam. In the Fall semester, D4 students take a fixed prosthodontics exam, an operative exam, and an endodontic typodont exam. These exams are designed to closely mimic the structure, content, and performance expectations of the ADEX clinical board exam. Students are provided with practice teeth and are required to complete a minimum of 20 hours of typodont/practical board simulation exercises as additional preparation.

(TT) – Sessions are held with small groups of students (15 -30 at a time) in which they prep/restore (operative), scale (perio mannikins), access (endo), prep and provisionalize (fixed) and then get feedback.

(UM) – Yes. Board prep course senior year.

(UO) – Students practice independently for their licensing exams. They can bring practice preps and restorations to identified faculty who are well-versed in the rubric of the boards. Class meetings are held, giving an orientation of what to expect and information surrounding the licensing exam.

(UT) – Yes. Students receive targeted didactic instruction on the structure, requirements, and grading criteria of the ADEX/CDCA/WREB examinations. This includes formal classroom sessions that review the Mock Licensing Candidate Manual, evaluation criteria, and exam protocols aligned with the ADEX standards. The faculty provide overviews of each section—Restorative, Fixed Prosthodontics, Endodontics, and Periodontics—and discuss the scoring system (ACC, SUB, DEF), time management, infection control, and procedural sequence expectations. Students are also oriented on instrumentation, typodont setup, and procedural guidelines, mirroring the real licensing exam environment. Regular reinforcement through lectures, calibration videos, and department-specific briefings ensures familiarity with ADEX criteria and updates. Our preparation for national licensing exams is multifaceted and intentionally structured to build competence and confidence through progressive exposure to exam content, simulation, and evaluation standards.

(UTH) – An instructional session covering all parts of the CDCA ADEX exam (PEP and Restorative) is mandatory for the students. The students also have a CDCA ADEX manual exam covering all the written instructions in the manual.

(UTSA) – Yes. Students receive structured classroom instruction focused on exam expectations and clinical performance criteria.

ii. Mock boards?

(LSU) – Yes, mock board exams are given to the D3 and D4 students.

(AM) – Mock board exams are administered in the Spring semester for D4 students. This annual exam replicates the operative, prosthodontic, and endodontic sections of the actual board exam. The mock board is strictly timed,

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and all clinical faculty are calibrated to ensure standardized grading and feedback. This experience provides students with a realistic simulation of the board exam environment and expectations, reinforcing both clinical skills and time management.

(TT) – Mock boards are carried out on mannikins within the term that boards are administered.

(UM) – No longer except in board prep course.

(UO) – No official Mock board. DS4's in both the Fall and Spring Semesters have competencies tied to clinical courses designed to mimic the ADEX exams.

(UT) – Yes. Each year, students participate in comprehensive Mock Board Examinations designed to simulate the actual ADEX and CRDTS testing experience. The Mock Licensing Exam replicates manikin-based exams using the Acidental ModuPRO system evaluated by calibrated faculty examiners using ADEX-based criteria.

(UTH) – This is similar to the preparation for the CDCA ADEX. Students will have an instructional session on the format of the ADEX exam, the same rubrics, and step-by-step instructions. After Mock Boards, the course director will carry out a review addressing the main concerns and how to improve the course. If a student fails, they have to remediate until they successfully pass the procedures.

(UTSA) – Yes. Mock board examinations are conducted to simulate the testing process and assess readiness for clinical licensing exams.

b. How are students assessed when scheduled on external rotations?

(LSU) – Students are assessed by the attending faculty.

(AM) – There are no formal assessments administered while students are scheduled on clinical rotations. The procedures performed during these rotations are recorded and counted only as clinical experiences, similar to the experiential learning students encounter during their regular time in dental school clinics.

(TT) – Preceptors are calibrated on how to give feedback. Assessment is P/F. Problems with sub-optimal performance are reported to the faculty in charge of rotations.

(UM) – By attending faculty.

(UO) – The calibrated dentist overseeing the student will determine if the procedure is clinically acceptable or not.

(UT) – Students receive oversight and guidance from faculty and preceptors; however, no competencies are completed during external rotations. Treatment records are collected, tabulated, and reviewed for performance monitoring.

(UTH) – The local faculty assesses students and reports their performance to the Director of Community Outreach Program and the Assistant Dean for Clinical Education.

(UTSA) – The Calibration Committee is currently standardizing expectations and assessment tools to ensure that students are evaluated identically on rotation and in the main clinical setting.

i. Do you count those procedures for meeting requirements?

(LSU) – Students will receive RVU credit.

(AM) – No.

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(TT) – The procedures are documented in Axium via code, and they are counted for RVU as experience. Because the sites are considered “minor sites,” no competencies are challenged or credited at external sites.

(UM) – Some credits.

(UO) – Students will be given RVU credit but do not receive credit for procedural experiences. Example: students still need to complete a determined number of direct restorations in our student dental clinics.

(UT) – Yes. Students receive Operative credit for procedures completed during external rotations based on the following scale. Each rotation has an overall maximum of 300 points, and students may receive credit for up to two rotations (for a maximum total of 600 points).

2025-2026 Clinical Rotation Points		
Less than 8 procedures	Sealant (only 4 count) or SDF	10 points per tooth
	Class I, Class V, and Class VI Procedures (O, Buccal/Lingual Pit, Facial/Lingual)	40 points
	Class II Procedures (MO, DO, MOD)	50 points
	Class III Procedures (MF, ML, DF, DL, MFL, DFL)	50 points
	Class IV and 4+Surface Procedures (including core-buildups)	75 points
8+ procedures		300 points

(UTH) – The only procedures that count towards the student’s requirements are operative procedures and extractions done in adult patients.

(UTSA) – Currently, some rotations count toward requirements while others do not. Students have requested uniform inclusion of requirements completed during rotations, as off-site experiences can represent a significant portion of clinical time. However, maintaining fairness remains a challenge, as productivity varies significantly among community health sites and rotation weeks.

IV. Administration

- a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?

(LSU) – There are various wellness workshops that we can attend.

(AM) –

(TT) – The university offers workshops on achieving this, and there is a committee that organizes events/workshops within the SDM. Despite this, some people are overworked while others are not. Pareto’s Law of Optimality.

(UM) – None.

(UO) – For our department, your personal life is how you balance it.

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(UT) – As a department, we promote work-life balance by encouraging open communication, teamwork, and mutual support among faculty and staff. Workloads are distributed fairly, and flexibility is provided, when possible, to accommodate personal and family needs. We emphasize time management, professional boundaries, and the importance of taking time to rest and recharge. Additionally, the department fosters a positive and collaborative environment that supports both professional excellence and personal well-being.

(UTH) – We promote flexible scheduling, provide wellness resources, and encourage regular breaks to maintain a successful work-life balance.

(UTSA) – Faculty and staff engagement is encouraged through morale and wellness initiatives including holiday events, faculty development retreats, wellness programs, and cultural celebrations such as Thanksgiving lunches, fall festivals, International Culture Night, and the annual Christmas dinner. Additional support includes access to the UT Health Wellness Program, free flu vaccinations, and team-building activities coordinated by faculty and staff leadership.

- b.** What assistance in terms of initiatives/support/strategies does your school/university provide?

(LSU) – The Health Science Center offers various workshops and wellness resources.

(AM) – Texas A&M College of Dentistry supports faculty work-life balance by providing ongoing development opportunities, and comprehensive wellness resources. Faculty development includes workshops, seminars, continuing education, and peer mentoring, fostering career growth and personal well-being. The college's wellness initiatives offer access to mental health support, fitness programs, work/life assistance, and the Faculty Health & Wellness Series, which brings expert speakers to promote healthy lifestyles. The institution also encourages peer mentoring and networking among faculty, creating a supportive environment that helps maintain both professional excellence and personal well-being.

(TT) – Same as above—university level and school level. Since the students get a break between terms, it provides a chance to catch up. We have a wellness committee with sponsored events.

(UM) – None.

(UO) – The University had monthly “LiveWell” events, such as Zoom meditation times, Well-Being awareness fairs, Round Table events like “Ask a certified personal trainer”, and rare Chair massages at the Bird Library, a “reflection room” on the 2nd floor.

(UT) – The University of Tennessee Health Science Center (UTHSC) provides extensive resources to support work-life balance through programs such as the Employee Assistance Program (EAP), Wellness on Campus, and the Teaching and Learning Center’s Faculty Well-being Initiatives. These programs offer confidential counseling, wellness activities, and professional development opportunities that promote physical, emotional, and mental health. Additionally, UTHSC encourages flexibility, mentorship, and community engagement, fostering an environment that supports both personal and professional fulfillment.

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(UTH) – The school/university offers a range of initiatives, including personalized academic advising, tutoring programs, mental health resources, and career counseling. Engaging in extracurricular activities further enhances student success and community connection.

(UTSA) – Faculty have access to resources for protocol development, research support, budgeting, and grant assistance through the Office of Research and Academic Affairs. The university offers Institutional Review Board (IRB) training and internal research program support (IRP).

c. Calibration

- i. How often does your operative faculty meet as a group, and what are the objectives of those meetings?

(LSU) – We meet on a weekly basis. We discuss current issues, resolutions to current issues, class progress and general brainstorming.

(AM) – In preclinical courses, operative faculty meet primarily within the context of D1 and D2 classes. The course director for each course is responsible for scheduling meetings with involved faculty to ensure calibration and consistency in teaching methods and evaluations. Additionally, clinical faculty hold regular calibration meetings specifically dedicated to operative assessments. The main objectives of these meetings are to uphold uniform grading standards, review and update course content, and refine evaluation criteria. Faculty meetings are regularly held prior to typodont assessments and before mock board exams to ensure calibration, and there are also end-of-year academic meetings where each disciplines review changes and updates for the upcoming year.

(TT) – We teach an integrated curriculum, so there are not faculty that are strictly operative. Those who teach operative also teach/participate in endo, fixed, perio, exodontia, anesthesia, peds, etc. Each unit faculty will calibrate before each unit exam (OSPE and OSCE). Objectives are set before each term begins, and each group reassesses after each exam.

(UM) – At least yearly in the past.

(UO) – We meet twice a year at the end of Fall and Spring Semesters. We review the past semester's courses in operative and present class scores/results and invite reflections from the faculty on the different projects and course content, syllabus, grading, etc.

(UT) – The Operative faculty meet **twice per year** to discuss course coordination, review and update rubrics, evaluate student performance trends, and share instructional strategies. These meetings also provide an opportunity to address curricular alignment between preclinical and clinical courses, review assessment criteria, and discuss any pertinent updates or changes impacting Operative Dentistry education.

(UTH) – Our operative faculty meets quarterly to discuss calibration processes, review updates, and share best practices. We also address challenges from lectures and demonstrations to ensure high-quality education. Regular attendance in lectures is required for faculty to stay aligned with our objectives. We are also required to meet for course calibration immediately before a semester starts.

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(UTSA) – Operative faculty meet at least once per week to discuss curriculum updates, standardize forms for rotations, and calibrate both school-based and off-site faculty. Calibration efforts include digital resources, instructional videos, assigned readings, and online Canvas calibration modules.

ii. Are your calibration efforts discipline-based or across all disciplines?

(LSU) – Our calibration sessions are mainly discipline-based in nature.

(AM) – Calibration efforts at Texas A&M College of Dentistry are primarily discipline-based, particularly in preclinical courses, due to the variety of rubrics and assessment approaches used within each specialty. For example, fixed prosthodontics relies on discipline-based calibration, with separate meetings and grading strategies calibrated specifically for fixed prosthodontic procedures. To ensure alignment and address any calibration challenges, end-of-semester faculty meetings are also held across disciplines to discuss what aspects worked well and what could be improved. In addition, calibration between clinical and preclinical faculty is reinforced by having preclinical faculty participate in grading ADEX mock board exams, promoting consistency in evaluation standards throughout the curriculum.

(TT) – Calibration is carried out as global (discipline-based) or as problem-based—whatever we see as problematic or inconsistent, then becomes a topic for calibration.

(UM) – All!

(UO) – Our calibration is discipline-based. We have had PowerPoint presentations detailing the multiple rubrics' grading criteria with pictures taken of preps and restorations documenting the grades associated with each.

(UT) – Calibration efforts are discipline-based and conducted specifically within Operative Dentistry for both laboratory and clinical settings. Faculty participate in calibration sessions focused on preparation design, evaluation rubrics, grading consistency, and clinical performance standards to ensure fairness, reliability, and alignment with departmental expectations.

(UTH) – Our calibration efforts are primarily discipline-based, allowing us to tailor our approaches to the specific needs of each area. We also encourage interdisciplinary collaboration to share insights and enhance the calibration process across all disciplines. This approach helps maintain high educational standards throughout our program.

(UTSA) – Both. Operative calibration occurs within the discipline, but cross-disciplinary collaboration is ongoing to reduce redundancy and ensure foundational consistency across courses. Shared calibration initiatives are coordinated through Canvas-based online modules and joint meetings among course directors.

d. What are your policies for student absences?

(LSU) – Students are required to attend all scheduled appointments/sessions in each course. Students not present when attendance is taken will be considered absent.

Absence in excess of 20% of the total clock hours in any course will result in a final grade

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reduction of one letter grade for that course. Each department will determine a general policy for monitoring attendance in assigned course(s).

(AM) – Texas A&M College of Dentistry follows Student Rule 7 for student absences.

Students are expected to maintain at least 95% attendance for their clinical hours, monitored by Patient Appointment Coordinators (PACs), with routine conferences held by student group leadership. All absences are determined as excused or unexcused by the Office of Student Affairs. For most preclinical courses, students must make up any missed lab, regardless of whether the absence is excused or unexcused. Assessments missed due to excused absences may be made up, but unexcused absences will result in a zero for the missed assessment.

Summary of Rule 7:

- Attendance is a student responsibility for both face-to-face and distance education. Instructors post exam dates and assignment deadlines on the first-class syllabus.
- Excused absences include religious holy days, active military service, pregnancy/parenting or related Title IX circumstances, disabilities under the ADA, personal illness/injury, major illness/death in the immediate family, legal or government proceedings, required interviews, presentation of research, authorized university activities, athletic competition, organ/stem cell donation, and approved compelling personal reasons.
- Documentation must be provided within three business days of return and include substantiating evidence. Instructors or, in some cases, college deans, confirm the excused status.
- For an excused absence, students may make up missed work or exams. For unexcused absences, instructors are not required to offer make-up opportunities.

Extended or repeated absences may result in withdrawal or no grade, per dean's decision.

(TT) – Students are allowed 11 personal days per year that previously was broken up by term: Summer term -3 days; Fall term -4 days, Spring 4 days. Personal days cannot coincide with Fridays (normal exam days), and once used up, any days off are unexcused.

(UM) – 10 per year.

(UO) – All student absences go through student affairs.

Students must receive prior approval for planned absences.

Excused absences include:

- Illness
- Personal emergencies or family tragedies
- Doctor's appointments
- Religious holidays (observed dates only)
- Residency/job interviews
- Jury duty
- Scientific/educational presentations or leadership representation at professional meetings

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Unexcused absences include Weddings, Family vacations, and personal obligations. Students with unexcused absences are not permitted to make up quizzes, exams, or assignments and will receive a zero for any missed work. Students are permitted up to five excused absences and two unexcused absences per academic year. Additional requests will be reviewed on a case-by-case basis.

(UT) – Our excused absence policy can be found here:

<https://www.uthsc.edu/dentistry/administration/academic-affairs/documents/excusedabsence2025.pdf>

(UTH) – Student attendance at scheduled classes, small-group sessions, lab sessions, preclinical labs, intramural clinics and rotations, extramural clinics and rotations, and official School- or University-required functions is **MANDATORY**. We use “Quickly Attendance”, it is embedded into Canvas, with QR codes that change every 5 seconds.

(UTSA) – The School of Dentistry follows the institutional attendance policy. Most exams, quizzes, and graded activities are not excused for absence unless approved in advance. Students must submit absence requests via the online portal; approval is determined based on the reason provided. Daily assignments may be eligible for makeup, but attendance remains mandatory for most classes.

e. What are the demographics of your current classes, and what are the trends?

(LSU) –

(AM) –

(TT) – 97% are Texas residents; Females exceed 50%; Hispanic—Asians—Caucasians—African Americans—Native Americans—Others

(UM) – Most diverse in the history of the school, trending mostly female.

(UO) –

(UT) – Our current class consists of **129 students**, reflecting a continued trend toward greater gender and ethnic diversity within the program. Female students now represent a significant majority, comprising approximately **63% of the cohort**, indicating an ongoing increase in female enrollment compared to prior years. In terms of racial and ethnic composition, **White students** remain the largest group (69 total; 59 female and 30 male), followed by **Asian students** (21 total; 13 female and 8 male), **Black students** (7 total; 5 female and 2 male), and **Hispanic students** (2 male). Additionally, **nine students** identified as **Two or More Races**, and **one student** identified as **Unknown**. Overall, the class demographics demonstrate increasing female representation and a gradual rise in racial and ethnic diversity, particularly among Asian and multiracial students. These trends align with broader national patterns in dental education, reflecting growing interest among women and underrepresented groups in the dental profession.

(UTH) – Most of our current students are from Texas, per State law (95%), with a smaller percentage from other states (5%). This trend highlights our program's local appeal, though we are looking for ways to attract more out-of-state students to diversify our learning environment. (Are we?)

(UTSA) –

i. Is student performance in courses declining?

(LSU) – Overall, the course performance has remained stable.

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(AM) – Student performance is generally stable and follows a bell curve, with few students struggling to complete competencies but ultimately meeting graduation requirements.

(TT) – Trick question. Students are increasing in performance with time and experience, and in technology, but if compared to pre-COVID performance or expectations, one would say the requirements/performance are declining. Our test metrics say that they are performing at greater than 95%.

(UM) – Good question.

(UO) – About the same.

(UT) – No. Student performance has remained consistent overall, with many students demonstrating improvement through early intervention, tutoring, and faculty mentorship.

(UTH) – No, student performance in courses is not declining; it remains consistent or shows improvement.

(UTSA) – Variations in instruction and overconfidence in certain content areas have been observed. Overall course performance has remained stable, but leniency tends to be met with decreased engagement, indicating the need for consistent expectations and accountability.

ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...?

(LSU) – Didactic courses do not include remediation opportunities. In clinical and Sim Lab competencies, students may repeat the competency as many times as needed to demonstrate proficiency, as long as they meet the requirement by the end of the course.

(AM) – Remediation attempts for exams, courses, and skills assessments vary based on the type of exam, discipline, and whether the assessment is on a patient or a typodont.

For clinical patient competencies (operative, fixed, and removable) at Texas A&M College of Dentistry, students are allowed multiple remediation opportunities as needed up to a specified deadline. If a competency exam, such as in removable discipline, is not completed successfully, the student must attempt an OSCE (Objective Structured Clinical Examination) at the end of the term. For clinical typodont exams, students generally have multiple chances to remediate after a failed attempt, but additional attempts do not change the original grade. In most preclinical hands-on courses, students must remediate failed practical exams until their work is graded as clinically acceptable; however, remediations do not change the original failing grade. For written exams, a student is given one comprehensive remediation opportunity, and the original failing grade remains.

(TT) – There used to be 2 remediations, now changed to 1 remediation. If a student does not satisfy the challenge, then the student goes to CAPS.

(UM) – Depends on the course coordinator.

(UO) – Didactic exams: no remediation is offered

Skills assessments: students perform a series of exercises to demonstrate competency, but the original grade remains.

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Courses: To satisfy degree requirements, all "D" grades must be remediated by enrolling in a special studies remediation course, the contents of which are determined by the course director. If the student satisfactorily completes the requirements for the special studies course, a grade of "S" will be recorded, and the degree requirement will be deemed fulfilled. If the student does not satisfactorily complete the requirements, the remediation is not considered successful, and the student receives a grade of Unsatisfactory (U) for the special studies course and must repeat the course.

This can result in the student repeating the year.

Didactic and preclinical courses in which an "F" grade is received must be re-taken and the student will be re-enrolled in the course. Both grades will appear on the transcript. The course director recommends a format by which the course may be re-taken, subject to approval of the Periodic Assessment Committee. This can result in the student repeating the year. (COD Handbook 4.3.1 Grading policy)

(UT) – The number of remediation attempts is determined collaboratively by Academic Affairs, the individual course directors, and any relevant academic or promotion committees. Decisions are made on a case-by-case basis to support the student's holistic educational development. The process takes into account the nature of the deficiency, the student's overall progress, and institutional policies to ensure fairness and academic integrity.

(UTH) – Remediation for skills assessments is required until clinical competence is achieved, while the number of attempts for failing courses is based on the committee's recommendation. I would add that it depends on the Syllabus, some Syllabi will allow only one remediation attempt.

(UTSA) – Remediation opportunities depend on the student's overall course performance. Multiple attempts may be permitted if cumulative averages reach a passing grade.

- f. Are you considering a switch from axiUm to EPIC as your Electronic Health Record?

(LSU) – No, we are not considering a switch from axiUm to EPIC at this time.

(AM) – We are not considering a switch from axiUm to EPIC as our Electronic Health Record system in the near future. Any decision regarding a change will ultimately be made by Clinical Affairs.

(TT) – No.

(UM) – First school on EPIC- dental program is called WISDOM.

(UO) –

(UT) – Currently, there are no plans to transition from axiUm to EPIC.

(UTH) – Yes, we are considering a switch from axiUm to EPIC, and we plan to implement the transition gradually. The change will happen; our Faculty Practice has transitioned first, starting this Fall (2025).

(UTSA) – The transition to EPIC has been completed; however, the process has presented challenges related to workflow, faculty adaptation, and system navigation.

V. CaMBRA Questions

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This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.
 - i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?
 1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?
 - (LSU) – Yes. Students document lesions in the Oral Diagnosis Treatment Planning Bay
 - (AM) – Yes. Students document it in a progress note.
 - (UM) – No. On EPIC.
 - (UO) – Yes. During the Treatment Planning appt. each lesion is diagnosed according 1/3rds of the enamel and dentin depths, but a tooth would not be treatment planned to restore until it reaches the threshold of operative treatment, not in the preventative treatment stage.
 - (UT) – Yes. Lesions are documented in the odontogram as well as in a list in the Treatment History of the HER.
 - (UTH) – Yes. Caries lesions are documented most specifically in a separate form as a part of our Center for Health Promotion – this occurs for all patients. On this form, per tooth/per surface documentation of clinical (ICDAS) and radiographic findings are recorded, in addition to caries risk assessment. Both tooth-level findings and patient caries risk level are tagged to treatment recommendations. Caries lesions are also recorded in the odontogram.
 - (UTSA) – Yes. Faculty and students have been calibrated to document tooth-level caries lesions. However, consistent oversight occurs primarily when operative faculty are directly involved in reviewing student charts.
 - Students document findings in both the odontogram and comprehensive exam notes, formatted as:
 - Tooth 1: M, D2 primary caries
 - Tooth 2: Sound
 - ...etc.
 2. If NO, why are lesions not documented?
 - (UM) – On EPIC.
 - b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use and how granular is your documentation? For example, some schools may note lesions on a simply binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression (“incipient” vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?

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(AM) – Some faculty in Public Health use the ICDAS/ADA CCS systems for initial exams and diagnoses, while faculty in the Comprehensive Dentistry department record the location of decay as either primary or secondary and level of progression.

(TT) – We have had calibration exposure to ICDAS, but it is a concept foreign or not in employment by those new to academia. Very few faculty are using E1/E2. D1/D2/D3 as a method of describing the extent of caries.

(UO) – In the Odontogram, “watches” are placed on lesions that can still be preventatively treated, and lesions to be surgically treated are then categorized by 1/3rds of dentin penetration. We use the ICDAS/ADA CCS approach.

(UT) – Caries is noted as Incipient, Primary, Secondary, or "Watch- Possible caries," with applicable surfaces noted.

(UTH) – Our Center for Health Promotion Form documents tooth-level caries lesions per tooth/per surface using the ICDAS System (scale 1-6, including active [+] vs inactive [-] designations). This is the most accurate documentation of our tooth-level caries lesions. The odontogram, which is tied to historic Axium nomenclature, is not as specific – there are only a few choices for caries, such as “primary, secondary, incipient.” Eventually, we will get IT to change these to harmonize with ICDAS.

(UTSA) – Caries is recorded as yes/no with radiographic approximation using standard descriptors (E1, E2, D1, D2, D3).

- c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?

- i. If YES, which diagnostic codes/descriptors for caries lesions do you use?

(TT) – Yes. We are mostly using CDT codes in the daily Axium notes, although diagnostic codes are used to formulate the treatment plan.

(UT) – Yes. C3001 -Primary caries, C3002 - Incipient caries, C3003 - Secondary caries, C3004 - WATCH- Possible caries.

(UTH) – Yes. Every treatment code (CDT) must be accompanied by a diagnostic code in our Axium; this has been the case for over a decade. Currently, we use a much-shortened list of codes from the original COHRI diagnostic codes in Axium. The overall list is confusing and has too many codes, so we “inactivated” the majority of them to distill the list down to what harmonizes with our Center for Health Promotions’ approach to tooth-level caries lesion documentation. The following are the codes we have active for use:

977804 Active initial dental caries outer 1/2 of enamel
942646 Active initial dental caries inner 1/2 of enamel
549595 Primary active initial dental caries outer 1/3 of dentin
941503 Primary active moderate dental caries middle 1/3 of dentin
759185 Primary active advanced dental caries inner 1/3 of dentin
977231 Primary active advanced dental caries to the pulp

976905 Secondary active initial dental caries outer 1/2 of enamel
942646 Active initial dental caries inner 1/2 of enamel
144173 Secondary active initial dental caries outer 1/3 of dentin
976062 Secondary active moderate dental caries middle 1/3 of dentin
976406 Secondary active advanced dental caries inner 1/3 of dentin

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976435 Secondary active advanced dental caries to the pulp

888259 Active non-cavitated root caries

888114 Non-active cavitated root caries

161157 Active cavitated root caries

473642 Non-restorable carious tooth (disorder)

ii. If NO, why are diagnostic codes not used?

(AM) – No.

(UO) – No. We do not have modifiers to the CDT code in Axiom.

(UTSA) – No. Diagnostic coding for caries has not yet been implemented institutionally within EPIC due to system limitations and calibration priorities.

Region IV

2025 National Agenda – Region IV

Response Color Key

(CW) Case Western University School of Dental Medicine – (No Responses)

(IU) Indiana University School of Dentistry

(MW) Midwestern University College of Dental Medicine – (No Responses)

(OSU) Ohio State University College of Dentistry – (No Responses)

(UB) University of Buffalo School of Dental Medicine – (No Responses)

(UDM) University of Detroit Mercy School of Dentistry – (No Responses)

(UIC) University of Illinois at Chicago College of Dentistry

(UM) University of Michigan School of Dentistry

(UP) University of Pittsburgh School of Dental Medicine – (No Responses)

(WVU) West Virginia University School of Dentistry

(*WU) Western University Schulich School of Medicine & Dentistry – (No Responses)

I. Curriculum

a. How are your external rotations organized?

Summary: All four institutions incorporate external rotations into their dental curricula, but the structure and duration vary significantly. UIC partners with **33 sites**, while IU organizes **community-based dental education (CBDE) rotations** during the D4 year in **4-week blocks**, involving FQHC clinics, private practices, and interprofessional experiences, with a total of **34 affiliated sites**. WVU offers short **single-day rotations** at free clinics during D3/D4 and requires a **mandatory 6-week rural rotation** in the fourth year, allowing students to rank preferred sites. UMICH currently utilizes **15 sites**, with **2 more under review**, for its external rotation program. Overall, these programs emphasize community engagement, service-learning, and diverse clinical exposure, though scheduling and site numbers differ by institution.

i. How many affiliation agreements/sites?

(IU) – Students are assigned in groups of 15 or fewer to community-based dental education (CBDE) rotations. The CBDE rotations are scheduled along with our internal rotations. We schedule rotations 2 years in advance to give students plenty of time to manage conflicts and make arrangements for being away from the school. CBDE rotations are scheduled in blocks of 4 weeks during the D4 year, and we currently have 8 blocks. During the 4 weeks, students participate in a 2-week community-based (FQHC) clinic rotation, a 1-week private practice experience, and a 1-2 day interprofessional education (IPE) clinic rotation. Students with families are given priority for placement closer to the school (Indianapolis). Trades and reassignments are allowed for legitimate and significant conflicts, but otherwise, students are expected to attend their assigned rotations. - The program currently has affiliation agreements with 20 FQHC sites and 14 private practice offices. Therefore, a total of 34 sites.

(UIC) – 33 partner sites.

(UM) – Michigan has 15 current sites and 2 under contract review.

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(WVU) – We offer a few types of external rotations. Our students rotate at a few free clinics throughout the state, for a day at a time only, during their D3 and D4 years. During their fourth year, after demonstrating appropriate quality and quantity of work in each department, students are qualified to go on their mandatory 6-week rural rotation. This course is a service-learning course, and students rotate throughout the state. The students rank order their choice of rotation site, based on the type of practice in which they wish to work (FQHC, private practice, rural area, more urban area, etc.) Once students are approved to go, the Office of Student Affairs and Community Outreach schedules them with a site.

ii. How many rotations?

(IU) – We have 3 different rotations in a single 4-week block of time.

(UIC) – D4 2 rotations (2 sites), AS4 one rotation (meaning one site).

(UM) – There are 15 current rotation experiences available.

(WVU) – 68.

iii. How many total weeks?

(IU) – 4-week CBDE assignment.

(UIC) – Depends on the year. AS4 4 weeks and 8 weeks for D4s.

(UM) – Each student completes 12 weeks of rotation during their fourth year, or four weeks per semester. Each student completes 1 week of pediatric experience on rotation during their third year.

(WVU) – 2-4 of the free clinic rotations, and one 6-week rotation; if the student has progressed through the clinical curriculum well, they may qualify for an additional rotation of anywhere from 2-6 weeks.

iv. When are the students scheduled externally? (DS4, DS3, etc...)

(IU) – DS4 year.

(UIC) – All four years of dental school.

(UM) – The students are scheduled in three groups each semester, which rotate in a 2-4-2 pattern; Two weeks out at rotation, four weeks at the School of Dentistry, two weeks out on rotation.

(WVU) – DS4 year.

v. How many weeks at a time?

(IU) – One 4-week block of time.

(UIC) – All four years of dental school.

(UM) – Each student rotates for two weeks at a time, returning home on weekends.

(WVU) – 6 weeks.

vi. How are students supported?

(IU) – At the CBDE sites, our students work alongside volunteer dentist(s). Depending on the site's staffing, dental students may also collaborate with dental assistants, expanded function dental assistants, dental hygienists, and the office manager.

(UIC) – We provide housing for the far sites.

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(UM) – Each student has a 24/7 contact number for the program manager and the administrative assistant for any issues or concerns that may occur.

(WVU) – For the 6-week rotation, extra financial aid is allotted for their gas/mileage, and housing is provided for those who need it. There is an MOU between the University and the site, so the students are covered under the school's insurance umbrella.

vii. Who pays for accommodations?

(IU) – The accommodations are paid out of the CBDE account.

(UIC) – It is a mix of sites and the College.

(UM) – The School pays for all single-room hotel accommodations, provides a carpool car to each location, and reimburses fully for gasoline.

(WVU) – WVU Institute for Community and Rural Health in partnership with WV AHEC (Area Health Education Centers).

viii. How are faculty/preceptors calibrated?

(IU) – Currently, the program calibrates volunteer faculty through an online calibration program. The program consists of modules that focus on content calibration in alignment with IUSD instructional standards. Faculty are asked to review the modules in Canvas and provide an attestation confirming they have completed the review.

(UIC) – Yearly through an information video and quiz.

(UM) – The Director of Outreach attends each clinic to give a calibration session on a yearly basis. Each preceptor is instructed to attend monthly Zoom calibration sessions presented by the Cariology/Restorative Sciences department, given by the School of Dentistry.

(WVU) – The preceptors take an annual calibration course and examination. The calibration content is derived from the on-site calibration content from each Department.

b. How are patients managed after the completion of their comprehensive care?

i. Ongoing recall/hygiene by students?

(IU) – The students complete a patient outcome form, and the patient is then included in a recall system, either with dental hygiene students or with dental hygiene staff. Students must complete the treatment plan. Recall appointments are only scheduled if a periodontal reassessment is needed. If the patient is periodontally stable, they may be referred to the incoming D2 students, to a dental hygiene student, or to the dental hygiene staff.

(UIC) – Treatment plans should include phase 4 periodic exam and periodontal maintenance or prophylaxis.

- Ideally, the patient status in the EHR should be changed to Recall status after the Phase 3 Re-Eval.
- Otherwise, if there was no phase 3 treatment, the student should request that the patient's status be changed to recall. Recall is ongoing with their assigned student.
- Side note: While the patient is being seen for active treatment under their prescribed treatment plan, the student has the responsibility

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of maintaining the patient's regular hygiene (periodontal maintenance or prophylaxis) intervals.

(UM) – After completing the disease control phase of their comprehensive care, students conduct a post-treatment evaluation and exam to assess outcomes and overall oral health stability. They are then responsible for managing the patient's ongoing recall and maintenance. Upon graduation, the patient's continued care is transitioned to the next student provider within the same vertically integrated care (VIC) team for ongoing management. Ongoing recall and hygiene care are managed collaboratively within the vertically integrated teams. Students are responsible for monitoring and maintaining the recall status of their patients and may refer them to the hygiene student assigned to their team for preventive care. It remains the dental student's responsibility to ensure that ongoing recall appointments are scheduled and completed, whether by a hygiene student or by themselves.

(WVU) – They will go into maintenance phase- either assigned to new dental students, or in the hygiene pool, receiving exams at each visit, and will go back to dental student if/when needed for treatment planning. If no pros or fewer than 5 lesions, they may be scheduled in a limited care clinic where restorations are completed.

c. Describe challenges you are experiencing related to the Gen-Z student learner?

Summary: Across all institutions, Gen Z dental students present similar challenges: they tend to have **shorter attention spans**, prefer **concise, easily accessible content** (such as short videos or clips), and often expect **immediate feedback**. Engagement in traditional lectures and hands-on sessions is harder to maintain, as many students favor **simpler approaches** and rely heavily on **technology and quick online answers** rather than deep research. There is also a noticeable shift toward **outcome-focused learning**, with less appreciation for the process, along with **grade negotiation**, inconsistent attendance, and more casual communication styles. Faculty are adapting by incorporating **digital resources, interactive strategies, and real-world connections** to sustain engagement and foster critical thinking.

(IU) – Gen-Z students are harder to engage and have difficulty maintaining attention and participation. Many prefer easier approaches, often do not want to attend class or lab, and expect immediate feedback on grades.

(UIC) – Want to be spoon fed, everything needs to be readily available, short clips, no long lectures. Sensitive. Want immediate feedback, want to see the outcome without enjoying the process.

(UM) – Gen Z learners often exhibit shorter attention spans and a preference for immediate, concise information, which can limit deeper engagement and critical thinking. Many rely heavily on technology and quick online answers rather than conducting thorough research or analysis. We also encounter increased grade negotiation and a focus on outcomes over process, along with inconsistent attendance and engagement. Faculty need to continually adapt content and teaching strategies to maintain engagement and connection to real-world practice.

(WVU) – Shorter attention span and more casual communication/professionalism styles.

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d. What strategies are you using to more effectively teach the next generation of dentists?

i. Techniques?

(IU) –

(UIC) – Constructive feedback, lots of mentoring and coaching. Clear expectations, incentives such as bonus points, quizzes, and support for accommodations.

Promote a collaborative environment. Video recordings, pre-huddles, practice questions. Flipped classroom model. Team-based learning.

(UM) – Case-based discussions, digital simulations, and interactive platforms, when possible, to promote engagement. Shorter, focused segments of material that can be recorded and viewed prior to class to allow for more meaningful in-class discussions

(WVU) – More digital content/videos, more animated PowerPoint presentations. Students seem more receptive to Menti polls and other formats that allow for instant feedback. We are also piloting a real-time, lecture-by-lecture, evaluation mechanism where instructors can provide polls to students based on that day's lecture.

ii. Delivery of student feedback?

(IU) –

(UIC) – Frequent formative feedback. Sandwich technique. Encourage self-assessment and self-reflection.

(UM) – Pre-clinical courses: students receive real-time daily session feedback and complete self-assessments using provided rubrics to guide their skill development. Clinical setting: feedback is enhanced through a daily feedback form, which students complete with the date, procedure, a brief reflection, and any questions for faculty. Students are given one week to submit the form, and while the content of the feedback is formative, the timely completion of the form contributes to their overall course grade. This process encourages accountability, reflection, and continuous communication between students and faculty.

(WVU) – Students receive daily evaluations for procedures in pre-clinic (and they must self-eval). In the clinic, similar rubrics are utilized for evaluation for every procedure. Verbal feedback/discussion is given as well, which can be completed in a FERPA-friendly environment. It's important for the students to "see" where they could have improved. While we went to digital evaluations, we did revert to circling certain aspects of a student evaluation on a physical rubric for better communication and feedback.

iii. Videos for preparation/restoration?

(IU) – As the other schools stated, however, students rarely watch videos or want extra feedback sessions.

(UIC) – Multiple video clips for operative procedures, fixed prosth and digital dentistry are posted to be reviewed by students prior to their preclinical sessions.

(UM) – Yes, instructional videos are provided to support student preparation and restorative procedures. These resources are supplemented by in-person demonstrations in the pre-clinic conducted by faculty and instructors.

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(WVU) – Videos are utilized, some YouTube videos are selected for watching as well. Some faculty have created their own videos, and some use text videos. In the first OP class (amalgam), live demonstrations are also completed

II. Materials and Techniques

Summary: All four institutions follow evidence-based approaches for vital and non-vital pulp therapy, emphasizing **selective caries removal** as the preferred strategy. For **vital pulp therapy**, commonly used materials include **calcium hydroxide (CaOH)**, **TheraCal**, and **glass ionomer liners**, with some schools also utilizing **Dycal**, **Biodentine**, and **MTA**. IU specifically references ADA Caries Removal Guidelines (2023) for clinical decision-making. WVU incorporates additional liners such as Vitrebond and GC Fuji LC, and uses rotary and hand files with BC sealer and gutta-percha for endodontic cases. UMICH adopts a structured approach: glass ionomer for indirect pulp capping and CaOH plus glass ionomer for direct pulp capping, while non-vital cases are referred for endodontic treatment after proper diagnosis and interim management. Overall, the schools prioritize conservative caries management and utilize a range of biocompatible materials tailored to clinical needs.

a. What types of materials and strategies are used for vital/non-vital pulp therapy?

(IU) – **Material(s)** used for vital pulp therapy in the UG DDS clinics are calcium hydroxide due to ease of placement and cost. Biodentine is available but not generally used due to time constraints and cost.

Strategies for vital/non-vital pulp therapy: selective caries removal is preferred if the caries approaches the pulp, but total caries removal may be used when indicated. ADA Caries Removal Guidelines-2023 are used as guidelines.

(UIC) – Our school supports direct and indirect pulp capping and selective caries removal. We have Dycal as the pulp capping agent. Theracal as well can be used as well as biodentin found in the endodontic clinic.

(UM) – In the pre-doctoral clinics, vital and non-vital pulp therapy utilizes evidence-based materials. For **vital pulp therapy**, a glass ionomer liner is used for **indirect pulp capping** following selective caries removal, and **calcium hydroxide (CaOH)** followed by glass ionomer, is used for **direct pulp capping**. Non-vital pulp therapy cases are typically referred for **endodontic treatment**, with students responsible for proper diagnosis, case selection, and interim management prior to referral.

(WVU) – Selective caries removal. Liners- MTA, Theracal, Vitrebond, GC Fuji LC. Endodontics- rotary and hand file, with BC sealer and gutta-percha with warm vertical technique.

b. Treatment planning

i. Describe the treatment planning process at your institution.

(UM) – Patients are initially screened through the admitting clinic, where appropriate radiographs are obtained to assess their oral health needs. The patient is then assigned to a dental student provider who performs a comprehensive examination and collaborates with the patient to develop an individualized treatment plan. During this process, necessary consultations with specialty faculty—such as periodontics and prosthodontics—are obtained to

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ensure a coordinated, interdisciplinary approach to care. The final treatment plan is reviewed and approved by supervising faculty before care begins.

(WVU) – Patients go through an initial assessment to create a problem list. Based on the problem list/ needs, patients are assigned to students. Students' complete treatment planning at the next appt, obtaining proper consults from different departments. OP and Perio consult for every patient unless edentulous. Other depts as needed (Endo, Oral Surgery, OP faculty can do Fixed/Removable consult-but not pros review if it is a complex case). For complex prosthodontic treatment (Fixed 4 or more units, Removable- Immediate dentures or Interim dentures), the student must meet with a faculty member for a prosthodontic review. After the initial prosthodontic review, the student presents different options to the patient. The patient chooses and signs the treatment plan. After the Disease Control Phase is complete, the student must complete a post-treatment exam (making sure no new caries, periodontal stability, etc) and have a final prosthodontic review before starting the definitive phase. Any implant procedures must be approved by an implant committee.

1. Who "owns" the treatment plan?

(IU) – **Treatment planning** is a shared process between the disciplines (perio, operative, prosth) and the clinic directors. Endo & OS approve treatment plans for their discipline. The faculty covering the tx planning appointment who reviews the tx plan with the student approves it and/or asks for discipline consults. It can be modified by the faculty supervising the dental student during specific treatment.

(UIC) – The restorative faculty.

(UM) – The **student provider "owns" the treatment plan** and is responsible for its development, implementation, and ongoing management under faculty supervision. This includes coordinating consultations, sequencing procedures appropriately, and ensuring that all phases of care are completed and updated as needed throughout the patient's treatment.

(WVU) – The student/patient only.

2. Who can modify it?

(IU) – See above.

(UIC) – Any other restorative faculty.

(UM) – The treatment plan may be modified at any time by the student provider with approval from the supervising faculty present during that clinical session. Any revisions should reflect changes in the patient's condition, preferences, or overall treatment goals, and must be documented appropriately in the patient's record.

(WVU) – The supervising faculty at each appt may alter operative treatment as needed/appropriate. Changes in any prosthodontic plan must be approved through another prosthodontic review.

3. What educational methods and resources are used to teach treatment planning?

Summary:

Treatment planning education across all four institutions combines **didactic instruction, case-based learning, and clinical application**, but each school uses slightly different approaches. UIC employs a wide range of methods, including asynchronous and interactive lectures, case-based simulations, presentations, and faculty/peer evaluations, supported by the textbook *Stefanac: Treatment Planning in Dentistry*. IU emphasizes an **interdisciplinary process**, where treatment plans are collaboratively reviewed and approved by faculty from multiple specialties, with modifications allowed during care. WVU delivers treatment planning through a **structured five-phase model**: Assessment/Diagnosis, Urgent, Disease Control, Definitive, and Maintenance. UMICH integrates **case-based discussions, simulation exercises, and faculty-guided reviews**, reinforced by interdisciplinary consultations and standardized templates within the electronic health record to ensure consistency. Overall, all schools prioritize comprehensive, evidence-based planning through a mix of classroom instruction and real-world clinical application.

(IU) – **Treatment planning** is a shared process between the disciplines (perio, operative, prosth) and the clinic directors. Endo & OS approve treatment plans for their discipline. The faculty covering the tx planning appointment who reviews the tx plan with the student approves it and/or asks for discipline consults. It can be modified by the faculty supervising the dental student during specific treatment.

(UIC) – We teach treatment planning via a multitude of methods, including asynchronous lectures, interactive lectures, case-based software simulations, case-based presentations, faculty and peer evaluation of presentations, and traditional examination (multiple-choice and write-ups). In terms of resources aside from course lectures, we provide the following textbook: *Stefanac. Treatment Planning in Dentistry, 3rd edition*.

(UM) – Treatment planning is taught through a combination of **didactic instruction, case-based learning, and clinical application**. **Case-based discussions** and **simulation exercises** allow students to apply these concepts to realistic patient scenarios before transitioning to patient care. In the clinic, **faculty-guided case reviews** and **interdisciplinary consultations** reinforce comprehensive planning and. **Treatment planning templates** within the electronic health record system to support consistent phased and sequenced treatment plans.

(WVU) – There is a treatment planning course. We use five phases- 1) Assessment/Diagnosis, 2) Urgent, 3) Disease Control, 4) Definitive (Pros, Perio Surgery, etc), 5) Maintenance.

4. Are there individual courses dedicated to treatment planning or is treatment planning embedded throughout the curriculum (discipline based)?

Summary: All four schools incorporate treatment planning both through **dedicated courses** and **embedded instruction across the**

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curriculum. UIC offers a semester-long course, *Diagnosis and Treatment Planning*, supplemented by case presentations later in the program. IU introduces treatment planning early in D1 with a didactic course and reinforces it through discipline-specific instruction and clinical sessions during Rounds and GLA in D3/D4. WVU provides an individual course and integrates treatment planning concepts throughout the curriculum. UMICH takes a comprehensive approach, embedding treatment planning across multiple disciplines and clinical experiences, supported by dedicated courses on comprehensive care and case management. Overall, each institution emphasizes a **longitudinal, integrated approach** to ensure students develop strong treatment planning skills.

(IU) – **Basic treatment planning** is introduced to the D1s in a Spring didactic course. Each discipline also teaches specifics with regards to treatment planning in various courses, mostly in D1-D3 years. The clinic directors conduct tx planning sessions with their D3 & D4 students during Rounds and GLA.

(UIC) – There is an individual course dedicated to treatment planning, "Diagnosis and Treatment Planning," which is required of all the students, and spans an entire semester. certain elements of treatment planning are also repeated via embedding in the curriculum, such as the case presentations the students give later in their academic careers - I am referring to DOSI.

(UM) – Yes, treatment planning is **comprehensive in nature** and embedded throughout the curriculum rather than limited to a single discipline-based course. While specific instruction occurs within dedicated courses, such as those addressing comprehensive care and case management, the treatment planning process is reinforced across multiple disciplines and clinical experiences.

(WVU) – Individual course, also portions embedded throughout the curriculum.

c. How is your institution addressing the fluoride “controversy”?

Summary: All four schools address the fluoride controversy through **evidence-based education and communication strategies**. UIC focuses on educating the dental community about the biases and flawed analyses in studies questioning fluoride use. IU adheres to **ADA guidelines**, including the Clinical Recommendations for Topical Fluoride (2013) and the Clinical Practice Guideline on Nonrestorative Treatments for Carious Lesions (2018). WVU incorporates the topic into **Preventive Dentistry and Cariology courses**, presenting claims from both sides to prepare students for patient questions while emphasizing reliable evidence-based recommendations. UMICH engages students and faculty through **town halls**, featuring state water department representatives to provide accurate, science-based information and strategies for addressing concerns. Overall, these approaches aim to ensure students and faculty can confidently advocate for fluoride based on sound scientific evidence.

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(IU) – IUSD follows general ADA Guidelines on fluoride therapy such as the Clinical Recommendations for Topical Fluoride (2013) and the Clinical Practice Guideline on Nonrestorative Treatments for Carious Lesions (2018).

(UIC) – Our Chair for prevention (Spokesperson for ADA) has presented to the dental community the biases of the studies where the controversy came from. He has educated the community on explaining the studies' biases with regard to the setting, measures, and flawed statistical analysis.

(UM) – A town hall was held for students this past winter, featuring representatives from the state's water department who provided accurate information about community water fluoridation and answered questions directly. This ensured that students received consistent, science-based information to share confidently with their patients. On the same day, a separate faculty town hall for our department was conducted to discuss strategies for addressing patient and student concerns.

(WVU) – Discussed in Preventive Dentistry course with D1s. The discussion is continued in subsequent preventive and cariology lectures. Discussion surrounds reliable evidence-based practice and recommendations. We make students familiar with the claims on both sides, so they are prepared to answer patient questions.

III. Student Assessment

a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?

i. Classroom instruction related to the exam process?

(IU) –

(UIC) – We don't have an assigned course for licensure exam. Our students challenge ADEX exam and we do a mock board for each portion, 2 months before the exam. They receive a grade on the overall course from the outcome of the mock board (P/F) and if they fail, are required to remediate before they take the actual exam. They practice after hours and over weekends, (not included in preclinical courses).

(UM) – Preparation for licensing exams is **discipline-specific and coordinated through each discipline coordinator**. A one-time preparatory lecture is provided to review the restorative portion of the licensing exam.

(WVU) – Yes, via meetings/seminars: restorative, fixed, and endo all do laboratory practicals that mirror the licensing exam process.

ii. Mock boards?

(IU) – Indiana University School of Dentistry provides students with structured preparation for the ADEX/CDCA/WREB examination. An orientation lecture is delivered to all candidates in July, outlining the examination format as well as the grading standards and criteria. In addition, faculty hold office hour sessions where students may review preparations and receive individualized feedback. To further support readiness, the school offers two Mock Board examinations prior to the initial administration of the licensure exam in October at IUSD. Successful completion of the Mock Board is required for students to be eligible to sit for the actual examination. Additional Mock Board opportunities are offered in late

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October and in November for those who need further preparation to achieve clearance.

(UIC) – Yes. For Pros, Endo, and Perio, we do the same exam, but for restorative we hold “mini mocks” where students get more feedback. We changed this last year due to an increase in failures.

(UM) – For restorative dentistry, “**boot camps**” are held to provide hands-on practice opportunities with direct faculty feedback. This year, a **structured mock session** has been added to allow students to experience the **modification process** as it would occur during the actual examination. Students are not graded on these mock board activities.

(WVU) – We run a real-time mock board exam with one of the testing agencies. All portions of the mock board must be passed for the students to graduate, and we’re considering having them pass the mock board before certifying they can challenge the actual board exam. The Endo and Fixed Mock Board portions serve as clinical competency exams.

b. How are students assessed when scheduled on external rotations?

i. Do you count those procedures for meeting requirements?

(IU) – No. Any procedures done on external rotations do not count for requirements. The students write a reflection, and the site would return an email.

(UIC) – No.

(UM) – Preceptors give an overall assessment at the end of each rotation for the students. These evaluations are not part of their grades. No, we generally do not count any procedures on rotation for completing requirements, except for root canal therapy. Root canals need to be fully documented with radiographs shown to the Discipline Coordinator for Endodontics to have them approved for School credit.

(WVU) – Preceptors complete procedure evaluations as well as overall evaluations. Rural sites are considered minor sites vs. major sites, and therefore procedures do not count towards minimal requirements for competency; however, they are considered as part of a portfolio of experiences in the overall evaluation of competency.

IV. Administration

a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?

(IU) – Each faculty member independently employs their own strategies and initiatives to maintain a successful work-life balance.

(UIC) – It is challenging due to the demand for academicians. Balancing the expectations of clinical faculty for publications, service, and scholarly activities. Advocate for yourself first. Be in line with your chair and the department’s expectations for your role at the college. Be religious during your protected time. Block time in your schedule to write or fulfill scholarly obligations.

(UM) – Intentional time management and prioritization, help me maintain a sustainable and balanced professional life.

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(WVU) –

- b. What assistance in terms of initiatives/support/strategies does your school/university provide?

(IU) – Faculty independently employ their own strategies and initiatives to maintain a successful work-life balance.

(UIC) – Wellness programs, faculty lounge, coffee with the dean, lunch with the Dean, welcome picnics, Christmas party, raffles, walking competition. The Faculty Affairs office sends newsletters to inform faculty on support for promotion, workshops, faculty advocate, courses, technical training, and support with teaching.

(UM) – The University provides a variety of seminars and workshops focused on maintaining a healthy work-life balance. Many meetings are offered in hybrid format, allowing flexibility for faculty who may be working from home or traveling. In addition, faculty are encouraged and supported in managing their own schedules and taking time away as needed.

(WVU) – Organization and prioritization. It's often more about work-life harmony, rather than balance. For employees, we have a generous leave policy, and our administration supports taking time off and unplugging. For our students, they receive larger blocks of time off following final exams/at the end of each semester. Wellness and BlueSky Committees try to host activities and highlight the importance of taking care of yourself, and these events are popular with faculty, staff, and students alike.

- c. Calibration

Summary: All four schools conduct regular faculty meetings and calibration sessions to ensure consistency in teaching and clinical evaluation, but the frequency and format vary. UIC holds **weekly preclinical huddles** and offers **on-demand clinic calibration sessions** with quizzes for completion, overseen by a designated faculty member. IU meets **as needed**, focusing on curriculum updates, calibration, and collaborative work. WVU schedules meetings **at least twice per semester**, covering student progress, calibration, curricular changes, and new materials or technology. UMICH requires **six mandatory calibration sessions per year** for all clinical faculty, emphasizing uniform grading and patient care standards; sessions are recorded, and faculty complete a quiz for continuing education credit. Overall, these efforts aim to maintain alignment in clinical instruction and evaluation across faculty and courses.

- i. How often does your operative faculty meet as a group and what are the objectives of those meetings?

(IU) – Operative faculty meet as frequently needed, mostly to discuss changes and developments in curriculum, calibration meetings, and for collaborative work.

(UIC) – In preclinic, every week we do a faculty huddle. In the clinic, there are calibration sessions that can be watched at any time and then take a quiz for the completion of the calibration. We have a faculty member in charge of keeping up with the faculty calibration activities.

(UM) – Faculty calibration sessions for our department occur six times per year and are mandatory for all clinical faculty. These sessions focus on ensuring consistency in clinical instruction, grading, and patient care expectations across all courses and clinics. Each session is recorded, and faculty complete a brief quiz at

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the end to earn continuing education credit and to confirm engagement with the material.

(WVU) – Meetings are held at least twice a semester. The agenda flexibly adjusts to pertinent topics as submitted by school administrative needs and faculty member-suggested items, but routinely covers a review of student progress and faculty calibration issues. Curricular updates, new dental material choices, and technology inclusion are routinely discussed.

ii. Are your calibration efforts discipline-based or across all disciplines?

(IU) – Both. They are generally discipline-based, and the clinical faculty are required to complete calibration on Canvas across all the disciplines.

(UIC) – In the preclinic, it is discipline-based. In the clinic, all faculty are expected to attend all calibration sessions.

(UM) – Calibration efforts occur at both the departmental and schoolwide levels. A schoolwide calibration retreat is planned once a year for all disciplines, fostering consistency in clinical evaluation standards and promoting interdepartmental collaboration.

(WVU) – They were initially established as discipline-based, but there will be a future emphasis on standardizing many things across disciplines.

d. What are your policies for student absences?

(IU) – Students fill out an absence request form and submit it on DentNet and notify the Office of Student Services via email.

(UIC) –
College of Dentistry Attendance Requirements.

Session Type	Requirement Level	Cohort Applicability
IDS/Lecture	Mandatory, unless otherwise specified- see syllabus	All
Group Learning (SGL/TBL)	Mandatory	D1, D2, A2, A3, D3
Pre-Clinic	Mandatory	D1, D2, A2
Lab	Mandatory	D1, D2, A2
Intramural Clinical Rotations	Mandatory	D2, D3, A2, A3
Clinic	Mandatory; exceptions for earned personal days & PG interviews; refer to DAOB syllabus & clinic manual	D3, A3, D4, A4
Extramural Clinical Rotations	Mandatory	D4, A4
Examinations	Mandatory	All

(UM) –

(WVU) – Attendance is mandatory and expected for all preclinical courses. Excused absences are permitted for illness, deaths in the family, religious holidays, and medical appointments. Unexcused absences result in a deduction of points, which can accumulate and result in a failure of the course. For clinical students/clinic attendance, students are required to maintain a minimum 90% attendance rate across all assigned clinical sessions throughout each semester. Excused absences include Professional Development and Interviews, Religious Holidays, deaths in the family, and Medical appointments.

e. What are the demographics of your current classes, and what are the trends?

(IU) – Current classes reflect a fairly balanced gender distribution. In terms of racial and ethnic background, the majority of students identify as white, while Hispanic, Asian, and Black students make up notable portions of the class, alongside a small representation

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from Pacific Islander backgrounds. Geographically, the majority of the class is predominantly made up of students from Indiana (around ¾ of the class), followed by students from nearby states such as Illinois and Michigan, as well as a smaller percentage from Florida, Utah, and several other states across the country.

(UIC) – For DMDS: 72 students: 60% male/40% female.

For DMDAS: 52 students: 79% women/21% men, last 2 years 21% Hispanic. More applicants from India.

(UM) – The most recent class has a demographic of 65% women. Students earned undergraduate degrees from 11 different colleges and universities in Michigan, as well as 37 higher education institutions outside of Michigan.

(WVU) – For the Class of 2029: Class size 48. 50%/50% Male to Female or non-binary. 30 (63%) in-state and 18 (37%) out of state. Overall average GPA 3.71, Average Science GPA 3.63.

i. Is student performance in courses declining?

(IU) – No current trends of decline in student performance have been noticed at IUSD.

(UIC) – Yes. Due to several reasons: Grade inflation, faculty demand, quality of teaching, relying on non-tenure track faculty (itinerant faculty), generational changes, social promotion, administration, and hard to fail students.

(UM) – No. Student performance has remained stable overall. While individual variations occur, overall trends in both didactic and clinical performance are consistent with previous years. To maintain this level of performance, we have implemented more remediation opportunities and developed alternative ways to engage learners.

(WVU) – No.

ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...?

(IU) – If the student's grade is within remediation range of 65-69.9%, the number of remediations allowed is decided by the course directors. Course directors decide on what the remediation is and what preparation and resources the student receives. The remediating student receives resources to support them in preparation for the remediation with support from the Office of Student Affairs. If the student passes remediation, they receive a C- grade with a maximum level achievable of 70%. Performance level below 65% constitutes a failing grade without a chance of remediation.

(UIC) – **from the syllabus: Remediation Policy**

Students who fail assessments may be required to remediate. All failures will be reported by the course director to the Subcommittee on Student Promotions (SSP).

SSP Charge, Rules and Procedures

Should a re-remediation of an assessment be required SSP action may include re-examination and/or additional work, repetition of the year, academic probation or dismissal. The SSP, based on SSP protocol will determine what form, if any, the re-remediation will take.

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Remediation occurs in accordance with the [College of Dentistry Remediation Policy](#). In the event that SSP permits subsequent remediation attempts, the following grading structure will apply:

- Second attempt (re-remediation attempt): Minimum passing score minus 1 % point
- Third attempt: Minimum passing score minus 2% points
- Fourth and final attempt: Minimum passing score minus 3% points

Students are limited to a maximum of four attempts for any given assessment. Failure of the fourth attempt will result in failure of the assessment, course, or course component, and will require SSP review for further academic action.

(UM) – The number of remediation attempts varies by course. In clinical restorative courses, students may challenge a competency twice before an individualized remediation plan is developed.

(WVU) – It is at the discretion of the course director and outlined in each syllabus (whether clinical or pre-clinical). APSC is also part of the decision- making process for clinical remediations.

- f. Are you considering a switch from axiUm to EPIC as your Electronic Health Record?

(IU) – No.

(UIC) – Yes. In September of 2026 we will make the transition.

(UM) – Yes.

(WVU) – We have purchased and are implementing the EPIC to axiUm bridge. We have not considered a full switch to EPIC yet.

V. CaMBRA Questions

This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.

- i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?

(IU) – Yes

(UIC) – Yes.

(UM) – Yes.

(WVU) – No.

1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?

(IU) – On Odontogram under “findings” on Axium.

(UIC) – Odontogram.

(UM) – Lesions are documented in the odontogram within Axium. Each lesion must have an associated diagnosis selected from a dropdown menu before treatment can be planned. The proposed treatment is then reviewed and approved by faculty.

(WVU) – No.

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2. If NO, why are lesions not documented?

(WVU) – They are documented on the odontogram as clinical or radiographic caries, and which surfaces are there. Incipient lesions are also documented on the odontogram. However, they are not classified according to the ADA CCS/ICDAS. Surfaces are recorded and planned according to Black's Classification. (This would be very time consuming to already lengthy treatment planning appointments, and thus not patient-centered care.)

However, every patient has a caries risk assessment according to CAMBRA completed. The student completes a CAMBRA form in axiUm and prescribes the appropriate treatment according to the patient's risk. Each student must also complete some test cases as part of a caries risk and management performance assessment.

However, students are taught ADA CCS and ICDAS in operative course didactically.

- b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use and how granular is your documentation? For example, some schools may note lesions on a simply binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression ("incipient" vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?

(IU) – We do document them as incipient, primary/cavitated, or secondary.

(UIC) – Yes, we chart carious lesions according to the ADA CCS on AxiUm. We will be transitioning soon to Epic.

(UM) –

Caries Non-cavitated (Active Initial) ICDAS 1-2

Caries Moderate cavitated lesion (Active Moderate) ICDAS 3-4

Caries Distinct Cavitation (Active Extensive) ICDAS 5-6

Non-restorable carious tooth

Active cavitated root caries

Active non-cavitated root caries

Secondary dentin caries

Arrested dental caries

- c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?

- i. If YES, which diagnostic codes/descriptors for caries lesions do you use?

(UIC) – Yes. Cavitated. -Non cavitated active. -Non cavitated inactive.

(UM) – Yes. The diagnosis accompanies the planned treatment code and is needed for any CDT code to be approved by faculty prior to patient consent.

- ii. If NO, why are diagnostic codes not used?

(IU) – No. Diagnostic codes are not currently used in our student clinics because our electronic health record system is set up to utilize CDT treatment codes only.

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At present, the curriculum and clinical requirements focus on CDT documentation, and diagnostic coding has not yet been integrated into our workflows.

Region V

2025 National Agenda – Region V

Response Color Key

- (BU) Boston University Henry B. Goldman School of Dental Medicine – (No Responses)
(CU) Columbia University College of Dental Medicine
(H) Harvard University School of Dental Medicine
(HU) Howard University College of Dentistry
(NYU) New York University College of Dentistry
(RU) Rutgers University School of Dental Medicine
(SBU) Stony Brook University School of Dental Medicine
(T) Temple University Kornberg School of Dentistry
(TC) Touro College of Dental Medicine
(TU) Tufts University School of Dental Medicine
(UC) University of Connecticut School of Dental Medicine
(UM) University of Maryland School of Dentistry
(UNE) University of New England College of Dental Medicine
(UP) University of Pennsylvania School of Dental Medicine
(*DH) Dalhousie University Faculty of Dentistry – (No Responses)
(*LU) Laval University Faculty of Dentistry – (No Responses)
(*MU) McGill University Faculty of Dentistry – (No Responses)
(*UT) University of Toronto Faculty of Dentistry – (No Responses)
(*UM) Universite de Montreal Faculty of Dental Medicine – (No Responses)

I. Curriculum

a. How are your external rotations organized?

(HU) – Coordinated through Office of Clinical Dentistry. Students attend various sites for various lengths of time (1 wk. up to 4 wks). Students are vetted by Discipline Directors for clinical progress, by the Office of Academic Affairs for academic good standing, and via discussion amongst faculty for behavioral aspects (e.g., communication, decorum, work ethic, etc.) and their potential to be favorable “ambassadors”.

i. How many affiliation agreements/sites?

(HU) – Four.

(UM) – 12 or 13.

(UNE) – AY24-25, 33 agreements.

(UP) – 4 sites (all minor sites).

ii. How many rotations?

(HU) – One per student.

(UM) – 2 per student.

(UNE) – One rotation - 8-10 weeks.

(UP) – Each student has a continuous 9-week rotation at each site.

iii. How many total weeks?

(HU) – One site is 4 wks, two sites are 2 wks, one site is a day-long rotation.

(UM) –

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- (UNE) – 8-10 weeks.
(UP) – 36 weeks total for each student.
- iv.** When are the students scheduled externally? (DS4, DS3, etc...)
(HU) – D4 year.
(UM) – D4 year.
(UNE) – D4 year.
(UP) – Rotations begin January of D3 and continue until December of D4.
- v.** How many weeks at a time?
(HU) – 1-4 weeks.
(UM) – 2-3 weeks.
(UNE) – 8-10 weeks.
(UP) – 9 weeks.
- vi.** How are students supported?
(HU) – Grants.
(UM) – Supervising faculty at the local sites.
(UNE) – Associate Dean for Community Partnerships.
(UP) – Day trips via walking or local transportation.
- vii.** Who pays for accommodations?
(HU) – Grants.
(UM) – Students commute, school pay for parking.
(UNE) – Students.
(UP) – Students do not rotate anywhere where accommodations would be necessary.
- viii.** How are faculty/preceptors calibrated?
(HU) – Via Zoom (each Discipline Director prepares material and presents to the distance faculty).
(UM) – We follow CODA guidelines regarding faculty calibration. All Operative Dentistry faculty participated in the development of lectures covering the main topics. The content of each lecture was reviewed by each instructor prior to recording. Questions related to the lectures were then created. Faculty from the Department of Comprehensive Dentistry will now be able to watch the recorded lectures and answer the questions, ensuring that all instructors are calibrated, regardless of their location or clinical setting.
(UNE) – Preceptor Calibration Day once per year.
(UP) – Rotation faculty are Penn faculty and are calibrated at regular in-house calibration sessions at PDM.
- (CU) – No external rotations.
(H) – Few rotations. Community Serv, OS and Pedo. 8 weeks, 4 of which are weeks children’s hospital. D4 only. Annual Mandatory calibration meeting. Formative count but no summative/comps.
(HU) – Coordinated rotation with lengths vary 1-4 weeks, 4 sites, one in Cali, Indian Health Service, etc. CODA-approved distance sites and procedures count as student experiences and get added to the list of procedures. Doesn’t count for comps. Faculty calibrated by distance. Every D4 gets to go to an external rotation (hopefully). Paid for by grants.

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(NYU) – Wide range, rotation 2.5 days/week, formative count; not summative. NYC public Schools. Calibrate.... people who oversee the program are faculty at NYU.

(RU) – 2 sites, no financial support to students for travel and lodging, faculty come to Newark for calibration, some students spend a full year, everyone else is one week in their D4 year. Have assistants. Is it ok that we have competencies there? The setup is different because there are assistants.

(SBU) – One: LI State Veterans, D4 one rotation one day a week, local, gen dent faculty with appointment in Veterans Home. Assigned to be there.

(T) – 2 sites in Restorative, hospital of FQHC, no comps, faculty are calibrated. D4's one week of each. Compensated for ride share. Online and in-person calibration.

(TC) – Rotation every 6 weeks D3/D4 pair 2 in their D3 and 2 in their D4 years. Two weeks each. Calibration: with faculty. Minor sites are not calibrated, so neither formative nor summative assessments.

(TU) – req 5-week rotation (33 sites). Final semester of D3 but mainly D4 year. Some stipends are available. Ex- Indian Health Center.

(UC) – One rotation OS hospital based for one week. No additional support. OS residents are calibrated and oversee predoc students.

(UM) – 2 rotations one in Spring and one in Fall. One major site, and another is an affiliate minor site. 2-week rotation. Pay for the drive, parking pass. The major site has AxiUm, the minor site is paper-based. Faculty sign and bring paperwork to input. Calibration online.

(UNE) – 30-40 agreements every year. One rotation. 8-10 weeks. D4 year. Mandatory. Students pay for their own accommodations. No competency.

(UP) – Academic Affairs organizes the schedules. 4 clinical sites, rotate one full day a week from Jan D3 year to Dec D4 site. Students must get there on their own. Faculty are Penn faculty. Report -all work in AxiUm. Students get credit but cannot take competency exams. A full-time person to oversee agreements, etc.

b. How are patients managed after the completion of their comprehensive care?

(UM) – After completing comprehensive care, patients are referred to the appropriate specialties if further treatment is needed. If no additional treatment is required, they are scheduled for a hygiene recall in six months.

i. Ongoing recall/hygiene by students?

(HU) – axiUm has “pop-up” box at the conclusion of treatment, where the desired recall interval should be entered. A report can be pulled monthly to list patients due for recall the following month. We’ve recently instituted a requirement for two recall codes (q6mo) to be typed into each treatment plan.

(UM) – Yes, patients are automatically scheduled in axiUm for a six-month recall for re-evaluation and oral hygiene care.

(UNE) – Vertical integration, the ongoing recalls are scheduled for D4 students and their D3 partners.

(UP) – Students keep their patients until they graduate and then transfer them. The assigned student usually does the recall visits. Occasionally, another student may do the recall. Students have recall requirements for graduation.

c. Describe challenges you are experiencing related to the Gen-Z student learner?

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(HU) – HAH!!!! Some don't want to read assigned material and want to rely completely on slide presentations. Some believe lecture attendance is optional. Some give an air of entitlement. Some overestimate their abilities (self-assessment scores are unrealistic). Some apparently don't handle stress well or have effective coping skills.

(UM) – Some challenges with Gen-Z learners include shorter attention spans, a preference for digital and visual learning tools, and the need for frequent feedback and engagement. Additionally, students often expect immediate access to learning materials (digitally) before/after lectures.

(UNE) – Students don't like reading the textbook. The Reading Assignments are mandatory, and several Quiz questions are based on the reading. Communication Challenges: Students don't check their emails routinely.

(UP) – Want immediate feedback. Not as receptive to constructive criticism as previous generations. Spoon feeding more frequently.

d. What strategies are you using to more effectively teach the next generation of dentists?

(UP) – Didactic D3 curriculum is asynchronous with follow-up in small group sessions (approximately weekly). The attendance policy incentivizes students to attend lectures. Students receive bonus points for attending lectures. Mastery exams are delivered to students who receive a grade below 80. These are optional for those who pass (70 or above), required for those who failed (below 70). The highest possible grade on a Mastery Exam would be an 80.

i. Techniques?

(UM) – Active learning, case-based discussions, simulation exercises, online quizzes before and after classes, question board discussions, self-assessments, and the use of digital 3D models. Primarily for new students, these 3D-printed models help them identify and answer exercises on each dental structure (dental anatomy course). Soon, students will also receive 3D-printed teeth with different textures to visualize various dental tissues and recognize differences in carious dentin (e.g., affected vs. infected dentin).

(UNE) – Didactic content: Games, e.g., Kahoot.

(HU) – Learning “games”, increased simulations and case discussions, write a reflection.

ii. Delivery of student feedback?

(HU) – Employ student self-assessments incorporated into evaluations.

(UM) – Feedback is provided frequently and immediately during clinical and simulation sessions to support skill development. They also receive feedback after quizzes and exams.

(UNE) – Students' Self-evaluation on every hands-on exercise in addition to the survey delivered at the end of each semester.

iii. Videos for preparation/restoration?

(HU) – Yes, (some self-made, some off credible internet).

(UM) – Instructional PowerPoints with step-by-steps are always provided before simulation labs, allowing students to review content at their own pace and reuse this material over the years. All preparations and restorations are also demonstrated live before their first attempts.

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(UNE) – Yes.

(UP) – Yes. We use videos which are posted on the course site and encouraged to view prior to the session. Videos are played during the session on a loop.

(CU) – Outcomes assessment, placed on recall, challenges Gen Z.... academic entitlement, coaching stress management, need frequent low-stakes feedback.

(H) – Outcomes assessment, Case completion types 1-6, Gen Z.... less personal approach. Once more personal, then they can take the constructive feedback. Need an active learning style. Need technology.

(HU) – Desired recall entered, pull monthly reports, build in two recalls into plan and case complete code. 7 case completes necessary. Gen Z doesn't want to read. Overestimate abilities, don't want to go to the lecture. Need: Increase simulations, etc. Case discussions. Write a reflection.

(NYU) – Gen Z constant feedback, peer teaching, etc. 0-2 assessment on grade card, doesn't affect a final grade. If they get a zero, they need to do a reflection of what went wrong and what not to do again.

(RU) –

(SBU) – Once students complete pt, do outcomes of care. Review chart, etc. Faculty member who has not worked on this case. That member will review everything. Additional text at subsequent visit. If good, pt placed on recare. Gen Z's challenge is critical thinking. Professionalism, faculty calibration of technology. CAD/CAM for feedback, digital resources. Faculty give feedback, Compare software, videos, etc.

(T) – AxiUm protocol for the comprehensive care model. Recalls currently scheduled by the patient. This will change. Phase I and Phase II complete case. Trying to get recalls up to an acceptable level. Clinical grading is changing. All courses are required for a method of student feedback. A summative does not get a grade. They are evaluated.

(TC) – Define what failure means. Talk about athletes (pep talk).

(TU) – Videos, constant feedback.

(UC) – Comp care completion at end of phase 2 with a phase 2 re-eval. Recall is different depending on risk, insurance, etc. Gen Z has challenges with limited social skills and communication skills. Expect an on-demand response. Shorter didactic. Have Simodont.

(UM) – Txt plan completion, group practice model, recall. Gen Z.... shorter attention span, more active learning, sim exercises, they have them make questions before the classes. Quizzes one day in person. One lecture to discuss the main questions, then a lecture with quizzes, and then exams. 3-D models, self-assessments.

(UNE) – Work around for students not checking emails. Didactic games.

(UP) – Comp care. Students keep their patients until graduation, recall requirements exist until graduation. Need a little more spoon feeding. Receive bonus points for attending the lecture. Below 80 can challenge a mastery exam to increase to an 80.

II. Materials and Techniques

- a. What types of materials and strategies are used for vital/non-vital pulp therapy?

(HU) – (1) Theracal and (2) MTA covered with Biodentine base.

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(UM) – Dycal (calcium hydroxide), Vitrebond (resin-modified glass ionomer), and MTA are used for vital pulp therapy. Non-vital pulp therapy follows standard disinfection protocols before obturation.

(UNE) – Calcium Hydroxide, Resin-modified Glass Ionomer, MTA.

(UP) – Bioceramics, MTA, partial pulp excavation. Details are part of the endo curriculum.

b. Treatment planning

i. Describe the treatment planning process at your institution.

1. Who “owns” the treatment plan?

(HU) – Module Coordinator and attending Faculty who signs off in axiUm own legally, STUDENT “owns” follow-through.

(UM) – Patients / student provider / GP director and other faculty.

(UNE) – Group Practice Leaders (GD).

(UP) – Student and Group Leader.

2. Who can modify it?

(HU) – Once “unlocked” by Business Office can be modified by faculty.

(UM) – Students can modify it, but the faculty must approve the change, and the patient needs to sign the consent.

(UNE) – Group Practice Leaders Only.

(UP) – Group Leader.

3. What educational methods and resources are used to teach treatment planning?

(HU) – Treatment planning courses at D2 and D3 level

(UM) – Treatment planning courses (year 2, year 3, and year 4).

(UNE) – D2 course, D3 and D4: Group Huddles and Case Presentations.

(UP) – Treatment planning seminars, Small group seminars, Interdisciplinary course presented by faculty, including the Dean, which addresses how a general dentist approaches a case. 7 cases are discussed in depth related to dental specialty referrals, dental materials, and medical considerations.

For some Pre-Clinical courses, pre-clinical “patients” are assigned and entered into the EHR. Risk assessments are completed, and treatment plans are created for the simulated patients.

4. Are there individual courses dedicated to treatment planning or is treatment planning embedded throughout the curriculum (discipline-based)?

(HU) – Both. We all espouse a phased tx planning approach.

(UM) – Separated, with 3 individual courses.

(UNE) – An individual course is dedicated to treatment planning.

(UP) – Both.

c. How is your institution addressing the fluoride “controversy”?

(CU) – CaOH and GI, MTA is in the background. Txt Planning in clinics under General with specialists as needed. Modify by faculty, Ed methods.... didactic, mock patients. Spring second semester D2; txt planning comp exams.

(H) – CaOH for direct and Biodentine for vital, MTA for non-vital pulp therapies. Diagnosis and Tx planning course.

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(HU) – Uses Theracal, endo wants MTA covered with Biodentine, Txt plan.... module coordinator, review for accuracy and txt recommendations. AxiUm in Spring D2, txt planning courses in D3, small group projects with a real patient from one of the groups. Phase tx planning approach. Honestly, hasn't been controversial here. Students are guided in how to educate their patients, and the patients make their decision.

(NYU) – Stepwise, exposure is Dycal and RMGI. Txt planning starts in D1. Gen dent and comp own the txt plan. Can only be changed by GPA. Try to handle what is appropriate within Gen Dent.

(RU) – Fluoride critical thinking and communication based on literature. Are there FI alternatives?

(SBU) – GI CaOH, they teach direct pulp capping. Txt planning.... D4...gen practice program and model, supervising faculty can modify, interdisciplinary based. Ed methods.... start in year 1, basic concepts of AxiUm, basic txt plan language, coding; D2-3 years txt planning courses. D2 someone else's patient and plan in D3 their own and develop that txt plan.

(T) –

(TC) –

(TU) –

(UC) –

(UM) – MTA. Group practice model. Txt Planning from year 2-4. Didactic and simulation. Our institution addresses the fluoride controversy by presenting current evidence and professional guidelines in our curriculum. We clearly communicate the positions of the ADA and AAC, which have published statements and resources regarding fluoride use. Additionally, we provide students with reference materials from the ADA that summarize key facts and discussion points, allowing them to respond appropriately to patient questions about fluoride. We also incorporate updates from relevant conferences and webinars to ensure students are aware of emerging data and ongoing professional discussions.

(UNE) –

(UP) – Patients are advised of risks/benefits as with other procedures. More patients are asking and thinking about declining.

III. Student Assessment

a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?

i. Classroom instruction related to the exam process?

(HU) – Yes.

(UM) – Yes, orientation, in person and recorded.

(UNE) – A review course.

(UP) – Fixed Pros course challenge exam same as the ADEX board. There is no operative mock board exam, but students have to challenge exam on CI II and CI III. We do not teach to the exam. Students learn conservative preps in D1 Operative.

ii. Mock boards?

(HU) – Yes (multiple in all areas/disciplines).

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(UM) – Mock boards for operative, perio, endo, and pros.

(UNE) – Yes.

(UP) – Yes, in the early D4 year.

b. How are students assessed when scheduled on external rotations?

(HU) – Supervision by calibrated distance faculty at that location

(UM) – They are scheduled when they are not in rotations.

(UP) – Same as all PDM.

i. Do you count those procedures for meeting requirements?

(CU) – Rotations, D4 summer Friday afternoons, orientation sessions, trying to implement MOCK Boards.

(H) – MOCK, credit for formative in external rotations.

(HU) – Mock Board exams and classroom instruction, students have to qualify to take the exam. Count procedures.... toward the prerequisite but all is done at the College of Dentistry. Only at minor sites. Procedures count towards pre-requisite accomplishments, but all competency/Entrustable Professional Activity assessments are at HUUCD.

(NYU) – Start in D1 so they can recognize caries, MOCK Boards, external rotations.... attendance requirements, the assumption is that if they treat enough patients, they will get the experience.

(RU) –

(SBU) – MOCK using compedont, classroom instruction.

(T) – Mock boards; rotations don't count as procedures.

(TC) – Mock Board exam, class as well. Written feedback, each rotation is P/F. Requirements need to be done on campus.

(TU) – Workshop and then comp.

(UC) – Practice sessions and MOCK boards, orientation session.

(UM) – MOCK boards. Yes.

(UNE) – Prep course and MOCK; rotations. Students are evaluated through our competency exams, not the board exam results.

(UP) – Classroom instruction, no Operative MOCK, but they have a challenge exam on a manikin. MOCK boards in D4. Yes. No off-site summative competencies since all minor sites.

IV. Administration

a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?

(T) – Separating work and personal life.

(HU) – Social interactions, taking time off, take care of yourself to take care of others.

(UC) – The school provides support, faculty development.

(NYU) – Program emails to send on Monday morning. Don't expect answers on weekends.

(TU) – Faculty development, Center for Teaching and Learning.

(UM) – Our department supports work-life balance through several initiatives. The chair invites guest speakers to give lectures and workshops on wellness, stress management, and work-life integration. We also promote a culture that values flexibility, encourages

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the use of vacation time, and respects personal boundaries. In addition, community-building events and informal gatherings help strengthen collegiality and provide opportunities to decompress outside of work.

(UNE) – Teamwork and support from the administration.

(UP) – Wellness center for faculty, Yoga class offered, Nutrition sessions offered.

- b. What assistance in terms of initiatives/support/strategies does your school/university provide?

(HU) – Center for Excellence in Teaching and Learning Assessment faculty resource, mental health counseling available, university Mental Health Days (one per semester)

(CU) – Has an office of work/life.

(UM) – The University of Maryland, Baltimore (UMB) offers extensive support for work-life balance, including the Employee Assistance Program (confidential 24/7 support), wellness and fitness programs through Launch Your Life and URecFit, professional development opportunities, tuition remission, flexible scheduling, and employee discounts. UMB also provides workplace mediation, ombuds services, and wellness initiatives such as the Comfort K9 program. The School of Dentistry (UMSOD) complements these resources with free counseling services, access to the gym, library, and student center, as well as mentorship opportunities through UMSOD Connect. Faculty foster a supportive culture by offering review sessions and maintaining accessibility to students.

(UNE) – University Benefit, HR support for FMLA.

- c. Calibration

- i. How often does your operative faculty meet as a group, and what are the objectives of those meetings?

(HU) – Monthly; some for calibration, some for typical updates, or discuss upcoming activities (e.g., Mock Boards).

(UM) – Operative faculty meet approximately once a month, at minimum, and additionally on an “as-needed” basis when new updates arise. The objectives of these meetings include discussing the incorporation of new teaching methodologies, improving existing assessment strategies, reviewing and updating course content, organizing schedules, and ensuring calibration for both competencies and the evaluations/feedback provided during classes. Most meetings focus primarily on calibration related to feedback and competency assessments.

(UNE) – SIM courses: Weekly Calibration. Objectives: Understanding of rubrics
Department Meeting: Bi-monthly.

(UP) – Calibration sessions are given prior to course beginnings. Pre-session huddles are done at the start of class. Clinical faculty have at least 1-2 calibration sessions per semester.

- ii. Are your calibration efforts discipline-based or across all disciplines?

(CU) – Two times a year; clinic closed.

(HU) – Both.

(NYU) – Monthly or bi-monthly meetings. Diff scenarios.

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(SBU) – Meet with faculty before the course and also have a meeting with the whole department. Topics are related to clinical protocols and evidence-based dentistry.

(T) – Quarterly. Calibration is discipline-based. You need to pass.

(TU) – Twice a year.

(UM) – Discipline-based.

Calibration efforts are conducted across the entire Department of Comprehensive Dentistry, rather than being limited to the Division of Cariology and Operative Dentistry. This approach is necessary because faculty members from Comprehensive Dentistry who are not specifically in the Operative division also perform restorations, both within the school and at external clinical sites where students are assigned. However, we also have calibration sessions specifically for the Division of Cariology and Operative Dentistry, which are more pertinent to us. Example: calibration among faculty to evaluate and grade students in practical exams (competencies).

(UNE) – Department level: Discipline-based

College-level calibration: Across all disciplines.

(UP) – Both. Beginning of each course and a huddle at each session.

d. What are your policies for student absences?

(CU) – Students must manage their own time in a professional manner, no show gets written up for professionalism.

(H) – Must be excused

(HU) – Excused absence: no penalty; if unexcused, then re-take with the highest score being a 75. If you miss more than 12% clinic sessions, 6 points taken off the final grade. School attendance is mandatory; you must have an excused absence documented to not lose points on missed assessments, must make up missed course activities upon return.

(NYU) – Clinic absences are five a year; more than five, they need to make it up.

(RU) – Need an excuse for exams only. Each course is different as to how to talk to the course directors. Some lectures are mandatory. If they miss more than a 1/3 of course, they are unable to remediate if they fail.

(SBU) – Three categories of excused absences.

(T) – Didactic mandatory can't miss more than 10%.

(TC) – Lab deduction from final points for unexcused absence.

(TU) – must be excused, but not all courses have mandatory attendance.

(UM) – Students must notify Student Affairs if they need to be absent. Student Affairs determines whether the absence is excused and then informs the instructor. For practical sessions, it is the instructor's responsibility to provide the missed activity to the student, either by incorporating them into another group with the same activity or by arranging the activity individually. The same procedure applies to didactic lectures; however, students can always access the live session or the recorded version via MediaSite.

(UNE) – Excused vs unexcused absences, the Student Affairs team will evaluate on a case-by-case basis.

(UP) – 100% attendance is required for all clinical and specialty rotations, and all 1st and 2nd year preclinical laboratory and clinical rotation sessions, including DAU and

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Comprehensive Care. Students are required to make up every missed rotation. A missed rotation due to an excused absence will require 1 make-up session. A missed rotation due to an unexcused absence will require 2 make-up sessions after the conclusion of the academic year. 90% clinic attendance is mandatory for graduation and promotion, inclusive of excused and unexcused absences.

e. What are the demographics of your current classes, and what are the trends?

(SBU) – Increase in female students.

(TU) – More female applicants.

(UM) –

- 3134 applications completed
- 14 states represented
- 5 students with MS degrees
- 51% in state - 49% out of state
- 67% female
- 21% US in Dentistry

(UNE) – Female: Male students = 1:1.

i. Is student performance in courses declining?

(HU) – Depends on the course.

(SBU) – Increasing.

(UM) – Yes.

(UNE) – No.

(UP) – No.

ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...?

(CU) – Two for summative and one for courses without having to repeat the entire year.

(HU) – Failed exam assessment one remediation attempt; failed final course grade (didactic) remediated within 2 wks of next semester start; “Incomplete” clinical or pre-clinical course remedied within 6-wk span.

(NYU) – Exam is up to CD; most preclinical courses have one re-take. If the retake is failed, then the student goes to remediation.

(RU) – Two attempts at competencies and practicals before formal remediation.

(SBU) – Up to CD.

(T) – Remediate a course; can re-take a practical in preclinic for a higher grade.

(UM) – Remediation throughout the semester and then over the summer. We aim to provide small, ongoing remediation throughout the semester as needed. For final practical and didactic exams, remediation takes place during the summer, and students are allowed up to two remediation attempts per exam they have not passed.

(UNE) – Three attempts allowed for Competency exams, two for written exams.

(UP) – Students who fail an exam have the opportunity to take another exam and receive a maximum grade of 80 on the second attempt. (Mastery Exam policy).

f. Are you considering a switch from aXiUm to EPIC as your Electronic Health Record?

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Most Schools said no, except Columbia (and one other school that is already on EPIC).

V. CaMBRA Questions

This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.
 - i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?
 - (CU) – Yes.
 - (HU) – Yes.
 - (RU) – Yes.
 - (SBU) – Yes.
 - (T) – Yes.
 - (TU) – Yes.
 - (UC) – Yes.
 - (UM) – Yes.
 - (UNE) – Yes.
 - (UP) – Yes.
 1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?
 2. If NO, why are lesions not documented?
- b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use and how granular is your documentation? For example, some schools may note lesions on a simply binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression (“incipient” vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?
 - (CU) – Presence, type, and severity.
 - (HU) – On odontogram. Initial, moderate and advanced. Diagnostic code: from AxiUm.
 - (RU) – Yellow hashtags for caries requiring non-surgical treatment.
 - (SBU) – Watch icon; any lesion is red. Document E0-E2.
 - (T) – Developed tooth-level diagnostics. Conditions and carious lesions. Degree and cavitated or not. Color-coded and hashtags. Update the carious risk assessment at every recall. Have to lower the risk to move through treatment.
 - (TU) – Diagnostic and treatment are separate, active and non-active, and they write a description. The management odontogram covers the treatment.
 - (UC) – Same as RSDM; 0-6.
 - (UM) – In the odontogram of AxiUm. Binary option, lesion or not. Students may add more detailed information.

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(UNE) – Odontogram. The Odontogram only shows incipient/dentin, but the ICDAS and ADA CCS are parts of the competency exam and note writing.

(UP) – Odontogram and Tx Plan diagnoses.

c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?

i. If YES, which diagnostic codes/descriptors for caries lesions do you use?

(CU) – Yes. CDT codes.

(UNE) – Yes.

(UP) – Yes. ADA Caries Classification System- clinical presentation, ICDAS appearance of occlusal pits and fissures, and smooth surfaces. Radiographic presentation of approximal surfaces E1, E2, D1, D2, D3.

ii. If NO, why are diagnostic codes not used?

(HU) – No. Haven't calibrated to that point yet.

Region VI

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Response Color Key

(ECU) East Carolina University School of Dental Medicine – (No Responses)
(HP) High Point University School of Dental Medicine and Oral Health – (No Responses)
(LE) Lake Erie College of Osteopathic Medicine School of Dental Medicine – (No Responses)
(LMU) Lincoln Medical University College of Dental Medicine – (No Responses)
(MUSC) Medical University of South Carolina College of Dental Medicine
(MMC) Meharry Medical College School of Dentistry
(NOVA) Nova Southeastern University College of Dental Medicine
(AU) The Dental College of Georgia at Augusta University
(UA) University of Alabama School of Dentistry – (No Responses)
(UF) University of Florida College of Dentistry
(UK) University of Kentucky College of Dentistry – (No Responses)
(UL) University of Louisville School of Dentistry
(UNC) University of North Carolina at Chapel Hill School of Dentistry
(UP) University of Pikeville Tanner College of Dental Medicine
(UPR) University of Puerto Rico School of Dental Medicine – (No Responses)
(VCU) Virginia Commonwealth University School of Dentistry

I. Curriculum

a. How are your external rotations organized?

(UP) – University of Pikeville Tanner College of Dental Medicine TCDM will utilize the facilities and rotations at the external sites to prepare student for transition into independent practice, and the sites are currently designated as enrichment sites (no competency grading); faculty charged with the external/outreach experiences report to the clinic team leader and the Office of Clinical Affairs; Office of Academic Affairs is in communication when academic performance or potentially academic violations are under investigation; the determination of which sites the students rotate is not final.

(AU) – We allow students to put in their preference and try to accommodate, but it is randomly organized to students, if there is housing/family/etc. close to a site, we try to work with the students to get them to that site.

(UF) – "Dept of Community Dentistry and Behavioral Science manages rotations, the course director has an Adm Assistant who assists with management and administrative tasks such as schedules, communication between sites and students, hotel reservations, reimbursements for travel etc. UFCD has 3 courses for senior year. Each course is designed to cover 2 weeks of rotation per semester.

(UL) – No response

(MMC) – Our external rotations are designed to give students diverse clinical exposure in community-based settings:

- Matthew Walker Comprehensive Health Center – our primary community clinic site.
- Shelbyville Clinic – a rural site where students treat a broader patient population and provide specialized services such as 3D dentures.

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- Mobile Dental Unit – travels to youth detention centers in Nashville, allowing students to serve a unique population and gain valuable experience in correctional settings.

(NOVA) – We have an Assistant Dean of Community Programs and Public Health. He and his team arrange rotations in communication with the Office of Academic Affairs.

i. How many affiliation agreements/sites?

(UP) – TCDM currently has affiliation agreements for five sites, with additional sites pending, to commence in Winter/Spring Term 2029.

(AU) – 27

(UF) – We have 9 external sites including 2 UFCD owned external sites.

(UL) – 4-5 sites affiliated with the university.

(MMC) – We currently have three affiliation sites:

- Matthew Walker Comprehensive Health Center
- Shelbyville Clinic (rural clinic, including 3D denture services)
- Mobile Dental Unit (rotations through youth detention centers in Nashville)

(NOVA) – We have a total of 9 sites. Five are for the main campus and the remaining four are the Tampa/Clearwater campus students. All those organizations have affiliation agreements with NSU that were completed by our HPD attorneys.

(VCU) – 14

ii. How many rotations?

(UP) – Third-year students will spend a total of eight weeks (two rotations of 4 weeks each) in the final semester of the curriculum.

(AU) – 6

(UF) – Each senior must complete 1 2-week rotation per semester, total of 6 weeks/3 rotations.

(UL) – A total of 4-8 weeks during the D4 year.

(MMC) – At Matthew Walker, students rotate for two weeks, other sites typically once or twice per semester.

(NOVA) – Some rotations are 2-4 days per student varying between one week to multiple weeks. One rotation, which is an NSU site, is for one day a week for 18 consecutive weeks per student.

(VCU) – Approximately 40. Students are randomly scheduled throughout the 4th year (DDS 30 days/DH 20 days) allowing for most clinics to be in the school.

iii. How many total weeks?

(See above responses)

iv. When are the students scheduled externally? (DS4, DS3, etc...)

(UP) – Students rotate during their D3 year (three-year DMD program).

(AU) – DS4

(UF) – DS4

(UL) – DS4

(MMC) – External rotations are scheduled during the D4 year only, ensuring students apply their advanced skills in real-world community settings.

(NOVA) – Mostly D4 students, but two pediatric rotations utilize D3 students.

(VCU) – DS4

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v. How many weeks at a time?

(UP) – Third-year students will spend 4 weeks (20 days) at one external rotation site and 4 weeks (20 days) at another external rotation site in the final semester of the curriculum.

(AU) – 2

(UF) – 2

(UL) – One week at the time to ensure continuity of patient care at the DMD clinics.

(MMC) – Rotations are structured in two-week blocks, which allows students adequate time to integrate into the clinic and provide continuity of care.

(NOVA) – Typically, rotations are completed within the same week. This is except for the NSU main site (our Ryan White Clinic).

(VCU) – 1 day-4 days, varies for each site.

vi. How are students supported?

(UP) – Broadly, all students at TCDM have access to support services offered through the Office of Student Affairs and Academic Excellence; specifically, as related to external sites and rotations, the students have the opportunity to have their input considered regarding site locations and any circumstances that may impact their involvement at that site; comments also included under the next question. Within our current academic fee structure, students do not incur any financial costs as a result of their reasonable involvement with external site participation.

(AU) – HRSA Grant.

(UF) – Some rotations provide student housing and gas reimbursement. Some rotations do not have available housing, and students are expected to make their own arrangements.

(UL) – At every site, there is “The point of contact” that is usually the lead dentist on site, as well as a designated person from the office “assistant or a scheduler” that student can reach out to for help

(MMC) – Students are supported by faculty and preceptors at each external site, who provide oversight, feedback, and guidance consistent with the support students receive at the dental school.

(NOVA) – There is no financial support for the students. Most rotations are in town.

(VCU) – Provided lodging and stipends for sites far from the school. CANVAS site houses information on all sites to include map, link to clinic website, and general information about the facility. Students have access to an anonymous survey to give feedback about the sites and preceptors. The director for the rotations has an open-door policy and welcomes students to bring forward any concerns.

vii. Who pays for accommodations?

(UP) – All rotation/external sites are currently planned less than 50 miles from TCDM; the university plans to provide transportation to/from the sites; in the event that additional sites are developed and require accommodations, the

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reasonable costs for lodging, meals will be paid by the external site sponsor and/or TCDM.

(AU) – HRSA Grant.

(UF) – UFCD pays hotel rooms for 3 sites, if travel is longer than 60 mins to the site.

(UL) – Rotations to local sites are usually within a proximity to the school and is day trip only without a need for accommodations. In the case of long stay the outreach program in the school will pay for accommodations.

(MMC) – Because most external sites are close to campus, accommodations are rarely needed. If required, the school assumes responsibility for arranging transportation or covering costs to support student participation.

(NOVA) – Accommodation is usually not needed. The only accommodations provided are for the RAM initiative and hotel rooms. Students are responsible for their own travel expenses.

(VCU) – The sites.

viii. How are faculty/preceptors calibrated?

(UP) – The external sites are currently designated as enrichment sites (no competency grading); faculty/preceptors will undergo an annual calibration/training facilitated by TCDM faculty in conjunction with the Associate Deans of Academic Affairs and Clinical Affairs; external sites are subject to periodic inspections and student evaluations will be reviewed as part of QAPI.

(AU) – All are minor sites, so no credit is given for procedures, so no calibration is completed for clinical performances. Office of Student Affairs does go to each site on a regular basis to do site visits and check in on each site.

(UF) – Annually we provide in person calibration events for off-site rotation faculty. We share the instructional materials regularly.

(UL) – Faculty at external sites who are hired by the university participate in all calibration sessions provided by the school. In addition, they have continuous access to calibration resources through a dedicated Blackboard organization for Faculty Calibration.

(MMC) – Faculty and preceptors undergo a school-led calibration process that standardizes teaching methods, assessment criteria, and expectations across all external sites, promoting consistent evaluation of student performance.

(NOVA) – One of the external sites is an NSU facility, and the attending faculty there are standardized NSU full-time and adjunct faculty members. Another site is supervised by an adjunct faculty member who has also been calibrated by our department. A third site is directed by a former NSU student. Any faculty member outside of this standardized group and who is serving as a supervising clinical instructor in an external rotation is calibrated through a live Zoom session conducted by the Department Chair. Each department is responsible for calibration within its respective discipline. In our department, multiple recordings of previous calibration sessions are also available for faculty who were unable to attend or who have recently joined. When possible, those with access to the main campus are encouraged to shadow in the clinic, although this may not always be feasible.

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(VCU) – A preceptor manual is provided with clinical guidance documents and policies for the rotations. Preceptors come to an annual meeting at the school, those that can't attend are provided the meeting PPT's and minutes, and they sign off they have reviewed the materials. The Director visits the sites annually, more if indicated.

b. How are patients managed after the completion of their comprehensive care?

i. Ongoing recall/hygiene by students?

(UP) – Each student clinical team is responsible for the timeliness and tracking of their patients in recall and/or maintenance; patients are intended to remain in the assigned clinic family. Since the students will be assigned as a team, the team is accountable for comprehensive care.

(AU) – Patient “graduate” into our wellness program and then are seen by our students (and sometimes rotating students from our nearby hygiene school) for recall and hygiene visits.

(UF) – After the completion of comp care patients will be placed on recall in the DMD and DH recall clinics.

(UL) – They go into recall with the dental student; the dental student must do so many recalls. If the patient has no other dental work and is progressing well, they will go into Dental Hygiene.

(MMC) – When a student’s rotation ends, patients remain in the clinic system for follow-up, including recall and hygiene visits handled by clinic staff. All treatment is recorded in axiUm, which allows continuity of care and ensures that students receive proper credit for their work before patient records are reassigned to another provider.

(NOVA) – MPPs (maintenance pool patients), patients who completed their treatment plan and accepted to remain as a patient for their maintenance procedures are seen on a rotational basis by D3 and D4 students. Each student has 4 rotations: as the assistant, the provider with a student assistant, independent provider without an assistant and finally the last one being the ICPA.

(VCU) – No response.

c. Describe challenges you are experiencing related to the Gen-Z student learner?

(UP) – Students will not commence studies at TCDM until June 2026; therefore, no data is available at this time.

(AU) – I am not sure this is just Gen Z or every generation to an extent, but 1) Taking feedback that is critical (failing grade, etc.) is tough for many of the students, 2) Addressing mental health issues is a challenge.

(UF) – Wellness and work-life balance have been stressed with focus on students’ mental health especially as anxiety among students appears to be on a rise including addition of a “wellness week”, students are asking for one-on-one tutoring/TAing in greater numbers beyond current capabilities of our system

(UL) – Communication/ interaction skills.

- Prefer peer interaction over traditional lecture format

They like the info to be delivered in a variety of ways.

- Expect immediate feedback. They want their questions answered immediately.

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They prefer short cuts over detailed approach.

(MMC) – Reliance on online sources (Google/YouTube/TikTok). Shortened attention spans, influenced by quick-scroll media culture. High expectation for instant feedback, not always practical in clinic settings. Preference for digital/interactive learning over traditional reading. Difficulty with delayed gratification, desiring rapid progress in clinical skills. Mental health concerns, with openness about stress but challenges in resilience. Strong desire for early work–life balance, which can conflict with rigorous program demands.

(NOVA) – Gen Z students are, as a generation, less likely to have a long attention span. They tend to be focused and more goal-oriented, which can become a challenge when their goals do not align with the discipline. The unrestricted access to information introduces noise into both vertical and horizontal communication. The course director must remain proactive to prevent misunderstandings and misinformation.

(VCU) – No response.

- d. What strategies are you using to more effectively teach the next generation of dentists?
- i. Techniques?
 - ii. Delivery of student feedback?
 - iii. Videos for preparation/restoration?

(UP) – Emphasis in the operative and prosthodontic components is placed on the use of digital imaging (scanning, design, etc.) with traditional impression methods taught to augment their knowledge. Formative feedback will be delivered in both oral and written forms, designed to be as a “debriefing session” after each patient encounter; a mid-term and end of term summative evaluation will be reviewed with each student, verbally and in writing (via electronic evaluation form in axiUm).

(AU) – We are using more video supplements and more live video-based teaching, step by step, as the D1 learn basic operative dentistry. We link concepts between our D1 Anatomy and Occlusion course and the D1 Operative courses

(UF) – Videos and prerecorded lectures, as appropriate, have been well-received by students as well as use of digital platforms.

(UL) –

Problem-Based Learning (PBL):

- Encourages critical thinking and clinical reasoning.
- Students work through real-world dental problems collaboratively.

Clinical Case Presentations:

- Demonstrates the relevance of foundational sciences to dental practice.
- Bridges theory with practical application.

Embedded Multiple-Choice Questions (MCQs):

- Enhances engagement during lectures.
- Provides immediate feedback and reinforces key concepts.
- Gamified Learning with Kahoot:
- Introduces competition-based quizzes to boost motivation.
- Makes learning fun and interactive.

Videos for preparation/restoration?

- Live demos in labs

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- Instructional videos made by faculty and
- A few reviewed online references.

(MMC) – We emphasize hands-on and interactive learning over textbook-heavy models, while reinforcing the importance of foundational reading. Textbooks remain required, with incentives such as first-day extra credit to highlight their role.

Our teaching strategies include:

- Instructional videos for preparations/restorations, available for self-paced review.
- Step-by-step visual guides and annotated diagrams to support hand-skill mastery.
- Simulation and mannequin-based practice, with immediate faculty feedback.
- Case-based learning and text-based questions to build critical thinking.
- Kahoot! quizzes to reinforce content and promote active participation.
- Guest speakers (e.g., Social Determinants of Oral Health) to link coursework to real-world issues.

Feedback delivery:

We focus on timely, formative feedback—often in real time during labs/clinics—while also promoting self-assessment and peer feedback. This reflection-based model builds accountability and clinical judgment.

(NOVA) – Techniques: The primary strategy used is the Modern Flipped Classroom. This approach differs from the classical Flipped Classroom in the level of commitment required from students and in the technologies employed, such as interactive videos (self-produced, step-by-step tutorials) and Acidental OneScreen software. The lecture format shifts toward a podcast style with a storytelling approach, depending on the lecturer's preference and teaching style. The faculty are briefly calibrated before each simulation lab session to align on the class objectives, which follow a gradual, Bloom's taxonomy-based progression. Specific objectives are emphasized, while certain details are intentionally omitted to maintain clear and consistent communication with the students. We use a 4K camera installed in a 22x operative microscope is used for videos, and a DSLR coupled with a 100mm macro lens and ring flash for pictures.

Student feedback: The student feedback is delivered through project-based evaluations. The enlarged visuals (via microscope/ camera) enable both faculty and students to identify fine details and discuss areas for improvement. Some sessions we display deidentified projects in a constructive way. This method encourages peer learning, promotes critical analysis, and helps students better visualize the standards of care.

Videos: Yes, we prepare short videos of critical procedures offline and either post them on Canvas or play them during class. Additionally, we record some of the live demonstrations in the lab to share with students later.

(VCU) – Techniques? More incorporation of scanning. Delivery of student feedback? Mostly in-person. Videos for preparation/restoration? Yes, where possible.

II. **Materials and Techniques**

- a. What types of materials and strategies are used for vital/non-vital pulp therapy?

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(UP) – The specifics in the Endodontic pre-clinic and simulation module have not been finalized as of this meeting (expected in Spring 2026, with material to be covered in Spring 2027 in the D1 year).

Vital pulp therapy (VPT) utilizes caries removal as appropriate (use of selective caries removal is stressed), a final decision regarding pulp capping materials has not been made, but will likely be a resin-based material, Mineral Trioxide Aggregate (MTA), or bio-active cement (ex. Biodentine)

Non-vital pulp therapy (NPT) will follow the strategy of removing all pulpal tissue (including diseased and/or necrotic tissue) as part of the pulpectomy, and appropriate obturation (Medicaments have not been finalized by faculty and formulary committee).

(AU) – We do indirect and direct pulp caps. On directs we place the definitive direct restoration, not an Interim Direct Restoration. Preclinical is taught bioactives but only shown technique for CaOH/Vitrebond/Ultrablend. D4s can use bioactives as well as traditional CaOH therapy.

(UF) – UF students are taught didactically about various pulp capping materials for direct and indirect pulp caps. Currently our school does not teach vital pulp therapy beyond indirect and direct pulp capping. Clinically our students use calcium hydroxide (Dycal) and RMGI (Vitrebond) for both direct and indirect pulp caps. Material choice is primarily due to cost of dental materials for pulp capping. Students do receive information about predicting prognosis of pulp capping related to factors such as patient age, pulp diagnosis, size of exposure, quality of exposure, type of exposure etc.

(UL) – No response.

(MMC) – Vital pulp therapy: Dycal calcium hydroxide and Biodentine are used for capping and protection due to their biocompatibility and ability to stimulate reparative dentin. Non-vital pulp therapy: Approach varies by pathology; Biodentine may be used as a dentin substitute or sealing material.

(NOVA) – We follow the principles of regenerative dentistry and are aligned with the Endodontics Department. Our first-choice materials are next-generation biophosphate/biosilicate cements, with Biodentine (by Septodont) being our material of preference. For both direct and indirect pulp capping, the use of GIC bases has been reduced; when a base is required, RMGIC is preferred, as a support for the integrity and structural durability of resin composites. We have stopped using soluble calcium hydroxide-based cements for vital pulp therapy.

(VCU) – Vital Pulp Therapy:

Direct Pulp Cap: Dycal followed by Vitrebond Plus, Restore

Indirect Pulp Cap: If RDT <0.5mm, Dycal followed by Vitrebond Plus, restore; if RDT 0.5-2.0mm, Vitrebond Plus only then Restore

Non-Vital Pulp Therapy:

Non-surgical root canal treatment using the crown-down technique with Vortex blue rotary files for cleaning and shaping and sodium hypochlorite 2.5% for irrigation. The working length must be between 0.5-1mm from the apex. If the patient has acute periapical abscess or Chronic periapical abscess (with sinus tract) we prefer to do it in 2 sessions using calcium hydroxide between sessions. Once the canal is dry or the sinus tract is resolved we can obturate using lateral condensation technique and AH plus sealer.

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b. Treatment planning

i. Describe the treatment planning process at your institution.

(UP) – Non-emergency patients are assigned to clinical teams after completion of initial screening and intake. The diagnostic findings, radiographic findings, problem list are generated by the dental student, reviewed with the clinical faculty and the preliminary treatment plan is generated by the dental student. The plan is reviewed with the clinic team leader (CTL) or their designee, and the plan is modified for more efficient care delivery, urgency of care, and appropriate phase sequencing. The student will identify any appropriate specialty care consultations as part of the process.

In situations where the care will be complex or contingent on initial therapy or procedures, an initial phase only plan may be generated with the faculty. The plan is presented to the patient, with at least one alternative plan, reviewed and signed after patient approval.

(AU) – We use the axiUm tx planning module. We have Mentor/mentee teams assigned for D3 year. We spend the first few weeks of D3 year doing D0150's and D0120's and utilize a transfer checklist for pts of record. We have the student create a Holistic plan that covers the entire course of tx and serves as a case presentation tool and then a "D123" or "D12" plan which is a subset consisting of only the care the student will provide. The D123 or D12 plan will be signed at the completion of the D0150 or D0120. The Gap between the holistic plan and D123 plan will be covered by referrals to specialties such as OMS, Endo....Adjustments to the signed Tx plan will be captured in addendums.

(UF) – We have a comprehensive TEAM model in our clinics. Each TEAM has a mixture of 3rd and 4th year students working in associate pairs. Each TEAM has a TEAM leader who helps the students with treatment planning and patient case management. Each discipline provides instruction and feedback to the students during the examination process. For example, operative faculty are responsible for guiding students on radiographic interpretation and hard tissue clinical examination. Operative faculty will guide students to make recommendations for treatment for each tooth. Perio, Prosth, Endo will review their relevant components of the exam. Once all data is collected, the TEAM leaders help the student integrate the information to come up with an appropriate treatment plan or treatment plan options.

(UL) – Students complete all diagnostic exams, obtain medical consults, discipline-based consults and periodontal consultations prior to developing treatment plan. All treatment plans must be reviewed and signed by either the Program Director or Team leaders.

(MMC) – Patients begin with orientation, where they receive information on policies, rights, and payment options. They then proceed to the ODS Clinic, where radiographs and a tooth-by-tooth assessment are completed. Faculty review and approve treatment plans before care proceeds.

(NOVA) – No response.

(VCU) – No response.

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1. Who “owns” the treatment plan?

(UP) – TCDM manages and maintains the EHR, with the Office of Clinical Affairs serving as the administrative agent.

The clinical teams, with the supervisory role of the clinic team leader (CTL), are responsible for generating the comprehensive treatment plan and alternative plans for patient review and approval. Completion, management and modifications (where applicable) of treatment plans are a part of the student's patient management evaluation.

(AU) – Our D3 and D4 students have empaneled pts, and they are responsible for the holistic and D123/12 plans. The referred to specialties formulate their own plans for that referred out to care. As it is in private practice.

(UF) – Treatment plans are created and managed by the student who is assigned to a patient and approved by their supervising TEAM leader. The student stays with the patient throughout their comprehensive care. 3rd and 4th year students work together as associates and manage the same patient pool.

(UL) – Ownership officially falls to ULSD at the team level (including students) and team leaders.

(MMC) – The school owns the treatment plan.

(NOVA) – We have a team leader system. The team leader “owns” the treatment plan. Each clinic team has two partnering team leaders supervising a group of 32-34 students. The two team partners divide the task of treatment planning for the patient families between the two of them.

(VCU) – GP thru ODC and crowns, and then Prosth. through major restorative work (RPDs, CDs, etc.).

2. Who can modify it?

(UP) – The treatment plans can only be modified in consultation with the Team Leader and/or the Associate Dean of Clinical Affairs, and determined based on patient wishes after a review of clinical progress, changes in conditions, etc.

Clinical (non-TL) faculty cannot modify any part of the plan without such consultation, and written documentation as to the rationale.

(AU) – D3 and D4 can make addendums only with the approval of attending faculty via the tx planning module in axiUm.

Treatment plan changes occur when a faculty covering a procedure in a specific discipline either disagrees with treatment or sees the need for additional treatment. In these cases, the disciple faculty and TEAM leader can have a discussion on the floor (away from the patient) to determine the best course of action. We have created overt policies regarding treatment plan changes in the clinics. Typically, only the TEAM leader can change a treatment plan.

(UF) – No response.

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(UL) – Anyone within the team can modify the treatment plan, subject to oversight by the team and team leaders.

(MMC) – Only faculty may modify treatment plans.

(NOVA) – The team leaders can modify it in the form of a revised treatment plan. Ideally, the same team leader should make the modifications, as the Axiom system only allows the original creator to reopen their treatment plan. However, in the absence of the treatment planning team leader, the other team leader can prepare a revised treatment plan of a particular part of the treatment. The partnering team leaders are expected to work off each other's treatment plans. If both team leaders are unavailable and a modification is needed, the floating team leaders within the department are allowed to modify the treatment plan then notify the team leader of this change.

(VCU) – No response.

3. What educational methods and resources are used to teach treatment planning?

(UP) – The curriculum utilizes both PBL and CBL, in addition to traditional lectures, and using simulated and actual cases (no unique identifiers).

(AU) – We delve deeply into tx planning in the D2 year in what we call Sophomore Block. There is a didactic portion and clinical portion. Its methodology is carried forward to D3 and D4 year.

(UF) – UF's students receive a treatment planning course during the spring semester of their D2 year (right before they head to clinic). The course includes reviews from all disciplines as well as many treatment planning practice patient cases. These are complete in a group setting with a faculty lead. There have also been efforts bring the treatment planning philosophy to the preclinical setting by using patient cases as well as applied exam questions.

(UL) – Lecture-based course with Panopto recordings, textbook, video and case reviews.

(MMC) – ODS radiology integration

- Lectures and hands-on demonstrations

- Videos and clinical observation

- Role-playing exercises with classmates

(NOVA) – Our department teaches two treatment planning courses within the predoctoral program. Students are given tx planning didactic sessions through a multidisciplinary approach. In addition to the didactic teachings, tx planning assignments and short evidence-based dentistry tasks are incorporated.

(VCU) – Treatment planning courses in the curriculum.

4. Are there individual courses dedicated to treatment planning or is treatment planning embedded throughout the curriculum (discipline-based)?

(UP) – During the student D1 year, specific treatment planning courses are taught, and the student development or treatment planning skills is

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embedded in the comprehensive dental care courses in their D2 and D3 years.

(AU) – It is embedded in the Sophomore block course mentioned in question 17 and reinforced in the D3 and D4 clinical courses.

(UF) – Both.

(UL) – ULSD offers a D2 Preclinical Treatment Planning Course, an D3 Clinical Treatment planning Course and a D4 Clinical Treatment Planning Course, in addition to discipline-based treatment planning lecture in the discipline courses.

(MMC) – We have a dedicated course (ODS) in the D2 year.

(NOVA) – There are 3 treatment planning courses within the curriculum. D2 (winter), D3 (winter) and D4(summer) courses. In addition, each discipline provides instruction on its own protocols, which guide treatment planning decisions. The primary aim of the dedicated treatment planning courses is to integrate the knowledge from all disciplines, helping students understand how to develop comprehensive, multidisciplinary treatment plans.

(VCU) – Individual treatment planning courses that have GP faculty (D2), GP, Prosth, Endo, and Perio faculty (D3 & D4). In the D4 year, the treatment planning course is a capstone of 4 years with seminars: the student must present to their peers and specialists.

c. How is your institution addressing the fluoride “controversy”?

(UP) – The fluoride controversy is not currently an issue since we did not have students or patients in our facilities; the community served by TCDM has fluoridate community/municipal water, however many residents in the outlying areas still rely on well water, and most water in the Commonwealth lacks naturally present fluoride; a plan is to conform to the ADA language and evidence-based sources to address and concerns that may arise.

(AU) – No response.

(UF) – The UF College of Dentistry values the evidence available on the efficacy and safety of water fluoridation, topical fluoride application, and prescription-level fluoride toothpaste and follows/supports the statements from the ADA and the Florida Dental Association. We are focusing our efforts on patient education and autonomy. We are exploring other adjunct caries management approaches with the knowledge that fluoride still has the best evidence in caries management and prevention.

(UL) – Students are taught evidence-based findings of fluoride efficacy and benefits vs. risks. Encourage critical thinking. Students are encouraged to acknowledge public concerns regarding fluoride and allow patient autonomy. Offer alternatives such as nano HA but studies are currently limited. Emphasize effective manual debridement regardless of fluoride use for caries prevention. Modified bass brushing method. C shape flossing technique.

(MMC) – Although insurance coverage for adult fluoride is limited, we emphasize evidence-based instruction in Preclinical Operative Dentistry. Students are taught proper

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indications, applications, and caries-prevention benefits, preparing them to educate and advocate for patients in practice.

(NOVA) – Water fluoridation in our state was initially banned in certain counties and is now prohibited statewide as of July 1, 2025. However, we continue to use topical fluoride treatments and materials containing fluoride. The content expert and the Chair have prepared a statement on fluoride and its implications highlighting not only its benefits but also potential downsides and the risks of misuse. A departmental meeting was held where this statement was discussed with the aim to have a united front when it comes to addressing patient concerns.

In collaboration with Student Association, Operative Dentistry course director gave a special lecture on “How to talk about fluoride to patients”, from the scientific, clinical and legal point of view. These discussions were internal discussions.

(VCU) – Faculty refer to the ADA fact sheet “Community Water Fluoridation Key Messages & Resources Updated 1/23/25”. Additionally, we defer to guidance from the Virginia Department of Health at <https://www.vdh.virginia.gov/oral-health/cwf/>

III. **Student Assessment**

- a. What are your student preparation strategies for licensing exams (ADEX, CDCA, WREB)?
 - i. Classroom instruction related to the exam process.
 - ii. Mock boards?

(UP) – The preparation of students for licensing exams is designed with a focus on their future challenge of the CDCA examination, but student should be comfortable with any of the examinations toward licensure in the U.S. Mock CDCA examinations will be facilitated at the start of the D3 year, and the competency evaluations that are relevant to the CDCA examination components are to be administered in a format like the CDCA (check-in, preparation evaluation steps, instructions to candidate, etc.)

(AU) – We provide a Mock Board Course.

(UF) – Students are very well-prepared from preclinical exercises that mimic ADEX steps and with classroom practice sessions in the SIMLAB as well as a D4 course which provides lectures and mock boards very specifically taught for ADEX preparation.

(UL) – Mock Boards and Licensure Exam review course

This course is designed to prepare predoctoral students for the ADEX licensure examination through a series of lectures and review sessions presented by predoctoral program directors.

The content focuses on:

- Technique Review: Detailed demonstrations and refreshers on approaches to treatment.
- Rubric Interpretation: In-depth comparison of the released ADEX grading rubrics to help students understand evaluation criteria and performance expectations.
- Mock board performance review: Review of rubrics and critical errors through scenarios from the MB examination.

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- Strategy Development: Guidance on time management, techniques and critical thinking during the exam.

A series of Mock Board (MB) examinations are held from the Fall through the Midspring semester, simulating the licensure examination setting. The series includes assessments in Periodontics, Prosthodontics, Endodontics, and Operative Dentistry."

(MMC) – We have incorporated clinical courses entitled Regional Licensure Review I (D3) and Regional Licensure Review II (D4) into the curriculum.

D3 Students:

- Participate in simulated procedures using ADEX criteria.
- Disciplines covered include restorative dentistry, prosthodontics (crown and bridge), Periodontics, and endodontics.
- Students complete three simulated exams in the fall semester and three in the spring semester.

D4 Students:

- Continue licensure-based review with integrated simulated procedures.
- In January of the senior year, students complete a comprehensive two-day simulated licensure examination modeled on ADEX standards.
- The exam includes restorative, prosthodontics, endodontics, and periodontal components.

This structured approach provides repeated opportunities to practice competency-based assessment, preparing students for regional licensure examinations.

(NOVA) – Yes, we do have a Regional Board Preparation Course that runs in the fall semester and winter semester of the D4 year. In the winter term there are a total of 6 weeks of teachings to prepare for endo, prosth and perio boards. In the winter term, there are 4 weeks to prepare for the restorative boards. Both semesters are taught by the Restorative Department, but our main focus is on the restorative boards. Yes, we have mock boards in the 4 disciplines. We divide each discipline on different days and give mock exams during the allocated time of the course, rather than closing the clinic and fully simulating a full day mock exam.

(VCU) – No response.

b. How are students assessed when scheduled on external rotations?

i. Do you count those procedures for meeting requirements?

(UP) – External rotation sites are deemed as for student skills development and enrichment, and formative feedback will be provided by the preceptors, but do not impact the student grading; at the end of the rotation each student will receive a summative assessment of their overall rotational performance, professional conduct, etc. and is included in their evaluations for community-based care.

Student procedures on external rotations are currently designated as for enrichment only, and do not count toward procedural or competency requirements; students are required to satisfactorily complete all clinical competency evaluations before their assignments to external rotations.

(AU) – No response.

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(UF) – Students must enter procedures in CORE system and RVUs from external rotations count towards graduation expectations, but specific experiences and competencies must be completed on-site at the dental school in our TEAMS clinics

(UL) – Faculty in lead at the external sites are calibrated to utilize the evaluation criteria followed by ULSD.

Students earn PCUs (patient care units) for the experiences completed at the site

(MMC) – Students are assessed through evaluations completed by site faculty and preceptors. These assessments are reviewed and incorporated into their academic record. Yes, procedures completed externally are documented in axiUm and count toward meeting requirements.

(NOVA) – The NSU site for external rotations employs our three full-time restorative faculty members, so procedures completed their count toward graduation requirements without restrictions. Students are also allowed to challenge ICPAs at this site. The remaining external rotation sites do not follow this standard. While we do count procedures completed during external rotations toward graduation requirements, there is a cap. The primary instruction must take place on the main campus; therefore, students may not fulfill more than 20% of their requirements through these external rotations. We are gradually reducing this allowance each year, and beginning this year, we are transitioning away from counting these procedures toward graduation requirements.

(VCU) – No assessments, this is an experiential learning experience to expose students to access to care issues, different clinic models and different patient population. Dental students complete six online modules about oral health disparities to add to their public health knowledge while providing care in free clinics, FQHC's, Assisted Living Facilities and Community Health Centers. Both dental and dental hygiene students reflect on the experience and submit a fall and spring guided reflection.

Do you count those procedures for meeting requirements? No. No procedures are counted for school requirements.

IV. **Administration**

- a. What initiatives/support/strategies do you employ to maintain a successful work-life balance?

(UP) – TCDM leadership recognizes the intensity and stress that is associated with programs such as our three-year DMD curriculum, and work-life balance will be key to our overall success.

TCDM students, like all other Graduate and Health Professions students, are provided with a reduced membership rate with the local YMCA, are encouraged to participate in intramural sports, and we are surrounded in Eastern Kentucky by some of the best outdoor activities with recreational opportunities (Bob Amos Park, Hatfield and McCoy trailhead in Pikeville) and surrounding state and regional parks. Attendance at university sporting events (Football, Basketball, etc.) are free for faculty, staff and students. Any nursing parent who is a UPIKE community member can use the mother's rooms.

(AU) – No response.

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(UF) – Our college, HR office, and administration have policies in place that value work/life balance and boundaries such as set work hours, limited after hours/weekend obligations, and flexibility.

(UL) – No response.

(MMC) – Faculty/Staff: Defined work hours for clinics, classes, and labs; wellness days built into the schedule; paid time off; and protected time for faculty development.

Students: Student Time Off (STO) days to manage personal matters. Both faculty and students have access to the Counseling Center and Fitness Center.

(NOVA) – Faculty tasks are assigned in advance to promote better planning and a healthier work-life balance. In our department, the Chair refrains from weekend or late-night communications, especially those involving action items. There is need for more faculty members to balance the workload within each department.

(VCU) – On the VCU website, there is a Work/Life webpage with links for student, faculty and staff, providing "resources and support you need to achieve a healthy work-life integration. Discover strategies to manage stress, enhance your well-being, handle challenging situations and create a fulfilling personal life while excelling in your professional role."

- b.** What assistance in terms of initiatives/support/strategies does your school/university provide?

(UP) – For students, the University of Pikeville has a long tradition of student services, including a pending placement of a Director of student Affairs and Academic Excellence at TCDM; specific programs include on campus ministry and related support; UPIKE THRIVE Counseling Center provides short-term mental health services including personal counseling, group counseling, consultation and referrals, and services are free and confidential for all currently enrolled UPIKE students

UPIKE partners with an insurance carrier to provide 24/7 access to mental health support services including substance abuse help through our student assistance program. TCDM students may use this service anywhere in the US, including external sites or in their hometown.

(AU) – No response.

(UF) – The university HR office sends out weekly emails promoting health. They host walking challenges and provide opportunities for mental health counseling and support.

(UL) – No response.

(MMC) – The school conducts bi-annual Orientation workshops that include the Center for Academic Success and Achievement (CASA). CASA provides tutoring, skills assessment, and counseling. Students also have access to library services.

(NOVA) – This year, the main administration decided to designate team leaders as dedicated team leaders, meaning they can no longer serve as course directors. This change was implemented to help reduce the already heavy workload of team leaders within the institution.

(VCU) – For students, we have a variety of wellness initiatives and programming throughout the calendar year to support their well-being. Furthermore, we also provide tutoring services in addition to all the campus-wide resources students have access to academic coaching, mental health counseling, etc.

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c. Calibration

- i. How often does your operative faculty meet as a group, and what are the objectives of those meetings?

(UP) – The plan is for operative faculty to be at least once per term to address feedback from student evaluation of teaching, and update faculty on changes in protocols, materials, etc.; asynchronous training modules are planned and will be required for clinical faculty; additional meetings will be on an as-needed basis

(AU) – The operative faculty does an intentional calibration prior to each semester. Content from those calibrations is provided periodically to our part-time and full-time faculty (who are also invited to the calibrations). Faculty huddles at every session to normalize prior to engaging in preclinical activity and during the first few weeks of D3 clinic.

(UF) – Our department hosts a retreat with breakout sessions every 2 years. Our department also meets once per month. Our smaller division of operative dentistry meets once per month to discuss current issues in clinics and preclinic and upcoming events. Our preclinical faculty huddle before every simulation lab session to calibrate. Our course directors host instructional faculty in an informational/calibration session at the beginning of each semester to review course expectations and evaluation.

(UL) – At the beginning of each semester, operative faculty and course directors convene as a team to collaborate, align instructional strategies, and calibrate course delivery. Additionally, prior to the launch of each course, individual course directors meet with the Predoctoral Program Director to review course content, confirm topic coverage, and ensure continuity across the curriculum.

(MMC) – Faculty meet regularly to review clinical criteria, grading rubrics, and teaching strategies. These meetings ensure consistency in expectations, assessments, and delivery of instruction.

(NOVA) – We hold monthly departmental meetings to discuss, review, and update specific topics, as well as to announce important changes. The objective is to bridge our preclinical teachings with their application in clinical procedures. Each meeting varies in format: some include hands-on exercises, while others feature didactic lectures. All meetings conclude with an open discussion.

(VCU) – For the pre-clinical operative courses, the faculty meet prior to every lab session. During this time, we review the laboratory projects for that day, faculty calibration, student progress and other items of importance.

- ii. Are your calibration efforts discipline-based or across all disciplines?

(UP) – Calibration is designed to be across all disciplines, with content expertise in specialty care areas providing the training to clinical faculty in their area (all clinical faculty should be comfortable covering the foundational areas of general dentistry).

(AU) – Both. We have a committee that is tasked to normalize operations for common task across depts and disciplines. (CEPAC). We are also doing Peer Review and drafting DCG level Clinical Practice Guidelines.

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(UF) – Calibration is discipline based. However, there are some broader departmental policies that are reviewed periodically.

(UL) – Our program is committed to maintaining consistency and excellence in teaching and assessment through regular calibration efforts:

- Within disciplines, faculty engage in ongoing collaboration to align instructional approaches, performance expectations, and evaluation standards.
- Across disciplines, all faculty in the department that are involved in teaching DMD students convene twice annually to conduct broader calibration sessions. During these meetings, Predoctoral Program Directors present updates specific to their areas, including:
 - Changes to instructional materials
 - Revisions to performance criteria
 - Updates to definitions of critical errors
 - Modifications to evaluation methods

(MMC) – Calibrations are multidisciplinary, as our team clinic model involves oral diagnostic sciences, periodontics, endodontics, and restorative dentistry working together.

(NOVA) – We hold separate monthly departmental calibration sessions for our faculty. In addition, we run a joint calibration program with the Department of Prosthodontics approximately three times a year. Furthermore, our Dean of Clinics has initiated a weekly interdepartmental meeting series, where all departments are invited. Each week, one department delivers a two-hour lecture to educate the others about its protocols.

(VCU) – No response.

d. What are your policies for student absences?

(UP) – Attendance is mandatory for didactic, simulation and clinic activities, and in most courses, attendance is a component of course grading (10% is the standard); unexcused absences and tardiness are components considered as part of unprofessional behavior in the Student Handbook.

All UPIKE-TCDM students are expected to arrive at lectures, practical exams and other scheduled activities on time. Excused absences must be requested in advance using the Excused Absence Form. If an emergency, students are to contact the Graduate and Health Professions Student Affairs office.

(AU) – No response.

(UF) – D1s and D2s will be allowed 10 total personal leave days (PLDs) during semesters 1-5. D3s and D4s will be allowed 14 total PLDs during semesters 6- 11. PLDs can be considered planned or unplanned, and excused or unexcused. Absence for didactic and/or laboratory classes will be subject to grade penalties imposed by the course director or in accordance with policy stated in the course syllabus. Each course director for mandated attendance classes, labs and clinics scheduled during a planned absence need to sign the student's request to miss their activity and provide appropriate make-up session(s) as necessary. Course directors are not obligated to sign and/or remediate students requesting this leave. A student who is absent because of an acute illness or personal

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emergency is required to notify the Office of Academic Affairs immediately to advise them of the situation. Extended unplanned absences (greater than 3 days) and/or absences occurring on days of scheduled examinations, assignment deadlines, supervised laboratory projects or clinical rotations may require documentation from the student by the Office of Academic Affairs or Course Director. Acceptable documentation includes verification of the doctor's appointment, visit Student Health Services or an obituary announcement. Requested leave of absence, except for acute emergencies, will be granted only to students in good academic standing. Absences for personal reasons will be granted only when the course director(s) determine that such absence will not be detrimental to the student's progress in the course, or that such absence will not affect the teaching of the course. The student assumes full responsibility for their actions should their academic progress or graduation be jeopardized through failure to complete courses, clinical competencies, and electives in a timely and satisfactory manner. Students absent without prior approval may be suspended from further clinical activity within the Clinic Care Group. The student will be referred to the Associate Dean for Clinical Affairs along with objective documentation of the unexcused absence. Unexcused absences will be considered as patient abandonment and as such are a violation of clinic policy. Students and faculty must cooperate to allow each person to observe the holy days of their faith. A student needs to inform the faculty member of the religious observances of that their faith will conflict with class attendance, with tests or examinations or with other class activities prior to the class or occurrence of that class, test or activity. The faculty member then is obligated to accommodate the student's religious observances. Because our students represent a myriad cultures and many faiths, the University of Florida cannot ensure that scheduled academic activities do not conflict with the holy days of all religious groups. We, therefore, rely on individual students to make their need for an excused absence known in advance of the scheduled activities.

(UL) – Attendance is mandatory in scheduled classes, laboratory sessions, examinations, clinics, and rotations.

It is recognized that there will be legitimate unavoidable times when a student may be absent. This must be reported to the Office of Student Affairs via an online form. This office will communicate absences to the appropriate course director who will decide if the absence is excused. Any absence longer than 2 days must be supported by appropriate documentation.

Students who observe work-restricted religious holy days must be allowed to do so without jeopardizing their academic standing in any course. Faculty are obliged to accommodate students' request(s) for adjustments in course work on the grounds of religious observance, provided that the student(s) make such request(s) in writing minimum two (2) weeks prior to the anticipated absence with documentation submitted to the Office of Academic Affairs.

During D3 and D4 year students are allotted 20 clinic sessions of absence, but these absences must be requested and approved in advance. The types of absences recorded include approved, excused, and unexcused:

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- Approved - an allowable absence that counts against the 20 sessions allotted to each student for time off. i.e.: doctor's appointments, unavoidable events like car trouble or illness, other personal reasons.
- Excused - an allowable absence that does not count against the 20 sessions allotted to each student. i.e.: school related obligation, national meetings, pre-natal appointments, national boards, work restricted holy days*, interviews*, bereavement*.
- Unexcused - an unapproved absence that counts against a student's 20 approved sessions AND negatively impacts the ICS grade AND may result in referral to the Student Review Council (from which recommendations may result in a delayed graduation). These can be applied to any clinical activity, (i.e.: failure to sign in, failure to attend, arriving more than 15 minutes late, leaving without being dismissed by faculty, forging sign in for other students).

(MMC) – Attendance is mandatory for all clinics, classes, and rotations. Guidelines are outlined annually in the Academic Policies & Procedures Manual. Students are allotted 10 full Student Time Off (STO) days or 20 half-days per year.

(NOVA) – The Dean of Student Services evaluates each student's request for an excused absence. If approved, we are required to provide a make-up exam; however, make-up simulation lab sessions are not mandatory. Attendance is strictly enforced, and students are responsible for making up any missed material. Unexcused absences are handled according to the student handbook and may impact on the student's grade average. Recently, we added a clause in some courses stating that if excused absences accumulate to a level that could affect the learning experience, remediation may be required at the discretion of the course director.

(VCU) – No response.

e. What are the demographics of your current classes, and what are the trends?

(UP) – The inaugural class will commence in June 2026- no data is available at this time.

(AU) – No response.

(UF) – Class of 2029. 93 enrolled students. 71 females, 22 males. 84 Florida residents. Avg GPA 3.82. Avg DAT 460. Avg PAT 450. Age range 20-31 years. Avg age 23.

(UL) – Our demographics have remained relatively consistent over quite some time:

- 120 students per cohort
- 25% in-state
- Average age 22-24
- 20 - 25% First generation college students
- About 30% rural, remaining 70% is suburban or urban.
- Approximately 65-70.

(MMC) – The student body is approximately 70% female and 30% male. While the number of females has increased, women remain underrepresented in surgical specialties and leadership roles. The student body, faculty, and staff remain diverse.

(NOVA) – We have a very diverse group of students. Many in-state but we have a lot of out of state students as well. Currently we have mostly female students.

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(VCU) – Incoming (current) D1 class: VA Residents = 63, Non-VA Residents = 32, Female = 58, Male = 37

i. Is student performance in courses declining?

(UP) – N/A

(AU) – According to the range and average of our GPA's, it has remained consistent.

(UF) – Performance is not declining. However, it has been noted that retention of information from semester to semester and into clinics may be declining.

(UL) – No difference in trends has been observed.

(MMC) – No. Student formative and summative evaluations continue to improve. Our INDBE and regional licensure pass rates remain above 95%.

(NOVA) – We have not noticed such a trend. We do see that every class has its own culture, and each class has varying levels of success but there is not a consistent trend of decline or an incline between cohorts.

(VCU) – No response.

ii. How many remediation attempts do you allow for exams, courses, skills assessments, etc...?

(UP) – Remediation for pre-clinical skills assessments is generally allowed as a first retake after a meeting with the course director and completion of remedial prep work; subsequent remediation will require consultation with the Committee on Academic Performance and Standards Committee (CAPS), as outlined in the Student Handbook.

(AU) – No response.

(UF) – If a student fails a semester course, they are offered 1 remediation attempt. If they fail the remediation attempt, they fail the course. In clinics, if a student fails a competency, they cannot fail another competency within the next 8 weeks. If they fail another competency within an 8-week period, they go into a remediation program. If they don't pass the remediation program, they fail the clinical course that semester.

(UL) – Exams: No remediation for failed examinations. Exam grade will contribute to the final course.

Courses, Student might be given the opportunity to remediate a class if they meet the minimal qualification stated in the syllabus.

Clinical Skills Assessment: Students are given the opportunity to reattempt the failed assessment a maximum of two times, with consequences, after completing a remediation plan outlined by the course director.

(MMC) – Students are allowed up to three remediation attempts, pending approval by course directors and Clinical Affairs.

(NOVA) – We are given the autonomy to implement retakes and even multiple retakes attempts within our individual courses. These need to be clearly mentioned in the syllabus. As a department, we do not prefer to allow multiple retakes, and our preference is to only allow one remediation. There have been exceptions where the students were given another remediation attempt after appeals processes.

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(VCU) – No response.

- f. Are you considering a switch from axiUm to EPIC as your Electronic Health Record?
(UP) – The TCDM will be initially using only axiUm (June 2026), and EPIC is not being considering for the near future.
(AU) – No response.
(UF) – Not at this point.
(UL) – No.
(MMC) – No. The School uses approximately 90% of the AxiUm software for patient registration, billing, evaluation, dispensary, and scheduling.
(NOVA) – Our institution has been considering it for a while now. We are not aware of a definite switch.
(VCU) – No.

V. CaMBRA Questions

This agenda can be thought of as a continuation of a conversation regarding caries management education and clinical implementation at our schools, and it should be of special interest to operative dentistry educators:

- a. Tooth-level caries lesion classification and documentation.
- i. In your student clinics, are tooth-level caries lesions documented in your electronic health record (YES/NO)?
(UP) – YES (Planned- see Question 32).
(AU) – Yes
(UF) – Yes
(UL) – Yes
(MMC) – Yes
(NOVA) – Yes
(VCU) – Yes
1. If YES, where are the lesions documented? Odontogram, a specialized form, and/or somewhere else?
(UP) – Plans are to document carious lesions in axiUm (Odontogram).
(AU) – We use AxiUm. We have "condition" codes that give line-item identification of conditions (caries, fractured cusps, etc.) tooth by tooth that is in the Tx Hx. As those are generated it also give a graphic annotation on the odontogram
(UF) – Not on the odontogram but “yes” in the treatment planning and on our Hard Tissue examination paper worksheets.
(UL) – All caries, both radiographic and clinically
Caries is documented in odontogram as:
Primary Caries (C3301)
Secondary Caries (C3303)
Arrested Caries (C3304)
Primary Root Caries (C3305)
Secondary Root caries (C3306)

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(MMC) – Carious lesion findings are documented in the Treatment Plan module of AxiUm. Findings are also charted on the Odontogram. A caries risk assessment is completed for each patient.

(NOVA) – They are documented in the Odontogram within AxiUm.

(VCU) – Initial assessment form, Caries assessment form.

2. If NO, why are lesions not documented?

- b. If you answered YES to the above question about documenting tooth-level caries lesions in your electronic health record, then what classification system do you use and how granular is your documentation? For example, some schools may note lesions on a simply binary basis (lesion or no lesion). Others may use general terminology referring to location (primary/secondary) and/or level of progression (“incipient” vs dentin). Or others may use approaches like ICDAS/ADA CCS. What are you documenting for your tooth-level caries lesions?

(UP) – Initial plans are to use ICDAS Codes for dental caries for formal description, but this may change prior to students starting in June of 2026.

(AU) – We enter tooth #, then primary, secondary, then surface.

(UF) – We typically indicate inactive versus active lesions: primary, secondary or cervical/root caries; and radiographic interpretation such as E2 lesion.

(UL) – ULSD uses the ADA caries classification system.

Lesions are noted on a binary basis and documented as present or not present in the AxiUm odontogram.

The students are asked to classify caries as part of their patient-based caries detection competency D4 year

The students receive practice classifying caries as part of their D1 intro to preventive dentistry course in which they complete patient-based case studies.

(MMC) – Lesions are recorded with location and level of progression (incipient, moderate, extensive). Documentation follows ADA CCS standards to ensure consistency.

(NOVA) – In the previous findings part of the Odontogram in AxiUm, we document lesions as primary caries, secondary caries, incipient caries, root caries etc. The treatment planning module provides additional classifications within the diagnosis list to specify the extent of each lesion. In the D3 year, students complete a Caries Prevention and Health Promotion ICPA, where they are required to chart lesions using the ICDAS categories for their ICPA patients. This charting is done in the ICPA form, not in AxiUm.

(VCU) – ADA CCS: E1, E2, D1, D2, D3.

- c. Do you utilize diagnostic codes for caries in your student clinics to accompany CDT treatment codes (YES/NO)?

i. If YES, which diagnostic codes/descriptors for caries lesions do you use?

(UP) – Yes (planned). Plans are to use CDT codes, where applicable, in planning treatment, and conditions codes (axiUm) for description of location/type/etc.

(AU) – Yes. We use the Findings option of the charting tab as well as Problem list and Dx codes in the AxiUm Tx planning module

(UL) – Yes. C3301-Caries

- C3303 Secondary Caries
- C3304 Arrested Caries

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- C3305 Root Primary Caries
- C3306 Root Secondary Caries

(MMC) – Yes. ADA dental procedure codes.

(NOVA) – Yes. We use nomenclature rather than codes but internally each diagnosis is linked to a CDT code.

ii. If NO, why are diagnostic codes not used?

(UF) – No. We do not currently use this feature in axiUm.