Fall 17

Consortium of Operative Dentistry Educators (CODE)

Annual National Report: Regions I - VI

Prepared by:

Gary L. Stafford DMD – National Director

gary.stafford@mu.edu

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National Director's Update

In late September, I had the good fortune to attend Region I's 2017 Fall Meeting held at the Oregon Health Science University School of Dentistry in Portland, OR. I would like to extend my personal thanks to Dr. Rose McPharlin who went to great lengths to ensure that the attendee's had an informative and enjoyable few days. I would also like to thank Dean Phillip Marucha for hosting the large contingent of CODE representatives, sponsors, and other guests at OHSU. With 100% participation from the fifteen regional schools, Dr. Oanh Le, our Region I Director, continues to impress everyone with her organizational skills and ability to effectively lead the discussion surrounding our National Agenda.

Although I was only able to attend one Regional Fall Meeting this year, our other Regional Directors, hosts, and host schools are equally deserving of special recognition and thanks:

- Region II Director, Dr. Christa Hopp and host, Dr. Melynda Meredith at the University of Missouri Kansas City School of Dentistry.
- Region III Director, Dr.Shalizeh Patel and host, Dr. Nick Miniotis at the LSU Health New Orleans School of Dentistry.
- Region IV Director, Dr. Michelle Kirkup and host, Dr. D. Stanley Sharples at the Ohio State University School of Dentistry.
- Region V Director and host, Dr. James Kaim at the University of New York College of Dentistry.
- Region VI Director, Dr. Mary Baechle and host, Dr. Alex Delgado at the University of Florida College of Dentistry.

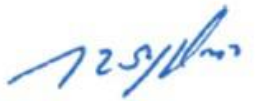
As always, thanks must also go to Dr. William Johnson for his continued service as webmaster for the Consortium. Please continue to provide both he and I with any updates regarding your contact information.

With 76 North American Dental Schools (66 U.S. and 10 Canada), for 2017/18 we have 68 participating CODE member schools (60 U.S. and 8 Canada). While I am proud of the level of institutional participation, I would ask that if your school is listed as one of those not being a member (see the Schools and Regions section of the 2017 Annual National Report at www.unmc.edu/code), please help facilitate payment by following up with the individual who is responsible for sending in the annual dues. Contact me directly at gary.stafford@marquette.edu with any questions you might have.

Dr. Taiseer Sulaiman has agreed to provide a presentation on *Light Curing and Its Importance in Pre-clinical Education* at the 2018 CODE Annual National Meeting that will be held at 5:10 pm in the Parkside Room of the Drake Hotel in Chicago, IL on Thursday, February 22nd, 2018. Dr. Sulaiman is the Director of Biomaterials and Biomimetics at the University of North Carolina School of Dentistry and will be representing Region VI. The Academy of Operative

Dentistry continues to graciously provide support for this annual event so I would hope that many of you would be able to join us during the AOD's Annual Meeting. I will 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 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 complied 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.

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, banks 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 and edited 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	Marquette 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 on 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 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 their Regional Director. The National Director and/or the Executive Council may select the at-large member(s).
- The terms are three years, renewable, 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 region while working in concert with the national director
- 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 assist on dues "nonpayment" by schools
- Ensure that reports of regional meetings are submitted **within 30 days** of 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
- Other, as required

Advisory Committee

(Board of Directors)

Updated 12.30.17

	Region	Regional Directors	Phone/email	3 Year Term
I	Pacific	Oanh Le DDS Clinical Professor PRDS University of California San Francisco School of Dentistry 707 Parnassus Ave. San Francisco, CA 94143	650.558.9253 oanh.le@ucsf.edu	2015 - 2018
II	Midwest	Christa Hopp DMD Associate Professor Restorative Department Southern Illinois University School of Dental Medicine 2800 College Ave. Alton, IL 62002	618.474.7052 chopp@siue.edu	2015 - 2018
III	South Midwest	Shalizeh A. Patel Associate Professor Department of Restorative Dentistry and Prosthodontics University of Texas Health Science Center at Houston, School of Dentistry SOD-5442 Houston, TX 77030	713.486.4269 Shalizeh.Patel@uth.tmc.edu	2016 - 2019
IV	Great Lakes	Michele L. Kirkup DDS Clinical Assistant Professor Department of Restorative Dentistry Indiana University College of Dentistry 1121 West Michigan St. Indianapolis, IN 46202	317.278.3398 mkirkup@iu.edu	2016 - 2019
V	Northeast	James M. Kaim DDS Professor Department of Cariology and Comprehensive Care New York University College of Dentistry Floor 6, 137 East 25th St. New York, NY 10010	212.995.4889 jmk2@nyu.edu	2016 - 2019
VI	South	Mary Baechle DDS Associate Professor Virginia Commonwealth University School of Dentistry 520 North 12th St. Box 980566 Richmond, VA 23298-0566	804.828.7297 mbaechle@vcu.edu	2016 - 2019
		At-Large Members	Phone/email	3 Year Term
II	At-Large	William W. Johnson DDS MS Professor and Vice Chair Department of Adult Restorative Dentistry University of Nebraska 4000 East Campus Loop South Lincoln, NE 68583-0740	402.472.9406 wwjohnson@unmc.edu	2016 -2019
III	At-Large	Edmond R. Hewlett DDS Professor Associate Dean for Outreach & Diversity University of California Los Angeles School of Dentistry 10833 Le Conte Ave., 23-088D CHS Los Angeles, CA 90095-1668	310.825.7097 edhewlett@dentistry.ucla.edu	2016 - 2019

Consortium of Operative Dentistry Educators (CODE)

		At-Large Members	Phone/email	3 Year Term
VI	At-Large	Kevin B. Frazier DMD EdS Vice Dean Professor, Oral Rehabilitation Dental College of Georgia, GC 5210 Augusta University Augusta, GA 30912	706.721.2881 kfrazier@augusta.edu	2016 - 2019
II	Web Master	William W. Johnson DDS MS Professor and Vice Chair Department of Adult Restorative Dentistry University of Nebraska 4000 East Campus Loop South Lincoln, NE 68583-0740	402.472.9406 wwjohnson@unmc.edu	No Term
II	National Director	Gary L. Stafford DMD Associate Professor and Chair Department of General Dental Sciences Marquette University School of Dentistry 1801 W. Wisconsin Ave. Rm 336C Milwaukee, WI 53233	414.288.5409 gary.stafford@mu.edu	2016 - 2019

Regions and Schools

North American Dental Schools = 76 (10 Canada* and 66 United States) + the Naval Dental Center

Region I (Pacific) – 15 Dental Schools (2 Canada* and 13 United States)

Region	Dental School	2018 Member
I	University of Alberta*	✓
I	University of British Columbia*	✓
I	AT Still University of Health Sciences - Arizona	✓
I	Midwestern University - Arizona	✓
I	Loma Linda University	✓
I	Roseman University of Health Sciences	✓
I	University of Nevada at Las Vegas	✓
I	University of Southern California	✓
I	University of California at Los Angeles	✓
I	University of California at San Francisco	✓
I	University of the Pacific	✓
I	Oregon Health Sciences University	✓
I	University of Utah	✓
I	University of Washington	✓
I	Western University of Health Sciences	✓

Region II (Midwest) – 11 Dental Schools (2 Canada* and 9 United States)

Region	Dental School	2018 Member
II	University of Manitoba*	✓
II	University of Saskatchewan*	✓
II	Missouri School of Dentistry & Oral Health	✓
II	University of Colorado Health Sciences Center	✓
II	The University of Iowa	✓
II	Southern Illinois University	✓
II	University of Minnesota	
II	University of Missouri at Kansas City	✓
II	University of Nebraska Medical Center	✓
II	Creighton University	✓
II	Marquette University	✓

Region III (South Midwest) – 7 Dental Schools (7 United States)

Region	Dental School	2018 Member
III	Louisiana State University Health Sciences Center	✓
III	University of Mississippi Medical Center	✓
III	Oklahoma University Health Sciences Center	✓
III	University of Tennessee	✓
III	Baylor College of Dentistry	✓
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	2018 Member
IV	The University of Western Ontario*	✓
IV	Midwestern University - Illinois	✓
IV	The University of Illinois – Chicago	✓
IV	Indiana University School of Dentistry	✓
IV	University of Detroit Mercy	✓
IV	University of Michigan	✓
IV	University of Buffalo	✓
IV	Case Western University	
IV	The Ohio State University	
IV	University of Pittsburgh	✓
IV	West Virginia University	✓

Region V (Northeast) – 18 Dental Schools (4 Canada* and 14 United States) + 1 NDC Member

Region	Dental School	2018 Member
V	Dalhousie University*	✓
V	McGill University*	✓
V	University of Toronto*	✓
V	Laval University*	
V	University of Montreal*	
V	University of Connecticut Health Center	
V	Howard University	✓
V	Boston University	✓
V	Harvard University	✓
V	Tufts University	✓
V	University of Maryland	✓
V	Naval Dental Center	
V	University of New England	✓
V	Rutgers University	✓

V	New York University	✓
V	Stony Brook University	✓
V	Columbia University	✓
V	Temple University	✓
V	Touro College of Dental Medicine	✓
V	University of Pennsylvania	✓

Region VI (South) – 13 Dental Schools (13 United States)

Region	Dental School	2018 Member
VI	University of Alabama	✓
VI	East Carolina University	✓
VI	Lake Erie College of Osteopathic Medicine	
VI	Nova Southeastern University	✓
VI	University of Florida	✓
VI	The Dental College of Georgia at Augusta University	✓
VI	University of Kentucky	✓
VI	University of Louisville	✓
VI	University of North Carolina	✓
VI	University of Puerto Rico	
VI	Medical University of South Carolina	✓
VI	Meharry Medical College	✓
VI	Virginia Commonwealth University	✓

2017 Regional Meeting Hosts

Region/Dates	University/Address	Host Name/Phone/email
I – September 28-29, 2017	Oregon Health Sciences University School of Dentistry 2730 SW Moody Ave Portland, OR 97201	Rose McPharlin 503.494.6209 mcpharlin@ohsu.edu
II – September 28-29, 2017	University of Missouri at Kansas City School of Dentistry 650 E 25th St Kansas City, MO 64108-2784	Melynda Meredith 816.679.7186 meredithmm@umkc.edu
III – November 2-3, 2017	Louisiana State University School of Dentistry 110 Florida Ave, Box 137 New Orleans, LA 70119	Tom Giacona 504.941.8257 fgiaco@lsuhsc.edu
IV – October 12-13, 2017	The Ohio State University School of Dentistry Postle Hall 305 W 12th Ave Columbus, OH 43210-1267	D. Stanley Sharples 614.688.5808 sharples.3@osu.edu
V – October 2-3, 2017	New York University College of Dentistry 345 E 24th St New York, NY 10010	James Kaim 212.998.9720 Jmk2@nyu.edu
VI – October 25-27, 2017	University of Florida College of Dentistry 1935 Center Dr Gainesville, FL 32610	Alex Delgado 352.273.5849 adelgado@dental.ufl.edu

2018 Regional Meeting Hosts

Region/Dates	University/Address	Host Name/Phone/email
I – September 27-28, 2018	Oregon Health Sciences University School of Dentistry 2730 SW Moody Ave Portland, OR 97201	J. Martin Anderson 206.543.5948 jma@uw.edu Yen-Wei Chen 206.543.5948 ywchen@uw.edu
II – September 20-21, 2018	University of Nebraska Medical Center College of Dentistry 4000 East Campus Loop South Lincoln, NE 68583-0740	Bill Johnson 402.472.9406 wwjohnson@unmc.edu
III – TBD, 2018	TBD	TBD
IV – October 4-5, 2018 Tentative	University of Detroit Mercy School of Dentistry 2700 Martin Luther King Jr. Blvd (MB 98) Detroit, MI 48208-2576	Swati Chitre 313.494.6783 chitresd@udmercy.edu
V – October 1-2, 2018	New York University College of Dentistry 345 E 24th St New York, NY 10010	James Kaim 212.998.9720 Jmk2@nyu.edu
VI – October 4-5, 2018	University of North Carolina School of Dentistry 441 Brauer Hall Chapel Hill, NC 27599	Sumitha Ahmed 919.537.3146 sumitha_ahmed@unc.edu

Regional Meeting Reporting/National Meeting Information

The 2017 National Agenda was established after a review of the suggestions contained in the reports of the 2016 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 as to what has changed and 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 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 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.unmc.edu/code or within this document)

Send an electronic copy of the final regional report via an email attachment to the National Director (gary.stafford@mu.edu) within thirty (30) days of the meetings conclusion.

National CODE Meeting:

The meeting will be held Thursday, February 22nd, 2018 from 5:10 – 6:30 pm in the Parkside Room at the Drake Hotel, 140 East Walton Place, in Chicago, IL.

2018 ADEA Section on Operative Dentistry and Biomaterials Meeting:

The meeting will be held on Monday, March 19th at 7:00 am during the ADEA Annual Session & Exhibition, March 17-20, 2018 in Orlando, FL.

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.

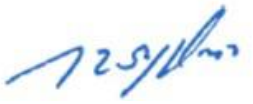
You may update your university's directory listing on the CODE website at www.unmc.edu/code or by sending an email directly to the National Director at gary.stafford@mu.edu.

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

1. *School name and complete mailing address*
2. *Individual names: (F/T Faculty), phone number and email address of F/T Faculty who teaches operative dentistry.*
    a. This could be individual's 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 helps save time and effort in maintaining a complete National Directory and publishing the Annual National Report in a timely fashion.

All my best,



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2017 National Agenda

I. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

i. What types of procedures? – Examples include:

1. Extra/intraoral examination (Yes/No)
2. Periodontal probing (Yes/No)
3. Alginate impressions (Yes/No)
4. Photography (Yes/No)
5. Radiographs (Yes/No)
6. Local anesthetic (Yes/No)
7. Prophylaxis (Yes/No)
8. Retraction Cord Placement (Yes/No)
9. Others – Please be specific

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)

ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)

iii. Will this policy change when INDBE is in place? (Yes/No)

iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?

v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

c. What is the student/faculty ratio in your school's pre-doctoral clinic?

i. Does case complexity play a role in determining this ratio?

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ (Yes/No)
2. ZOE (Yes/No)
3. RMGI (Yes/No)
4. MTA (Yes/No)
5. TheraCal LC (Bisco Dental) (Yes/No)
6. Biodentine (Septodont) (Yes/No)
7. Others (Yes/No)

ii. Technique(s) taught – Please be specific

III. Materials and Techniques

a. Provisionals

i. Material(s) used – Please be specific

ii. Technique(s) taught

1. Discuss various techniques

a. Traditional
    i. Describe
b. CAD/CAM (Yes/No)
c. 3D Printing (Yes/No)

b. Direct Pin Placement
    i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?
        1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

c. Restoration Repair
    i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?
    ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

d. Clinical Guidelines – Amalgam/Resin
    i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

IV. Assessment

a. Clinic Productivity
    i. Is the clinic productivity of your student a graded element in their clinical progress assessment?
    ii. Do you believe that it should be?
    iii. How do you assess their productivity?

V. Administration

a. Attendance Policy
    i. Describe the attendance policy for your school's students.
        1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.
    ii. Is the policy enforced?
    iii. Do you feel that this policy is fair?
    iv. Do you feel that the policy is appropriate?

b. Millennial Students
    i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?
    ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?
    iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?
    iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

2018 Regional Meeting Report Form

Region:

Host University, Address, and Dates of 2018 Regional Meeting:

Host University	Address	Dates of Meeting

Chairperson and Contact Information for 2018 Regional Meeting:

Chairperson	University/Address	Phone/email

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

Contact Person, Host University, and Dates of 2019 Regional Meeting:

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

Suggested Agenda Items for 2019:

2018 Regional Meeting Attendee's Form

Name	University	Phone	email

2018 Regional Meeting Attendee's Form

Name	University	Phone	email

Please return all completed enclosures to:

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

Associate Professor and Chair
Department of General Dental Sciences
Marquette University School of Dentistry
1801 W. Wisconsin Ave.
Rm 336C
Milwaukee, WI 53233

414.288.5409
gary.stafford@mu.edu

Deadline for return: 30 days post-meeting

Please send the requested documents via email with attachments

Fall | 17

Consortium of Operative Dentistry Educators (CODE)

017 National Agenda

epared by:

ıry L. Stafford DMD – National Director

ry.stafford@mu.edu

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ənd an electronic copy of the final regional report via an email attachment to the National Director ary.stafford@mu.edu) within thirty (30) days of the meetings conclusion.

ational CODE Meeting:

The meeting will be held Thursday, February 22nd, 2018 from 5:00 – 6:00 pm in the Parkside Room at ıe Drake Hotel, 140 East Walton Place in Chicago, IL. Any member who would like to present or who has ıggestions for speakers should contact the National Director for more information.

)18 ADEA Section on Operative Dentistry and Biomaterials Meeting:

ıe meeting will be held during the ADEA Annual Session & Exhibition, March 17-20, 2018 in Orlando, FL.

ational Directory of Operative Dentistry Educators:
ıe CODE National Director maintains the National Directory of Operative Dentistry Educators as a resource for :her dental professionals. It is critically important that this information be as current as possible.

ɔu may update your university's directory listing on the CODE website at www.unmc.edu/code or by sending ı email directly to the National Director at gary.stafford@mu.edu.

an effort to keep the National Directory up to date, please have each school in your Region update the ıllowing information:

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

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

l my best,

ary L. Stafford DMD
ɔnsortium of Operative Dentistry Educators (CODE)
ational Director
ssociate Professor and Chair
epartment of General Dental Sciences
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lilwaukee, WI 53233
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2017 National Agenda

I. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)
    i. What types of procedures? – Examples include:

1. Extra/intraoral examination (Yes/No)
2. Periodontal probing (Yes/No)
3. Alginate impressions (Yes/No)
4. Photography (Yes/No)
5. Radiographs (Yes/No)
6. Local anesthetic (Yes/No)
7. Prophylaxis (Yes/No)
8. Retraction Cord Placement (Yes/No)
9. Others – Please be specific

b. Benchmarks for entering the pre-doctoral clinics
   i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)
   ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)
   iii. Will this policy change when INDBE is in place? (Yes/No)
   iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?
   v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

c. What is the student/faculty ratio in your school's pre-doctoral clinic?
   i. Does case complexity play a role in determining this ratio?

II. <u>Biological Aspects of Operative Dentistry</u>

a. Pulp capping and pulp tissue management
   i. Material(s) used – Please be specific
      1. $CaOH_2$ (Yes/No)
      2. ZOE (Yes/No)
      3. RMGI (Yes/No)
      4. MTA (Yes/No)
      5. TheraCal LC (Bisco Dental) (Yes/No)
      6. Biodentine (Septodont) (Yes/No)
      7. Others (Yes/No)
   ii. Technique(s) taught – Please be specific

II. <u>Materials and Techniques</u>

a. Provisionals
   i. Material(s) used – Please be specific
   ii. Technique(s) taught
      1. Discuss various techniques
         a. Traditional
            i. Describe
         b. CAD/CAM (Yes/No)
         c. 3D Printing (Yes/No)

b. Direct Pin Placement
   i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?
   ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

V. <u>Assessment</u>

a. Clinic Productivity
   i. Is the clinic productivity of your student a graded element in their clinical progress assessment?
   ii. Do you believe that it should be?
   iii. How do you assess their productivity?

V. <u>Administration</u>

a. Attendance Policy
   i. Describe the attendance policy for your school's students.
      1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.
   ii. Is the policy enforced?
   iii. Do you feel that this policy is fair?
   iv. Do you feel that the policy is appropriate?

b. Millennial Students
   i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?
   ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?
   iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?
   iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

Regional Meeting Report Form

Region: I (Pacific)

Host University, Address, and Dates of the 2017 Regional Meeting:

Host University	Address	Dates of Meeting
Oregon Health & Sciences University School of Dentistry	2730 SW Moody Avenue Portland, OR 97201	September 28-29, 2017

Chairperson and Contact Information for the 2017 Regional Meeting:

Chairperson	University/Address	Phone/email
Rose McPharlin	2730 SW Moody Avenue Portland, OR 97201	503.494.6209 mcpharlin@ohsu.edu

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

Contact Person, Host University, and Dates of the 2018 Regional Meeting:

Contact Name Phone/email	Host University/Address	Dates of Meeting
Dr. J Martin Anderson **jma@uw.edu** **Dr. Yen-Wei Chen** **ywchen@uw.edu**	**University of Washington** **1959 NE Pacific St.,** **D322** **Seattle, WA 98119-6365**	**September 27-28, 2018**

Regional Meeting Attendee's Form

Name	University	Phone	email
Gary Stafford	CODE National Director	414.288.5409	gary.stafford@mu.edu
Rose Mcpharlin	OHSU	503-494-6209	mcpharli@ohsu.edu
J Martin Anderson	UW	253-631-0679	jma@uw.edu
Yen-Wei Chen	UW	206-353-9563	ywchen@uw.edu
Oanh Le	UCSF	415-519-9852	Oanh.le@ucsf.edu
Nirvana Anoosheh	UCSF		nirvanaa@comcast.net
Bernard Hurlbut	UNLV	702-774-2687	bernard.hurlbut@unlv.edu
Davin Faulkner	UNLV	702-774-2559	Davin.faulkner@unlv.edu
Loris Abedi	USC	818-620-3906	Labedi@usc.edu
Bernard Kula	Alberta University	780-953-5754	kula@ualberta.ca
Harold Haering	Midwestern	623-806-7011	hhaering@midwestern.edu
Jay Morrow	Midwestern	623-572-3818	jmorrow@midwestern.edu

Name	University	Phone	email
Klud Razoky	ATSU	480-219-6184	krazoky@atsu.edu
Reubin Kim	UCLA	310-825-7312	rkim@dentistry.ucla.edu
Marc Hayashi	UCLA	310-825-4855	mhayashi@dentistry.ucla.edu
Phil Buchanan	UOP	408-427-2552	pbuchanan@pacific.edu
Iris Nam	LLU	909-583-3834	inam@llu.edu
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Mark Christensen	WREB		mark@mlchristensendds.com
Karen Gardner	UBC	778-828-5202	kgardner@dentistry.ubc.ca
Mark Taylor	Utah U	801-455-9989	markrosstaylor@gmail.com
James Keddington	Utah U		James.keddington@hsc.utah.edu
Ben Wall	Roseman U	801-598-8013	bwall@roseman.edu
David Howard	Roseman U	801-878-1481	dhoward@roseman.edu
Jack Ferracane	OHSU		ferracan@ohsu.edu

Name	University	Phone	email
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Brent Fung	Western U		bfung@westernu.edu
Soh Yeun (Eileen) Kim	LLU	909-558-4640	sokim@llu.edu
Natalie Hohensee	LLU	909-558-4640	nhohensee@llu.edu
Phillip Marucha	OHSU		marucha@ohsu.edu

Suggested Questions for 2018 National Agenda

1. If a rubber dam is not a feasible option for composite under certain circumstances, does your school have any specific protocol for other isolation methods?
2. How many composite bonding systems do you have in your pre-doctoral clinic? If you have more than one type, are they different generations?
3. How many times do you assess your students for a particular procedure (ie, Cl II composite) after they have taken the course teaching that procedure? How is it assessed (manikin vs. live patient)?
4. At your school, when evaluating digital radiographs for interproximal caries, to what extent does the radiographic lesion need to reach before deciding the tooth needs a restoration?(ie. ½ way through enamel, to the DEJ, into dentin, etc.) Does the answer depend on the caries risk assessment of the patient? If so, please describe how a determination is made.
5. Other than lecture and practice on plastic teeth in typodonts, do you use additional methods to teach the concepts and hand-skills needed to prepare teeth and restore them? If so, please describe.
6. Definitions of a core build up vs a blockout.
7. Crowning/occlusal coverage of endo treated teeth. Are posteriors automatically crowned? Anteriors with small accesses get composites?
8. Types of indirect restoration materials used (PFM, emax, PFZ, zirconia), and when?
9. Resin infiltration (Icon) use/teaching.
10. Bleaching-take home trays vs in office. Are these procedures done? Or just taught in lecture?
11. Faculty calibration protocols.
12. Faculty management.
13. Criteria for determination of restorability/process for determination.
14. Clinic organization (geographic, home cubes, etc).
15. Scanning versus conventional impressions
16. Peer to peer learning of techniques
17. How to “flip” a simulation classroom?
18. Curriculum and national dental board changes

19. Do students do lab work for removable?

20. Meeting criteria for accreditation

Regional Nominee for Presenting at the 2018 CODE Annual Meeting (Please Include Topic)

Name	Topic	Contact Info
Jay Morrow – Associate Dean	**Peer to Peer Learning of Techniques**	**jmorrow@midwestern.edu** **602-509-2141**

Please return all completed enclosures to:

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

Associate Professor and Chair
Department of General Dental Sciences
Marquette University School of Dentistry
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Milwaukee, WI 53233

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Deadline for return: 30 days post-meeting

Please send the requested documents via email with attachments

Region I School Abbreviations

UA	**University of Alberta**	**ROSE**	**Roseman University-Utah**
UBC	**University of British Columbia**	**UU**	**University of Utah**
ASDOH	**Arizona School of Dentistry**	**UOP**	**University of the Pacific**
MWU	**Midwestern University College**	**UCSF**	**University of California-SF**
UW	**University of Washington**	**UCLA**	**University of California-LA**
OHSU	**Oregon Health Science University**	**USC**	**University of Southern Calif.**
WUHS	**Western University**	**LLU**	**Loma Linda University**
UNLV	**University of Nevada**		

I. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

UA Yes
UBC No response
ASDOH Yes
MWU No response
UW Yes
OHSU Yes for certain experience
WUHS No response
UNLV Yes
ROSE Yes
UU Yes
UOP Yes
UCSF Yes
UCLA Yes
USC Yes
LLU Yes

i. What types of procedures? – Examples include:

1. Extra/intraoral examination (Yes/No)

UA Yes
UBC No response
ASDOH Yes
MWU Yes
UW Yes
OHSU Yes
WUHS Yes
UNLV Yes
ROSE Yes
UU Yes
UOP Yes
UCSF Yes
UCLA Yes
USC Yes
LL Yes

2. Periodontal probing (Yes/No)

UA Yes
UBC No
ASDOH Yes
MWU Yes
UW Yes
OHSU No
WUHS Yes
UNLV Yes
ROSE Yes
UU Yes as part of a comprehensive oral exam
UOP Yes
UCSF Yes
UCLA Yes
USC Yes
LLU Yes

3. Alginate impressions (Yes/No)

UA Yes
UBC Yes
ASDOH Yes
MWU Yes
UW Yes
OHSU Yes
WUHS Yes
UNLV Yes
ROSE Yes
UU Yes
UOP Yes
UCSF Yes
UCLA Yes
USC Yes
LLU Yes

4. Photography (Yes/No)

UA	Yes
UBC	Yes
ASDOH	Yes
MWU	Yes
UW	Yes
OHSU	No
WUHS	Yes
UNLV	Yes
ROSE	Yes
UU	Yes
UOP	Yes
UCSF	Yes
UCLA	Yes
USC	No
LLU	Yes

5. Radiographs (Yes/No)

UA	Yes
UBC	Yes
ASDOH	Yes
MWU	Yes on dummies
UW	Yes
OHSU	No
WUHS	Yes
UNLV	Yes
ROSE	Yes
UU	Yes
UOP	Yes
UCSF	Yes
UCLA	No-dummies
USC	No
LLU	Yes according to FDA criterias

6. Local anesthetic (Yes/No)

UA	Yes
UBC	Yes
ASDOH	Yes
MWU	Yes
UW	Yes
OHSU	No, 2nd year dental student going with the mentor to give patient anesthesia (first time with patient approval)
WUHS	Yes
UNLV	Yes
ROSE	Yes
UU	Yes, students may opt out if a health risk exists, or they choose not to participate
UOP	Yes
UCSF	Yes
UCLA	Yes
USC	Yes
LLU	Yes

7. Prophylaxis (Yes/No)

UA	Yes
UBC	Yes
ASDOH	Yes
MWU	Yes
UW	Yes
OHSU	Yes
WUHS	Yes
UNLV	Yes
ROSE	Yes
UU	Yes as part of a comprehensive oral treatment
UOP	Yes
UCSF	Yes
UCLA	Yes
USC	Yes
LLU	Yes

8. Retraction Cord Placement (Yes/No)

UA	Yes
UBC	No

ASDOH No
MWU No
UW Yes
OHSU No
WUHS Yes
UNLV No
ROSE No
UU Yes, students may opt out if a health risk exists, or they choose not to participate
UOP No
UCSF No
UCLA No
USC No
LLU No

9. Others – Please be specific

UA No response
UBC No response
ASDOH No response
MWU Yes
UW No response
OHSU No response
WUHS No response
UNLV Occlusion evaluation, blood pressure, use of glucometer, informational forms
ROSE Oral cancer screening, medical history
UU Yes, shade matching
UOP No response
UCSF Yes, medical/dental history taken
UCLA Yes, – Nitrous Oxide (3rd year-summer); Facebow (2nd year)
USC No response
LLU

a. Cranial nerve exam
b. Endodontic vitality testing
c. Vital signs
d. Orthodontic and occlusion screening
e. TMJ Assessment
f. Patient screening
g. Comprehensive Oral Evaluation

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)

UA	No
UBC	N/A
ASDOH	Yes
MWU	Yes
UW	Yes
OHSU	No
WUHS	No
UNLV	No
ROSE	No
UU	No
UOP	No
UCSF	No
UCLA	No
USC	No
LLU	NO – if a student fails it twice, he/she is put on a LOA until he/she passes, and will join the next class. If the student fails a third time, he/she is discontinued from the program.

ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)

UA	No
UBC	N/A
ASDOH	No
MWU	No
UW	No
OHSU	No- this is taken in the DS3
WUHS	No response
UNLV	No
ROSE	No
UU	No
UOP	No
UCSF	No
UCLA	No
USC	No
LLU	NO. It is a requirement for graduation.

iii. Will this policy change when INDBE is in place? (Yes/No)

UA	No
UBC	N/A

ASDOH Yes
MWU Yes
UW Maybe
OHSU Yes
WUHS No
UNLV No
ROSE Do not know
UU Unknown at the moment
UOP No
UCSF Not quite sure yet
UCLA Unsure
USC Maybe (no decision made on this yet)
LLU Probably not

iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?

UA Yes
UBC Yes
ASDOH Yes- 40 questions OSCE type
MWU Yes
UW Yes
OHSU Yes
WUHS No response
UNLV No. Students begin treating patients at the start of the 2nd year even though they do not finish all pre-clinic courses until the end of the second year. However, students are not allowed to do a procedure in the clinic until they have passed the procedure in a pre-clinical course.
ROSE As primary provider must pass preclinical capstone
UU Students are allowed to perform procedures in the pre-doctoral clinic commensurate with their learning level in each of these disciplines. They continue with these studies as their clinical experience broadens. For Operative, the students will have finished their pre-clinical course work prior to entering into the clinic. Also, each student will have had to pass each course. Prior to entering into the clinic, the students will have also passed 2 summative competency examinations, which will allow them to enter the clinic
UOP Yes
UCSF Yes, I just hope so
UCLA No
USC To treat patients must pass all preclinical requirements
LLU No

v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

UA must pass everything before you can be promoted

UBC Local Anesthesia, Perio and Endo

ASDOH Passing the Pre-Clinical competencies

MWU Completion of the end of D2 year DEX Competency

UW None

OHSU No response

WUHS D1/D2 OSCE and all requisite courses.

UNLV Passing the 1st year courses.

ROSE Pre-clinical capstone assessment

UU Students are required to complete three semesters of Fixed Prosthodontics. During the first semester, students must successfully complete all simulated clinical exams successfully before they are allowed to treat patients in the pre-doctoral clinic on a limited basis.

UOP Passage of an end of the year Restorative and an OSCE exam

UCSF Passing all first and second year course work

UCLA Passing Practical and Written Exams in Direct and Indirect Restorations, Perio (No Sc/RP until passing Local Anesthesia course-fall qtr of D2). Direct, indirect, and perio get cleared independently.

USC Successful completion of the preclinical courses

LLU

1. D2 summative manikin exams for Class II and III composites
2. D2 Infection control summative examination
3. D2 OSCE with the following summative examinations:
   a. Medical history evaluation
   b. Vital signs
   c. Head and neck exam
   d. Informed consent
   e. Medical emergencies
   f. Bonding

c. What is the student/faculty ratio in your school's pre-doctoral clinic?

UA 4:1

UBC We usually have a ratio of 1:6 for beginning students (years 2 and 3) and then 1:8 in the 4th year

ASDOH 5:1

MWU 1 faculty covering clinic on floor for every 4.6 students seeing a patient

UW 7:1 ratio- 6:1 for 3rd year and 8:1 4th year

OHSU 1:6 ratio except in the summer

WUHS 7 /1 or 8/1- 13:2

UNLV 8:1

ROSE 6:1 ratio in clinic, 8:1 in pre-clinic

UU	Student to faculty ratio for the clinic is 6:1, and pre-clinically it is 7/8:1
UOP	5:1
UCSF	8:1 unless faculty is either sick, vacation, and or Research/dental meetings
UCLA	6:1
USC	8:1
LLU	6-8:1

i Does case complexity play a role in determining this ratio?

UA	No response
UBC	Complex cases are not a consideration in determining this ratio
ASDOH	Yes we have 2 faculties in the prosthodontic clinic overseeing 8 chairs
MWU	YES – some faculty may cover 5 to 7 students while another takes 3 or 4 same time period
UW	Generally No
OHSU	Yes, ratio decreased for Clinical Skill Assessments (competencies)
WUHS	Yes
UNLV	Not really. There are times when case complexity is taken into consideration and an attempt made to schedule accordingly, but the number of available clinical faculty for consistent coverage of a complex procedure plays a much bigger role.
ROSE	No
UU	Yes
UOP	Yes
UCSF	No
UCLA	NO, due to Advanced Restorative Clinic operations, Esthetic Clinic.
USC	Usually not
LLU	No. student/faculty ratio usually depends on faculty availability. However, some of the difficult cases are covered by the Clinic Director directly (not by attending faculty)

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ (Yes/No)

UA	No
UBC	Yes, for direct pulp capping (cement and/or PA powder) and some cases indirect pulp capping (less than 0.5 RDT)
ASDOH	No
MWU	Yes limited
UW	Yes

OHSU Yes
WUHS Yes
UNLV Yes
ROSE In pre-clinic students are taught the Bioclear system of composite placement. Generally, no indirect pulp capping is taught. Direct pulp cap technique is MTA covered by RMGI
UU Yes
UOP No
UCSF Yes
UCLA Yes
USC Yes
LLU Yes

2. ZOE (Yes/No)
UA Yes
UBC Occasionally in endodontics
ASDOH No
MWU No
UW Yes
OHSU No response
WUHS Yes
UNLV No
ROSE Yes
UU Yes
UOP No
UCSF No
UCLA No
USC No
LLU Yes

3. RMGI (Yes/No)
UA Yes
UBC Yes, liner (RMGIC liner) and base (RMGIC restorative or reinforced GIC)
ASDOH Yes
MWU Yes
UW No
OHSU Yes
WUHS Yes
UNLV Yes
ROSE Yes
UU More as a liner or to cover MTA or $CaOH_2$
UOP No
UCSF Yes

UCLA Not for direct pulp capping, only indirect
USC Yes
LLU Yes

4. MTA (Yes/No)
UA No
UBC Mostly endodontic
ASDOH Yes
MWU Yes
UW No
OHSU Yes
WUHS Yes
UNLV Preferred
ROSE Yes
UU Yes
UOP Yes
UCSF No
UCLA We have it, but don't really use it in the Restorative Clinic
USC No
LLU Yes

5. TheraCal LC (Bisco Dental) (Yes/No)
UA Yes
UBC Yes, direct and indirect pulp capping
ASDOH No
MWU Yes
UW Available
OHSU No
WUHS No
UNLV No
ROSE Not anymore. We use to use it, but don't have it anymore.
UU Yes, didactic, but not available in the pre-doctoral clinic.
UOP No
UCSF No
UCLA Yes
USC No
LLU No

6. Biodentine (Septodont) (Yes/No)
UA No
UBC No
ASDOH No
MWU No

UW No
OHSU No
WUHS No
UNLV No
ROSE No
UU Discussed in lecture, not used clinically
UOP No
UCSF No
UCLA No
USC No
LLU No

7. Others (Yes/No)

UA Yes
UBC No response
ASDOH Yes endotine
MWU No response
UW No response
OHSU No response
WUHS No
UNLV No
ROSE No
UU Ultrablend (Ultradent) – Yes (This is a $Ca(OH)_2$ in a urethane dimethacrylate vehicle.)
UOP Bioceramic
UCSF Yes SDF
UCLA Bioceramics (Brassler) in selected cases
USC No
LLU No

ii. Technique(s) taught – Please be specific

UA TheraCal placed on indirect and direct pulp caps
UBC No response
ASDOH CaOH clinic endotine MTA consult with Endodontist
MWU No response
UW CAOH2 PLUS RMGL; RESTORATIVE MATERIAL
OHSU Avoidance of exposure is taught. Indirect pulp capping is taught with CaOH and seal with glass ionomer prior to placement of restoration. Exposures may be treated with MTA.
WUHS Sandwich technique. Pinpoint with CaOH, then GI to 0.75mm or more to cover entire CaOH and onto dentin like a bullseye, then restorative above that.
UNLV Indirect pulp capping can be done with $CaOH_2$ or RMGI or not done at all

at covering faculty discretion in the given situation. Direct Pulp capping is done with MTA and covered with RMGI. The final restoration is then placed as usual.

ROSE No response

UU Indirect pulp capping is taught. Preoperative radiographs are taken to determine extent of caries. Preoperative pulp-tests are performed to determine pulpal diagnosis. Dental dam, or equivalent isolation method is in place. Preparation of the tooth includes ensuring clean (caries-free) DEJ margins peripherally. Caries removal ensues profoundly toward the pulp. Caries are left when the pulp is near exposure. $CaOH_2$ or MTA is placed in a thin layer (0.5 mm thickness) and allowed to dry. RMGI is placed to completely cover the MTA or $CaOH_2$. Direct restoration is then placed, either definitive or provisional as determined be the situation. Direct pulp capping is less desirable, and may be used with small mechanical exposures, pink hemorrhage occurs, and the preoperative pulpal diagnosis was normal to reversible pulpitis. MTA is the pulp cap material of choice. RMGI is placed to completely cover the MTA. Direct restoration is then placed, either definitive or provisional as determined be the situation.

UOP Yes DIRECT CAPPING IS ONLY ATEMPTED ON ASYMPTOMATIC TEETH. MTA OR BIOCERAMIC IS PLACED DIRECTLY ON EXPOSURE AFTER CLOTTING. MTA OR BOICERAMIC IS SUPPORTED BY A SECOND LAYER OF GLASS-IONOMER CEMENT, FOLLOWED BY A BASE AND RESTORATION.

UCSF we teach not to expose the pulp, mechanically, on a vital asymptomatic or reversible pulpitis, even if leaving caries at the pulpal 1/3. We also teach SDF, silver diamine fluoride for arresting caries at the pulpal 1/3 and then restoration, rather than expose the pulp.
We also teach the decision to treat, i.e. prevention vs drill. We are diagnostic centric, heavily preventative and minimally invasive.

UCLA Partial caries removal; CaOH2 covered by RMGI liner

USC Dycal placement followed by GI

LLU

- $CaOH_2$: for pinpoint exposure: control the hemorrhage, apply sparingly only to over the exposed area, cover with Vitrabond (RMGI) or Ultrablend ($CaOH_2$ with resin), and place either temporary or definite restoration
- MTA: for pinpoint exposure: control the hemorrhage, mix with sterilized liquid (local anesthetic) as thin paste, apply sparingly only to over the exposed area, cover with Vitrabond (RMGI) or Ultrablend ($CaOH_2$ with resin), and place either temporary or definite restoration

- RMGI (Vitrabond): for indirect pulp cap: apply sparingly on the area close to the pulp with dentin less than 0.5 mm then place restoration
- $CaOH_2$ (Ultrablend): for indirect pulp cap: apply sparingly on the area close to the pulp with dentin less than 0.5 mm then place restoration
- ZOE: used as temporary restorative material, not as a pulp capping material
- Step-wise caries excavation with temporization and use of Silver Diamine Fluoride to arrest caries.

III. Materials and Techniques

a. Provisionals

i. Material(s) used – Please be specific

UA Bis-acryl placed with a putty matrix for all single restorations
Methyl methacrylate with a putty matrix for bridges

UBC Integrity/Dentsply

ASDOH Integrity, Snap and Protemp

MWU Integrity, Luxatemp

UW Bis-acrylic (Protemp) and PMMA

OHSU Provisionals are made with matrix and Integrity for single units. Jet is recommended for multiple unit FPD or longer term provisionals

WUHS Luxatemp

UNLV Max-Temp, Bis-Acryl is used most often. Jet methylmethacrylate acrylic is sometimes used when strength is needed.

ROSE Pre-operative impression for matrix, and expertemp

UU

1. Bis-acryls (Integrity)
2. Methyl methacrylate
3. Light-cure methyl methacrylate (Unifast)
4. Ethyl methacrylate (Snap)
5. Urethane Dimethacylate Putty (Triad temporary material)

UOP Integrity

UCSF aluminum crown, protemp, jet acrylic

UCLA Visalys (Kettenbach); Duraseal and Dental Stopping (inlays/partial gold/ceramic cases); Jet Acrylic; Polycarbonate shells

USC PMMA and Bis-acryl

LLU

1. Acrylic resin: Trim & Integrity
2. Pre-formed aluminum shell crowns
3. Telio for inlays and onlays

ii. Technique(s) taught

1. Discuss various techniques

a. Traditional

i. Describe

UA Putty matrix

UBC A clear vacuum formed matrix is prepared in advance on a working cast, we don't allow the use of PVS impressions/putty for making provisional crowns/FD

ASDOH Using a bite registration material or Putty to make the provisional

MWU Putty or alginate impressions, or "suckdown" stints

UW Bis-acrylic (Protemp) provisional material is mainly indicated for the single unit restoration. A silicone matrix is fabricated prior to the tooth preparation. Direct technique is applied to fabricate the provisional made of Bisacrylic material.

PMMA provisional material is indicated for multiple-unit restorations. A PMMA provisional shell is fabricated prior to the tooth preparation. The provisional shell is relined intraorally after the teeth preparation.

OHSU We teach the fabrication of a clear matrix for visualization of provisional during fabrication. Integrity or Jet are the materials taught.

WUHS Ellman and Putty Matrix direct fabrication.

UNLV A stent is made using Vacuform material or PVS Impression material. After the tooth preparation is completed, the stent is used to create the provisional using either Max-Temp or Jet material. The provisional is adjusted as needed and cemented with Temp Bond, Temp Bond NE, Duralon, or SensiTemp Resin.

ROSE Pre-operative impression for matrix, and expertemp

UU a) Traditional

i. Direct
ii. Indirect
iii. Indirect-Direct

b) Materials

i. Putty matrix
ii. PVS matrix
iii. Alginate matrix
iv. Polypropylene vacu-form matrix

UOP Putty Matrix done on a study model

Vacuum press forms done on Study models

UCSF PVS matrix , putty matrix, vacuum press forms, Pre-formed aluminum shell crowns

UCLA i. Indirect method (alginate of pre-op, pour up in plaster, suck down

clear stent, rubber sep and Acrylic)
ii. Direct with matrix button or putty stent and Visalys;
iii. Inlays w/ Duraseal and Dental stopping

USC Indirect or Shell with PMMA, Direct with Bis-acryl
LLU

1. Quadrant putty impression or PVS impression is made before the tooth preparation.
2. Tooth preparation is completed.
3. Acrylic resin temporary material is injected to the pre-made impression and placed on patient's mouth and the impression is seated completely. At this time, students may inject little bit of the acrylic resin on the tray as a reference for setting of the material.
4. The set provisional is finished (shaped to fit to the tooth with appropriate margins, proximal contacts, and occlusion), polished, and cemented with temporary ZOE cement.
5. For pre-formed aluminum shell crowns, it is cut 1mm short of the margins, acrylic resin temporary material is injected into the intaglio, seated on patient's mouth with appropriate occlusion, finished appropriately, and cemented.

b. CAD/CAM (Yes/No)

UA Yes
UBC No
ASDOH Yes
MWU Yes
UW YES. The CAD/CAM provisional restorations are indicated when the long term provisional are needed such as the combination of the orthodontic treatments and complex complete mouth reconstruction.
OHSU No
WUHS No
UNLV Lectured, and provided with one for seating.
ROSE No- We have E4D at the school. Students are given extensive education with E4D in pre-clinic. We are planning to transition away from traditional impressions to lab for single unit restorations in the future. Furthermore, we have begin restoring cases with Pala digital dentures and will continue to pursue scanning and digital options for edentulous patients.
UU Yes
UOP Pending
UCSF No

UCLA Yes
USC No
LLU No but in the works (Yes, needs further development – taught both in didactic and clinical setting, but have not achieved full integration yet)

C. 3D Printing (Yes/No)

UA No
UBC No
ASDOH No
MWU No
UW No
OHSU No
WUHS No
UNLV No
ROSE No
UU Is this not CAD/CAM?
UOP Pending
UCSF No
UCLA No
USC No
LLU No

b. Direct Pin Placement

ii. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

UA We teach/place pins but clinically recommend that their use be limited and used as a last resort.
UBC We teach pin placement for complex amalgam restorations only; however, we warn against using it due to the inherent risks. This is exposure level teaching only, not a routine we encourage in patient care.
ASDOH We teach it in the pre-clinic .it is rarely used in the clinic

MWU We do not teach pins.
UW ONE TMS PIN PER MISSING CUSP; PLUS SLOTS, GROOVES, CHANNELS; POT HOLES
OHSU No response
WUHS We have taught this in the past but have stopped.

UNLV The teaching of direct pin placement was just removed from the pre-

clinic curriculum. It was found that pins were rarely utilized in the school clinic and in practice in general. Many faculty had been weary of using them in the school clinic due to student inexperience paired with the delicate nature of placing them. It was decided to stop teaching the technique at the school and instead focus on alternative methods of augmenting resistance and retention. The concept is still taught in didactic courses, but the students do not practice placing pins in the sim-lab and do not place them in the clinic.

ROSE Do not teach pin placement

UU Pin placement in vital teeth is taught, in conjunction with retentive pothole and groove placement. The students (and faculty) are strongly cautioned that pin placement is a high risk procedure that requires judicious use, and only infrequently. Students are also taught that patients must be informed of the inherent risks of tooth fracture &/or pulpal involvement whenever pins are utilized to augment resistance and retention.

UOP We do not teach pins

UCSF At UCSF we teach complex amalgam lecture to the D2 class that includes how and when to use pins to retain the amalgam. In the lab portion they do a plus amalgam restoration MODL++ and place a slot

for retention for one cusp and a pin for the other. Our philosophy at UCSF however is to de-emphasize the use of pins and favor the use of slots or troughs because it is a more controlled procedure. As far as amalgam vs. composite use in the first two years it is approx 40% amalgam to 60% composite.

UCLA We currently teach the students to place Max 021 pins for extensive amalgams or composites, as well as buildups.

USC We do not use pins anymore and have not been teaching the use of pins in courses in at least 20+ years

LLU Direct pin placement is recommended for the complex amalgam restoration with no macro-mechanical retention. It is not recommended for composite restoration because the difference on coefficient of thermal expansion of metal pin and composite may result in the failure of the restoration.

c. Restoration Repair

i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?

UA Yes
UBC We permit repair with amalgam only when clinically justified.
ASDOH Total removal
MWU No
UW No
OHSU We are not repairing amalgams that we did not place originally. In most cases, if an amalgam we place is defective, we are replacing it.
WUHS No
UNLV Defective amalgam margins are not repaired with composite resin.
ROSE It is permitted, but not encouraged. Depend on patient needs and wants, clinical judgement
UU Depending on the history of the restoration, we typically encourage replacement of the entire restoration. However, if repair is indicated at the margin of an amalgam restoration, amalgam would be the material of choice for the repair.
UOP No
UCSF Yes, repair with composite. We teach minimally invasive dentistry, with repair vs replace for both amalgam and composites. We do teach repair of a defective amalgam with amalgam
UCLA Total restoration replacement
USC Total replacement

LLU No. We do not permit amalgam margin repair with composite. The carious marginal defect requires a total restoration replacement and the non-carious minimal marginal defect may be put on a short-term watch.

ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

UA Allow repair
UBC We permit repair with composite resin only when clinically justified.
ASDOH Total removal
MWU No
UW REPAIR WITH COMPOSITE IF INDICATED
OHSU If the composite was placed by us and has a defective margin, we are open to fixing the defect without total removal of the restoration.
WUHS Margin repair okay
UNLV Defective composite margins can be repaired with composite resin if placed at the institution. The size of the defect and condition of the remaining restoration determines whether the total restoration needs replaced.

ROSE It is permitted, but not encouraged. Depend on patient needs and wants, clinical judgement.

UU Depending on the history of the restoration, we typically encourage replacement of the entire restoration. However, if repair is indicated at the margin of an resin restoration, resin would be the material of choice for the repair.

UOP Yes, if repair is not large

UCSF Yes, repair vs replace
We do teach repair of a defective composite margin with a composite resin not require a total replacement of restoration.

UCLA Generally total restoration replacement, depends on the recent natures of the placement

USC Repair if possible (clinical judgment-may or may not be fully replaced)

LLU No. Defective composite margin, whether it is carious or non-carious, requires total restoration replacement. However, if the restoration is fresh and recent and it is proved that there is no caries present under the entire composite restoration, marginal repair may be permitted. If we placed the restoration within a year, we permit removal of composite in the area of the open margin until acceptable margins are found and then replace with new composite.

d. Clinical Guidelines – Amalgam/Resin

i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

UA Yes recommend enamel on all finish lines for composites.

UBC Yes, posterior composite resin is only indicated for small restorations when isolation is possible

ASDOH Patient preference. We do have guidelines in regards isolation

MWU NO – pt choice

UW NO STRICT GUIDELINES; DEPENDS ON MANY FACTORS such as the isolation of the operating field, the extent of tooth structure loss, the patient's preference of the material of choice ….etc.

OHSU Yes, size, function, isolation, caries risk are the guiding factors

WUHS Smaller leans to composite. Amalgam where we can't achieve predictable isolation, but rarely do amalgams anymore.

UNLV Risks vs. Benefits of each material are taught to the students and listed in procedure manuals. These Risks vs. Benefits are discussed with the patient and a recommendation is given for whichever material the student and faculty mentor feel is most appropriate for the situation. A California style consent is captured for all direct

restorations.

ROSE No

UU Yes, Amalgam is indicated for moderate to large posterior tooth restoration. Amalgam is also indicated when isolation becomes an issue. Composite is indicated for esthetic restorations of small to moderate sized posterior tooth restoration, and anterior tooth direct restoration.

UOP We use composite exclusively, unless the patient stipulates amalgam. The fees are the same

UCSF Yes

UCLA YES. Composites are to be used when hygiene is optimal, not on root surfaces/primarily enamel margins, esthetic desires.

USC We don't use amalgam in our regular clinic anymore. (Very rarely a faculty may prefer to use amalgam on a specific case just based on their preference)

LLU Yes. Composite restoration is indicated for esthetic anterior restoration and small to moderate size posterior restoration when isolation is feasible. Amalgam restoration is indicated for posterior restoration with a difficulty in isolation and large size posterior restoration with heavy occlusal load

IV. Assessment

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment?

UA No

UBC No we grade on clinical experience. However, we do review their CPVs as indication of busyness and will meet with students when their busyness is more than 1 SD from the class average. Their lack of busyness will indicate a deficiency in the bredth &/or depth of their clinical experience and we will move to help them in their area of weakness.

ASDOH No

MWU NO to $ we track procedures

UW Yes

OHSU Yes, for 4th year students—there is a minimal threshold to reach. There is not increasing grade for increased productivity

WUHS No, but considering

UNLV Yes. 40% of their clinic grade is based on production.

ROSE No

UU Not at the present time.

UOP Yes

UCSF	Yes
UCLA	YES, they are graded on RVU's.
USC	Clinical Experiences and Comprehensive Care of Patient
LLU	No, but it is used to assess student progress to determine if a student has sufficient clinical experience to be promoted or allowed to graduate

ii. Do you believe that it should be?

UA	Yes
UBC	Only to determine their bredth and depth of clinical experience.
ASDOH	No
MWU	Yes
UW	Yes
OHSU	We believe that students should be aware of their productivity as a function of practice management, but we do not incentivize productivity
WUHS	Yes
UNLV	Clinic productivity is important for the students to receive needed experiences before graduating. It also demonstrates organization and the potential to be successful in practice after graduating. It should be a factor in determining the Clinical grade. How to grade this and to what extent it should effect the grade is always a topic of discussion.
ROSE	It should be one element of the assessment of competency.
UU	We are currently developing a process to incentivize students based upon their productivity. It will not be based solely on productivity, however, but will include RVUs for procedures that are critically important, but may not carry a big dollar value. It will also include criteria like clinic attendance.
UOP	Yes
UCSF	No
UCLA	No
USC	Comprehensive Care of Patient
LLU	No

iii. How do you assess their productivity?

UA	Not done
UBC	CPVs
ASDOH	We receive production report for each student.
MWU	We do not assess $ productivity – we do track student EXPERIENCES within disciplines ensuring wide range of activity in all disciplines demonstrating micro-motor hand skills and critical thinking.
UW	PROCEDURES ACCOMPLISHED AND GRADES OF "U, P, H" We keep track of each student's accomplished procedures. There is a report

every quarter to assess the students' productivity on different restorative procedures.

OHSU $$/session. We are considering a financial report that would assess lab charges and remakes

WUHS Chair utilization and production are being considered.

UNLV Points are assigned to each procedure the students perform. The level of points a student reaches in a semester determines what grade the student receives for production as a part of the total clinic grade.

ROSE Faculty observation overtime to assess knowledge, skill, and values. procedure reports, formative evaluations, summative evaluations- one patient, case presentations etc.

UU We are currently developing a process to incentivize students based upon their productivity. It will not be based solely on productivity, however, but will include RVUs for procedures that are critically important, but may not carry a big dollar value. It will also include criteria like clinic attendance.

UOP Use a *Clinic Status Report* for each student and each Group Practice (8). Students are compared to their peer group and then each peer group to the entire class.

UCSF Each student is required to have a certain amount of production points for various procedures. Equivalent amount, the dollar value of the CDT procedures, irrespective of account type. We also have specific number of restoration requirements, direct and indirect restoration requirements.

UCLA Would like to focus more on case completion, and quality of products vs volume.

USC GPDs evaluate individual student progress regularly.

LLU We look at actual production amounts $$ and production/clinic session.

V. Administration

a. Attendance Policy

i. Describe the attendance policy for your school's students

UA Attendance is required for all clinics and students are required to apply to the student affairs director for any excused absences.

UBC See answer i..

ASDOH See answer i.

MWU See answer i.

UW Yes

OHSU We require 100% attendance

WUHS See answer i..
UNLV See answer i.
ROSE No response
UU See answer i.
UOP Clinic attendance is mandatory
UCSF 100% attendance for PCC clinic sessions
UCLA Not sure of the exact verbiage, but we have an 80% attendance policy.
USC All students are to attend, arrive punctually and to remain in attendance for all the scheduled courses. The term "courses" is defined as PBL sessions, lectures, laboratories, seminars, clinic assignments, extramural assignments, or special assignments for which a student is scheduled. (See more information on this at the end of this document)

LLU "Students are expected with 100% attendance and absence in excess 15 % may lead to a failing grade."

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

UA Attendance is required for all clinics and students are required to apply to the student affairs director for any excused absences.

UBC

7.1. Absence Policy Rationale

It is important that students understand and value the time commitments made by faculty, fellow students, and patients toward their learning, particularly in clinics and small-group sessions. Poor attendance has a negative effect on morale, is considered unprofessional and can lead to students not achieving the required breadth and depth of experiences. Being present when expected is a requirement of practice as a professional and regular attendance in all classes and clinics is a professional commitment that is expected of **all** students (see UBC Calendar Policies and Regulations > Attendance). Note that attendance is mandatory for all classes on days preceding and following holidays, long weekends and examinations. Satisfactory attendance includes, but is not limited to, attending on time and participating in all scheduled coursework and clinic sessions (including rotations) in their entirety.

ASDOH

- Students are expected to be in class on time and stay for the duration of the class time. At the discretion of the Course Director, students who miss more than 10% of a sim-clinic session or a course with mandatory attendance due to approved extenuating

circumstance will earn an Incomplete (I) final grade and MUST retake the course when it is offered again or as determined by the Course Director. Upon successful completion of all course requirements, the (I) grade will be changed to reflect the actual grade earned in the course. (Please see I grade protocol at the end of this syllabus).

- Students who miss more than 10% of sim clinic, clinic, lab time, or a course session with mandatory attendance due to unapproved absences will earn an (F) final grade and MUST retake the course when it is offered again at their own expense. This may include, but not limited to sim clinic sessions, group discussions, or as indicated in the course syllabus.

- Please note that random attendance will be taken by the instructor or other designated personnel during certain course sessions with mandatory attendance. This may include, but not limited to sim clinic sessions, group discussions, or as indicated in the course syllabus.

MWU 100% clinic attendance with 17 days off approved year; 4.5 days in clinic a week, 44 weeks of year.

UW No response

OHSU We require 100% attendance with exceptions outlined below (verbatim)

VI. Serious Illness
VII. Hospitalization
VIII. Death in the immediate family
VIII. Approved religious observance
IX. Approved accommodations for disabilities
X. Unique academic or professional opportunities (pre approved by the Office of Academic Affairs)
XI. SOD Approved Events (pre-approved by the Office of Student Affairs)
XII. Jury Duty
XIII. Other compelling reason (pre-approved by the Office of Academic Affairs

WUHS

PROFESSIONALISM: 10% of ECD IV Course Grade
• Attendance and participation in all activities is factored into the professionalism grade.

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- Poor utilization of resources including technology resources. Poor Practice management, poor time management, and lack of organization will reflect in reduction of the Professionalism grade. **
- Non-compliance includes unexcused absences, violations of the dress code, academic honesty policy, unethical behavior, and unprofessional student behavior, and is monitored by the Course Directors and the Office of Academic Affairs. **
- One or more unexcused absences, lack of active participation in daily activities, tardiness, or other forms of unprofessional behavior will reflect in a reduction in the professionalism grade commensurate to the infraction. **
- The professionalism grade is based upon formative feedback from participating faculty on daily and weekly evaluations. Poor performance review may reflect negatively on the Professionalism grade.
- Any occurrence that is recorded for the student requires a mandatory meeting with the Course Director.
- Professionalism deductions are up to the discretion of the Course Director and/or Academic Dean.

  A major or multiple minor violations of the Standards of Academic and Professional Conduct, as determined by the Course Director(s) and/or Academic Dean, may result in the course grade maxing out at 70% or C.

Category	Example of Unprofessional Action	Consequence
Unexcused Absences	Tardy to any curricular activity without the notification and consent of the Course Director and Academic Dean	Deduction in professionalism grade Documentation in Academic Notes on APP
	Leaving early from any curricular activity without the notification and consent of the Course Director and Academic Dean	

	Repeated unexcused absences	Meeting with Academic Dean and/or Course Director, in addition to those listed above

UNLV The class attendance policy will be written in the course syllabus.

You are expected to attend all scheduled programs, seminars, meetings, classes and clinical sessions regardless of date or time unless excused throughout the academic year. It is the personal responsibility of the student to consult with the professor regarding absence(s) from class.

You are expected to notify the Office of Student Affairs or Program Director (in the case of postdoctoral students) (or Dean's designee) by phone or e-mail prior to an absence. In the case of unexpected emergencies, notify the Office of Student Affairs/Program Director (or Dean's designee) as soon as possible afterwards.

You can be administratively dropped from the class after four (4) absences without instructor notification.

Absences will be approved only for reasons of illness or emergencies of the student

or immediate family, religious observance, jury duty, and participation in approved activities, such as those involving national organizations and professional activities. Family reunions, days off for recreation, travel, social events, additional vacation, etc., are not reasons for approved absence. Absences for pre-doctoral students for employment interviews and for postdoctoral residency interviews will be limited to a total of ten (10) days an academic year and approval will be dependent on academic progress. Students, course directors, and team leaders should follow these guidelines.

In the event of a student medical problem or medical problem of a student's family member, the student should contact the Assistant Dean for Admissions and Student Affairs (or Dean's Designee), who will inform the appropriate faculty member(s). The course director, team leader or Program Director, as applicable, will approve/disapprove the absence. At the discretion of the course director/Program Director, absence due to illness extending beyond three (3) days may require a physician's letter. In addition to this section, please see the University's Health Withdrawal Policy, which applies to Voluntary Health Withdrawals (*See* **Appendix B**).

When in doubt about who to contact regarding an unexpected emergency, you must contact the Office of Student Affairs who will then notify the applicable faculty member.

Activities missed during absences approved by course directors/team leaders or Program Director must be made up and the make-up activities will be determined based upon the discretion of the course director, team leader or Program Director, as applicable.

ROSE No response

UU "…attendance is a professional responsibility and is mandatory." (page 12 Interim Student Handbook 2016-2017)
Is the policy enforced? Usually, but not always. Also, there are circumstances (outlined on *pages 12 and 13* in the student handbook) which are very humanistic and allow for students to miss class for various good reasons.

UOP Clinic attendance is mandatory

UCSF This policy is not outlined in the "Academic Affairs Manual"; it is outlined in each course syllabus and there is variation for different courses.

UCLA Not sure of the exact verbiage, but we have an 80% attendance policy.

USC

ATTENDANCE POLICY

E-mail: ABSENT-L@usc.edu

All students are to attend, arrive punctually and to remain in attendance for all the scheduled courses. The term "courses" is defined as PBL sessions, lectures, laboratories, seminars, clinic assignments, extramural assignments, or special assignments for which a student is scheduled.

Students who anticipate an absence for religious holy days, scheduled appointments, weddings, etc. must notify in writing the Office of Academic Affairs and their course directors, group practice directors, facilitators and PBL group members no later than 2 weeks prior to the scheduled absence.

Faculty members are not required to provide make-up opportunities for students who fail to properly report their absences.

PROBLEM BASED LEARNING:

Attendance and punctuality in PBL sessions are **mandatory**. The power of PBL lies within the group. Group members who are late or absent deprive the Group of their reasoning skills and reports on learning issues. Each group member has a responsibility to his/her peers within the Group. Absenteeism and tardiness are disruptive to **PBL** and **Clinical groups** and must be avoided. **Non-adherence to this policy is considered an ethics violation and may result in disqualification from the program**. Absenteeism for any reason must be reported to Academic Affairs via e-mail at ABSENT-L@usc.edu before the session begins. Include the following information: name, student number, phone #, reason for absence and who you want notified. If you are unable to e-mail, please call Academic Affairs at (213) 740-1001.

CLINIC SESSIONS – ASPID, TRADITIONAL AND PBL STUDENTS:

Attendance for all clinic sessions (excluding night clinics) is mandatory. Students' attendance will be monitored on a daily basis. **Non-adherence to this policy is considered an ethics violation.**

In the event of illness or emergency, students must leave an e-mail message at ABSENT-L@usc.edu before the session begins. Include the following information: name, student number, phone #, reason for absence and who you want notified. Using this e-mail address will notify both your Group Practice Administrative Assistants and Academic Affairs. If you are unable to e-mail, please call Academic Affairs at (213) 740-1001.
Students will be accountable for attendance during the entire clinic session. If at any point you are found absent from your clinical session, you will receive an unexcused absence for that session and are subject to the consequences found in the Attendance Policy. Please note that some clinics begin earlier than others. When serving in these clinics, please be mindful of their start times.

LLU

Attendance

Regular attendance at lectures, clinics, and other assemblies is required of all students. All lectures and laboratories provide information essential for successful completion of the program. Each student is responsible for all material covered and assignments made. *Absences in excess of 15 percent may be sufficient cause for a failing or unsatisfactory grade to be recorded.* Clinics and individual courses/instructors may have more stringent requirements.

ii. Is the policy enforced?

UA Yes
UBC No punitive action outlined → we reach out to students to determine how we can help them.

ASDOH Yes
MWU Yes
UW Yes
OHSU Yes
WUHS Yes
UNLV Yes
ROSE New policy, it will be
UU Yes
UOP Yes
UCSF Supposed to be, but there are probably exceptions
UCLA No
USC Yes
LLU Yes

iii. Do you feel that this policy is fair?

UA	Yes
UBC	Fair to whom
ASDOH	Yes
MWU	Yes
UW	Yes
OHSU	Yes
WUHS	Mostly yes
UNLV	Making material available in various multimedia formats. Evaluating preparations with CAD/CAM technology. Flipping the classroom. Working in smaller groups/group projects and case base 3d learning. Each technique has had some success with certain groups of students. None of the techniques seem to be a one size fits all. Offering varied methods for learning and not relying on only one technique can be helpful.
ROSE	We will see
UU	Yes
UOP	Yes
UCSF	Yes
UCLA	Yes
USC	Yes
LLU	Yes

iv. Do you feel that the policy is appropriate?

UA	Yes
UBC	Yes, with the academic regulations of the University of British Columbia
ASDOH	Yes
MWU	Yes
UW	Yes
OHSU	Yes
WUHS	Yes, we even added a professionalism component this year.
UNLV	Yes
ROSE	To be determined
UU	Yes
UOP	Yes
UCSF	Yes
UCLA	Not sure if it's appropriate, as it's hard to define what is meant by attendance. On campus? Assisting others? Doing lab work? Not sure it's appropriate to dock a student who's running around getting signatures, lab prescriptions checked, etc.
USC	Yes

LLU Yes

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

UA Yes

UBC There are faculty orientations that may touch on this but nothing is formal or required by the Faculty or the university.

ASDOH Yes, with in the school we have an annual faculty development session we invite speakers to address this topic. Also we have scheduled faculty calibration and development session schedule during the year Within the university, workshops and lectures are provided for the faculty through the learning and teaching center.

MWU Yes

UW YES; WE OFFER SELECTIVE COURSES

OHSU I am not aware of training in house. Those who attend ADEA may have taken classes. Our university is working on a module related to teaching millennial/digital learners.

WUHS Yes

UNLV There have been a couple but the best method seems to be trial and error and learning from colleague successes and failures. As a Clinical Sciences Department we have regular faculty update meetings where this topic is frequently discussed. As a whole the students may be millennial but each student is still individual in how they learn. Also, what works for one class does not necessarily work for the next. We are constantly looking for alternative ways to teach/deal with the new generation of students.

ROSE Yes very limited

UU Yes but inadequate

UOP Yes, a series of lunchtime seminars

UCSF Yes

UCLA No

USC No

LLU Yes

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

UA No

UBC N/A
ASDOH Yes, surveys are taken after the annual faculty development. Also, during of the session we fill evaluation for the speaker and the content
MWU Yes
UW YES; STUDENT EVALUATIONS.
OHSU No
WUHS Not quite yet, but soon
UNLV Yes, by the curriculum committee.
ROSE No
UU Our question humanistic survey
UOP Yes
UCSF Not to my knowledge
UCLA No
USC No
LLU No

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

UA No
UBC Working with the students to establish ground rules and guidelines rather than a top down approach.
ASDOH Gaming technique works well.
MWU Yes
UW YES; WE USE TEACHING SEMINARS IN THE CLERKSHIP MODEL. HEAVY STUDENT PARTICIPATION.
OHSU We employ the "flipped classroom", we are investigating methods to allow objective assessment and feedback (haptic technology)

WUHS Creating a less adversarial relationship from which to work from.
UNLV Making material available in various multimedia formats. Evaluating preparations with CAD/CAM technology. Flipping the classroom. Working in smaller groups/group projects and case base 3d learning. Each technique has had some success with certain groups of students. None of the techniques seem to be a one size fits all. Offering varied methods for learning and not relying on only one technique can be helpful.

ROSE We have received extensive training on active learning techniques. Last year in sim clinic we administered the entire year of pre-clinical Restorative 100% active learning technique and gave zero lectures.
UU Varies Student to Student
UOP Yes, active learning Technology

UCSF Has not been definitely determined
UCLA Interactive, digital editions/convenience.

USC Not known

LLU They want powerpoints which contain everything the student needs to know for examinations and to be a competent dentist ;-) They do not appreciate the usefulness of textbooks! Students also make use of software that allows them to make notes on lecture slides. We use Canvas to organize resources online.

iv. Are students provide with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

UA No

UBC Yes, this is covered during orientation by the Assoc Dean Academic Affairs and sporadically in other courses during orientation.

ASDOH During orientation week.

MWU Yes

UW YES; THE STUDENTS ARE TAUGHT WHAT IS EXPECTED IN ALL COURSES; INCLUDING GOOD MANNERS.

OHSU Students are exposed to professionalism seminars that provide training in communication with faculty, staff, patients.

WUHS Yes. We even added a professionalism component this year.

UNLV Students are introduced to this interaction at orientation and it is reinforced at various times throughout their time in dental school.

ROSE D1 students have an ethics course covering general ethics. However, no specific student/faculty structural behaviors are covered.

UU Yes

UOP Yes We communicate our expectations for active participation and engagement in the "learning process".

UCSF Not to my knowledge

UCLA No

USC Students are given a presentation during their orientation week about academic integrity, proper behavior and professionalism. Professionalism and Ethics are evaluated during clinical procedures which also includes their Competency Exams

LLU The D2 students have a lecture on this topic. In addition, we spend quite a bit of time in various classes teaching about professionalism and ethics. They also take a Meyers-Briggs Type Indicator before orientation and we go over that information with them during orientation to help them better understand themselves and their communication styles.

2017 Midwest Region CODE compiled answers

I. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

Creighton: Yes: extra/intraoral exams, perio probing, alginate impressions, local anesthetic, prophylaxis

No: photography, radiographs, retraction cord

Colorado: Yes: extra/intraoral photographs, perio probing, alginate impression, extraoral photography, radiographs, local anesthetics, prophylaxis, retraction cord, AND facebow and CR records, rubber dam isolation, health history

No: intraoral photographs

Iowa: Yes: extra/intraoral exams (including caries risk assessment), perio probing, alginate impressions, photography, radiographs, local anesthetic, prophylaxis, retraction cord placement AND rubber dam placement, retainer and ligature placement, measuring adequate resin curing,

Minnesota: Yes: Periodontal probing in periodontology course, alginate impressions in prosthodontics course and VPS in pre-clinical operative, radiographs (without exposure), anesthetic in oral surgery and pre-clincial operative, prophylaxis in periodontology, make and deliver occlusal guards in prosthodontics course

No: extra/intraoral examination, photography, retraction cord (just stopped in 2017 due to AHC draft- see Minnesota notes.)

Nebraska: Yes: Extra.intraoral examination, periodontal probing, alginate impressions, local anesthetic, prophylaxis, retraction cord placement

No: photography, radiographs

SIU: Yes- extra/intraoral photographs, periodontal probing, alginate impressions, radiographs, local anesthetic, prophylaxis, CR records, Facebow, Plaque index, PSR, caries risk analysis, full periodontal exam, health history, ortho models

No- photography, retraction cord placement

UMKC: Yes- extra/intraoral examination, periodontal probing, alginate impressions, local anesthetic, prophylaxis

No- photography, radiographs, retraction cord placement

Marquette: Yes- extra/intraoral examination, periodontal probing, alginate impressions, photography, local anesthetic, prophylaxis,

No- radiographs, retraction cord placement

b. Benchmarks for entering the pre-doctoral clinics

Creighton: NBDE1 required before entering predoc clinic, NBDE2 NOT required before entry to predoc clinic. Policy will not change when INDBE is in place. Passing all …courses is a prerequisite for entry into pre-doctoral clinic

Colorado: NBDE1 required, NBDE2 not required, INDE unknown, Passing all…courses is a prerequisite for entry to predoc clinic

Iowa: NBDE1 is required, NBDE2 is not required , INDBE unknown, Passing all…courses is prerequisite

Minnesota: NDBE 1- yes, NDBE2- no (but required for graduation), , INDBE unknown, Passing all…courses is prerequisite for entry into predoc clinic, promotion to DDS3 status is required prior to treating patients

Nebraska: Second semester D-2 students enter limited clinics (operative, complete dentures and periodontal) and do not have to pass NBDE1 for that, but must pass the exam before entering D-3 clinics, NDBE2- NO, INDBE- unknown, passing all…courses is prerequisite for entry into predoc clinic

SIU: NBDE1 Yes, NDBE2- No, INDBE- policy will change, passing courses NOT a prerequisite; The policy has been to limit or prohibit the treatment delivery within the discipline failed while in the process of remediation.

UMKC: NBDE1- No, NBDE2 – NO, INDBE- unknown, passing all prerequisite courses- not required- can enter clinic on a limited basis while remediating coursework that was failed, Students must complete bridge course (2-week transition course between 2nd semester d@ and summer semester D3)

Marquette: NBDE1 Yes, NBDE2- No, INBDE- unknown, prerequisite courses not required however, we do administer a series of manikin based “Capstone” exams (manikin based skills exams, serve somewhat as “competency” exams). We are in the process of moving these earlier in the curriculum to function more like “gatekeepers”; that is, students should pass each discipline prior to being able to perform unrestricted clinical work of the same discipline.

What is the student/faculty ration in your school’s predoctoral clinic?

Creighton:

- Diagnostic Sciences – 1:7
- General Dentistry – 1:7
- Acute Care – 1:4

Endo – 1:4

Pros – 1:4

Perio – 1:7

Oral Surgery – 1:3

Pedo – 1:4

Case complexity does play a role

Colorado: 6:1 The complexity doesn't play a role in the ratio. However, in our comprehensive care clinic, two out of the six chairs are reserved for comprehensive exam. The most complex prosthodontic cases are covered by prosthodontists also in the same 6:1 ratio.

Iowa: 4:1 in sophomore and 5:1 in junior operative clinic, complexity does NOT play a role

Minnesota: Planned 8:1 Variation occurs when patients fail or students take patient elsewhere in school, or when an instructor is unexpectedly absent. If instructor absence occurs, patient census is used to determine if a color group (subdivision of clinic) can get by with less faculty oversight, faculty can be stretched over two adjoining groups, or faculty can be borrowed from the pre-clinical program. Because of this latter possibility, all pre-clinical faculty are required to maintain a dental license.

Case complexity doesn't play a role. Two instructors oversee the work of 16 students in clinic. If there are cases that are more time consuming, one instructor will be involved in that case, and the other will take up the slack. Complex prosthodontics cases are sent to the Advance Restorative Clinic (Prosthodontic Division clinic).

Nebraska: There are 24 D-3 and D-4 students per clinic. There is a group leader (who is a general dentist), a general dentist, a prosthodontist who oversees two groups, two or three periodontists who cover four clinics, an endodontist and oral surgeon who are available as needed. The general ratio is about 6 to 8 students per faculty.

More difficult prosthodontic and implant cases are referred to a different clinic where those cases are handled by one prosthodontist. In that situation the faculty member will have only 1 to 3 students.

SIU: 6:1, dependent on team coverage

Case complexity potentially plays a role; faculty within the team share responsibilities as appropriate

UMKC: Varies. Usually5-10 students per 1 faculty

Not necessarily based on case complexity, but faculty can limit themselves if too many difficult cases are going on concurrently

Marquette: Varies by day of the week, specific group practice area, and by term. In the predoctoral clinic it is approximately 8:1 to 10:1.

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Materials used

ii. Techniques taught

Creighton: CaOh2- Yes, Ultrablend

ZOE- rarely, IRM

RMGI- yes, Vitrebond

MTA- No, however used for perforations

TheraCal- No

Biodentine- No

Techniques: Direct pulp cap

- place $CaOH_2$ alone, or followed by RMGI

Indirect Pulp cap

- place $CaOH_2$ alone, or
- place RMGI alone, or
- place $CaOH_2$ alone, or followed by RMGI

Colorado: CaOH2- Yes, Life, Kerr Dental, Direct pulp capping when patient is expected to receive RCT

ZOE- yes, IRM, Protective restoration is final isn't a composite red=storation. Not used very often. First choice for protective restoration is GIC

RMGI- Yes, Vitrebond, 3M-liner; Fuji II LC, GC America- base, CLV restorations, protective restoration

MTA- Yes, Direct Pulp capping- mechanical exposure

Theracal LC- NO

Biodentine- No

Others:- Fuji triage, Fuji IX

Techniques: In our school, we have an established protocol for management of deep carious lesions. In summary, the recommendation is partial caries excavation if caries extent is ¾ or more of the dentin thickness on radiographic evaluation. The tooth must be diagnosed as vital pulp or reversible pulpitis. Depending upon restorability and the importance of the tooth to the

overall treatment plan, the tooth can be eligible for the deep caries protocol. A final restoration is placed over a base or liner of GI or RMGI. Then, pulp vitality is reassessed in 6 to 12 months.

In cases where deep caries protocol is not applicable, complete caries excavation is recommended. Then, Indirect pulp capping performed using RMGI (Vitrebond) as a liner if needed.

Direct pulp capping is recommended only when a mechanical pulp exposure occurs. Then, MTA is placed covered by Vitrebond and Final Restoration.

Iowa: CaOH2 YES

ZOE Yes

RMGI Yes- Vitrebond

MTA Yes

Theracal Yes

Biodentint- No

Others- No

Techniques: We avoid any carious pulpal exposure by teaching selective removal to soft dentin in teeth with deep caries lesions and reversible pulpitis. The teeth are restored with direct restorations.

If the tooth has a very deep caries lesion and large part of the tooth is damaged, and therefore a root canal treatment maybe necessary then we remove all carious tissue to firm dentin. And, if there is pulpal exposure we refer for root canal treatment.

The only time we do direct pulp cap is mechanical pulpal exposure where caries is NOT involved at all or on Trauma patients where the pulp is vital and the exposure is minimal. We DO NOT do pulp capping on cariously exposed pulp. If we do direct pulp cap, it is done using CaOH, MTA or TheraCal LC. Most likely MTA and TheraCal LC.

(Link: https://www.dentistry.uiowa.edu/operative-caries-management-lesion-removal)

(Schwendicke et al ADR 2016; 28:58-67

Ortega-Verdugo P et al. 2016 Factors Associated with Reevaluation of the Stepwise Excavation Procedure: An 8-Year Retrospective Study. Caries Res. 2016; 50(1): 71-7.)

Minnesota: CaOh2 Yes, Dycal

ZOE Yes, IRM- used as a sedative filing to assess reversibility of mild pulpitis

RMGI Yes, Vitrebond Plus clicker

MTA Mentioned in preclinical lecture but not employed in lab or undergrad clinic. MTA and other bioceramics used in grad (endo) clinic for vital pulp therapy, Cyek (partial) pulpotomies for trauma, regenerative endo, perforation repairs and apical surgery retrograde fillings

TheraCal No

Biodentine No

Others

Techniques taught: Indirect pulp cap: for asymptomatic teeth, to be used when remaining dentin thickness is <1.0mm. Place calcium hydroxide over deepest portion of preparation followed by a thin layer of resin-modified glass ionomer. Proceed with definitive restoration and monitor for symptoms at recall visits.

Nebraska: CaOH2 Yes

ZOE No

RMGI Yes, placed over CaOH2 or MTA in many cases

MTA yes

Theracal No

Biodentine No

In cases of mechanical exposure, $CaOH_2$ or MTA will be applied.

Then a layer of RMGI is placed over the exposure site to protect it from mechanical forces that may be applied during the placement of the final restoration, especially if amalgam is the final restorative material.

In a situation where a small amount of caries may remain to avoid a pulpal exposure, the technique is the same, except the area covered by RMGI may be larger, mainly for its fluoride release.

SIU: CaOH2 Yes

ZOE No

RMGI Yes, over top of CaOH2

MTA Available but rarely used by predocs, mostly utilized by grad endo

TherCal No

Biodentine No

Techniques: DIRECT PULP CAP WITH AMALGAM – CaOH, THEN RMGI (LAYER OVER DEEPEST PORTION TO PREVENT BREACH OF AMALGAM INTO PULP), THEN AMALGAM

DIRECT PULP CAP WITH COMPOSITE - CaOH, THEN COMPOSITE

INDIRECT PULP CAP - CaOH

UMKC: CaOH2 Yes

ZOE Yes, as interim material

RMGI Yes as indirect pulp cap and secondary over CaOH2

MTA Not in predoc clinic, but is taught in Operative 3 lecture (as well as endo course)

TheraCal No

Biodentine No

From the Clinic Manual:

-For preparations deeper than normal with less than 1.0 mm of dentin between the pulp and the amalgam a liner using a resin modified glass ionomer is recommended as a thermal insulator.

-For preparations with less than 0.5 mm of dentin between the pulp and the amalgam, a thin calcium hydroxide liner is recommended followed by a thermal insulator of resin modified glass ionomer.

-For preparations with a direct pulp exposure on a vital pulp a calcium hydroxide liner ~ 0.5 mm in thickness is recommended followed by a thermal insulator of resin modified glass ionomer.

Marquette: CaOH2 Yes Dycal

ZOE No

RMGI Yes- Vitrebond Plus and Fuji products

MTA Only in Endo

TheraCal No

Biodentine No

Techniques- Indirect pulp capping is performed on vital, asymptomatic teeth. Direct pulp capping is performed on small (<0.5mm), mechanical exposures.

III. Materials and Techniques

a. Provisionals

Materials used, techniques taught

Creighton: Integrity, an automixed two-component material based on multi-functional methacrylic esters

Technique: Preop diagnostic casts with suckdown matrix, or preop putty matrix, Regisil bite registration in triple tray at time of appt if tooth is in good anatomical shape (i.e. re-do on crown with a bad margin)

No CAD/CAM

No 3D printing

Colorado: Integrity, Acrylic (SNAP/JET)

Technique: Putty stent and suck down clear matrix

No CAD/CAM though students have a CAD/CAM experience in preclinic where they scan a previously prepped tooth

No 3D printing

Iowa: Protemp- 3M- onlays, CLIP-VOCO for inlays/onlays

Technique: Free-hand custom direct composite placement or matrix assisted (wax-up/ mock-up/ and or triple-tray intra-orally). Pre-formed celluloid crowns assisted (crown forms).

b. CAD/CAM- provisional fabrication available with Telio-CAD.

3D printing- no, though 3D printer is available

Minnesota: Integrity, cemented with Tempbond NE

Technique: Provisional restorations are taught in the Prosthodontic pre-clinical course. Direct provisional fabrication: Using VPS putty matrix as a stent to fabricate Integrity provisional restoration; finish and polish using burs and discs. Small voids or marginal discrepancies can be corrected with flowable composite.

CAD/CAM- not provisional (but definitive CAD/CAM restorations are made)

No 3D printing

Nebraska: Integrity, Alike, and Trim

Provisionals may be made directly on the tooth using acrylic in a preoperative impression or vacuum stint. Some are made using an Iso-Form™ temporary crown, which may be relined with acrylic.

CAD/CAM Yes, but not often used for this purpose

3D PRINTING No, but we do have the capability to do so

SIU: IRM –FOR INTRACORONAL INTERIM RESTORATION NOT INTENTED TO BOND (DUE TO EUGENOL)

DUOTEMP-FOR INTRACORONAL INTERIM RESTORATIONS INTENTED TO BOND, DUAL CURE (NON-EUGENOL), ZINC OXIDE AND FL CONTAINING

JET ACRYLIC – FOR CROWNS AND BRIDGES

ALUMINUM SHELL LINED WITH JET ACRYLIC – FOR POSTERIOR CROWNS

INTEGRITY – D4'S ONLY – FOR CROWNS ONLY, NO BRIDGES

Direct (polycarbonate crown, anodized aluminum shell, Putty ext. surface form, vacuform), Indirect and Indirect/direct for bridges only (putty external surface form)

CAD/CAM used, but only occasionally for long term provisional

No 3D printing

UMKC: Ion crowns, integrity, Jet acrylic

Technique: putty or suck down matrix for integrity or Jet, ion crowns lined with integrity or Jet and cemented with temp-bond or ultratemp, or lined with IRM

No CAD/CAM provisional (but is being used for definitive restorations)

No 3D printing

Marquette: Snap® Acrylic, Integrity to be cemented with TempBond or UltraTemp. Ion® crowns and polycarbonate crowns (pre-fabricated) are available but not widely used in the adult clinics.

Students make a clear pull-down matrix on diagnostics casts. They will fabricate the provisional in the mouth (direct technique) and complete finishing either extraorally and/or intraorally.

CAD/CAM No

3D printing No (available in Grad periodontics program, but not routinely used in predoctoral clinics for fabrication of provisionals

b. Direct Pin Placement

Creighton: in practice, when retention features are lacking and when building up extensive parts of the teeth prior to crown procedure

We see pins as having a valuable place as a retention option

Colorado: In the pre-clinical operative course, students have a lecture about foundations and complex amalgam and composite restorations. The recommended retentive features to restore extensively compromised teeth are retention grooves, coves, horizontal slot, amalgapin and amalgabond. The dentin pin will be used as a last resort for retention. The dentin pins we have in our clinics is the Max pins 0.017 and 0.021.

Iowa: Currently pins are not used in the operative clinic. Conventional retention features and amalgam pins are taught. Pins are available in the senior clinic, but it is not taught in the pre-clinic.

Minnesota: Our philosophy has been to provide students with a broad array of options to maximize their ability to handle difficult and unusual restorative challenges.

Pins are an accepted and valuable auxiliary retention option. Pins are recommended when adequate retention cannot be established with preparation design alone due to missing tooth structure. For large bonded restorations where the substrate is lacking (e.g., heavy erosion or attrition cases), pins can add significant retention. Pins improve retention of the restoration but the risks of pin placement include: craze lines, fractures and/or internal stress or pulpal perforation. We teach self-threaded pins with the pinhole prepared 0.0015 inch smaller than the diameter of the pin. As the pin is inserted, the threads of the pin engage the dentin and that is the mechanism by which the pin is retained within the tooth. We teach to place one pin per missing line angle and to use the fewest pins needed for retention. Pins should parallel external tooth surface and be placed on flat (horizontal) surfaces at ≥0.5mm from the DEJ within the dentin to prevent crazing and ≥ 1 mm from the external tooth surface to minimize enamel fracture. It is also important to allow 1 mm between the external surface of a pin and a vertical wall of the tooth preparation to allow room for restorative material.

Nebraska: We do use pins when cusps have been lost and it is felt that other forms of mechanical retention cannot be obtained. Generally one pin is placed for each lost cusp. In addition, amalgam bonding may be done. In very rare cases a pin may be used in a posterior composite.

SIU: DIRECT PIN PLACEMENT IS TAUGHT AND PRACTICED ON DENTOFORMS IN THE D1 AND D2 OPERATIVE COURSES AS A CAPSTONE OF MASTERING AMALGAM AS A MATERIAL, UNDERSTANDING THE PREPARATION DESIGN FOR AMALGAM AND DEVELOPMENT OF HANDSKILLS

CLINICALLY A COMPLEX AMALGAM RESTORATION IS REQUIRED BUT IT CAN BE WITH OR WITHOUT A PIN (PIN IS PLACED ONLY WHEN MECHANICAL RETENTION CANNOT OTHERWISE BE ACHIEVED), IT MUST INCLUDE A CUSP

REASONING BEHIND ITS CONTINUATION IN THE CURRICULUM DISPITE ITS LACK OF USE IN PRIVATE PRACTICE IS THE FEEDBACK FROM OUR STUDENTS IN MILITARY SETTINGS THAT

REPORT ITS CONTINUED USE AND ITS USE AS A CAPSTONE TO TEST ABILITIES TO MANIPULATE AMALGAM, PREPARATION DESIGN, AND HANDSKILLS

UMKC: Pin placement is taught in lecture and lab in Operative 2 in the D2 fall semester. It is done in clinic when a cusp is missing and faculty deems it appropriate. It is not a clinical requirement.

Marquette: Pins are taught didactically in the pre-clinic and students are given on opportunity to practice placement on a dentiform preparation. In the pre-doctoral clinics, pin use is discouraged (unless no other methods will result in adequate retention of the restoration). Clinically, the supervising faculty will ultimately decide if pin use is appropriate based upon the benefits of added retention and the risks associated with pin placement.

c. Restoration repair

Creighton: Very large SAs that are otherwise sound may be patched with SA. Smaller SAs are replaced.

Very large CRs that are otherwise sound may be patched with CR, smaller CRs are replaced.

Colorado: We allow repair, but is decided in accordance to the description of the covering faculty. Most times amalgam restorations are replaced if needed.

We teach and allow the repair of composite restorations; those repairs will happen more often than the repair of amalgam restoration.

Iowa: Yes, repair is advocated when possible

	Option A	Option B
Macroretention	Place retention in dental amalgam and bevel enamel where appropriate	Place retention in dental amalgam and bevel enamel where appropriate
Microretention and chemical adhesion##	(1) Dental amalgam: Air abrade, rinse, dry (2) Tooth: etch, primer	(1) Dental amalgam:Tribochemically abrade with CoJet silica# (30 µm @ 2.5 bar) remove excess with blast of dry air. (2) Tooth: phosphoric acid etch (3) Apply silane to dental amalgam (4) Apply dentin primer to tooth
Opaque metal prn	Apply opaquer over dental amalgam light cure with appropriate radiant exposure	Apply opaquer over dental amalgam light cure with appropriate radiant exposure
Wetting agent	Apply adhesive resin and light cure at appropriate radiant exposure	Apply adhesive resin and light cure at appropriate radiant exposure
Restorative material	Place dental composite and light cure with appropriate radiant exposure	Place dental composite and light cure with appropriate radiant exposure

CoJet Silica effectiveness on enamel and dentin is indeterminate
Cross contamination of surface treatments between amalgam and tooth structure may impair bonding

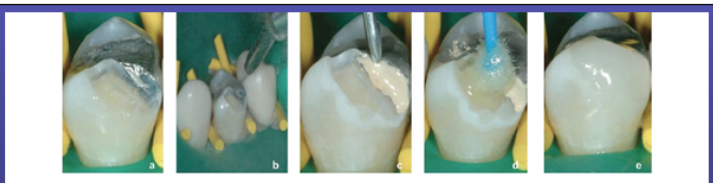

Figure 1. *(a): Baseline situation of fractured buccal cusp on maxillary right first premolar (tooth no. 5). (b): Silica-coating of the amalgam surface. (c): Application of the opaquer. (d): Application of the adhesive resin. (e): Final view of the finished restoration.*

Özcan & Salihoğlu-Yener Oper Dent, 2011, 36-5:563; Özcan &Volpato J Adhesive Dent 2016

Dental Composite Intraoral Repair*

	Option A	Option B
Macroretention	Place retention and bevel where appropriate	Place retention and bevel where appropriate
Microretention and chemical adhesion	Air abrade (50µm alumina), rinse, dry then apply silane	Tribochemically abrade with CoJet silica# (30µm) remove excess with blast of dry air then apply silane
Wetting agent	Apply adhesive resin and light cure with appropriate radiant exposure##	Apply adhesive resin and light cure with appropriate radiant exposure##
Restorative material	Place dental composite and light cure with appropriate radiant exposure	Place dental composite and light cure with appropriate radiant exposure

* Repairing a newly cured composite that has been contoured, polished or contaminated; simply etch for 5 sec, rinse, dry, apply a thin uncured adhesive then place repair composite. If repair area is very small, eg. void or marginal gap, remove enough composite to avoid repeating the error.
# CoJet Silica effectiveness on enamel and dentin is currently indeterminate
For very small repairs apply air thinned and uncured adhesive, see (Eliasson 2017 Acta Biomater Odonto Scand)

Minnesota: Amalgam Margin repair, no. However, with large amalgam restorations occasionally only a portion of the restoration is removed if the remaining restoration is judged intact and of good quality and self-retaining without the segment to be replaced.

Composite margin repair is permitted. Here is our protocol.

COMPOSITE REPAIR

1. Select the new composite resin shade.
2. Rubber dam isolation.
3. Roughen the old composite surface with intra-oral sandblaster for 10-15 sec.
4. Rinse with air-water spray for 15 sec.
5. Bevel enamel margins; etch enamel with 35% phosphoric acid for 15 sec; rinse with water for 10-15 sec; air dry.
6. Apply Scotchbond Universal Adhesive by scrubbing the microbrush on the composite surface for at least 15 sec.
7. Gently air-dry for 10-15 sec.
8. Light cure for 30 sec.
9. Apply the new composite resin and light cure for 40 sec each increment of 2mm or less.
10. Adjust occlusion if applicable.
11. Finish and polish.

Nebraska: Amalgam- We don't have a policy about this, but I'm sure it has been done. At times we will repair an amalgam with amalgam, if the restoration is otherwise in good condition and function.

Composite- Again, if the existing restoration is sound, has appropriate contours and esthetics, we will repair the composite restoration with composite.

SIU: Amalgam- no, not taught as standard procedure, but no prohibited, determined on a case by case basis by proctoring faculty

Composite- Yes, defects where all surrounding margins can be determined to be sound can be repaired with composite as a conservative approach.

UMKC: Amalgam No- we would not repair with an unlike material. Repair with amalgam might be a possibility depending on the faculty and the extent of the decay

Composite- Yes

Marquette: Amalgam- Marginal repair with amalgam is *strongly, actively* discouraged. There are limited circumstances where a portion of a large, complex restoration may be retained and a new preparation into the existing restoration may be performed. These are approved on a case-by-case basis and minimum criteria must be met (including existing restoration quality and integrity, location and extent of the defect, who/where the initial restoration was placed, etc.). Generally speaking, total replacement is the norm.

Composite- Marginal repair with composite resin is permitted. There are no formal protocols and the decision to allow or disallow this rests with the supervising faculty member. (One significant consideration is whether or not the initial placement was completed at the School.)

d. Clinical Guidelines- Amalgam/resin

Creighton: They are interchangeable for the most part except for:

deep interproximals that end on cementum – SA recommended

very acidic oral environment with rampant caries – SA recommended

Colorado: It is taught in pre-clinical operative course during their first year of dental school, but there are no official clinical guidelines. Our recommendation is that the students evaluate caries activity (CRA), size of lesion, tooth structure remaining, location of preparation margin, possible isolation technique and cost; then suggest the material to be used.

Iowa: No, selection of material is made on an individual base (factors affecting selection are: size of lesion/preparation, patient expectations, isolation, caries risk, etc.

Minnesota: Guidelines for Selecting Restorative Materials

(Operative Dentistry II lecture)

Prepared Cavity Characteristics that affects Restorative Material Selection

1. Isolation

- Saliva & tissue fluid contamination is detrimental to all restorative materials
- Composite Resin, RMGI, and Gold Foil are contraindicated if strict isolation not achievable
- Cast Gold & Porcelain require strict isolation for impression & cementation
- Amalgam is least sensitive to isolation difficulties

2. Access

3. Visibility

4. Heavy Occlusion

- Forces achieved during nocturnal bruxism are 2-3Xs that used in chewing hard foods
- Heavy bruxism can cause heavy attrition, fracture lines, chipping, and fracturing of teeth & restorations
- Composite & RMGI wear more rapidly than metal or enamel
- Weak tooth structure is best protected by onlay coverage or amalgam with cuspal replacement

5. Proximal Contact Involvement

6. Relationship with Periodontium

- Subgingival restorations, no matter how smooth, result in inflammation
- Restoration of cervical abrasion results in more marginal gingivitis than unrestored lesions
- Subginigival composite margins result in more bacterial growth & more pathogenic flora than amalgam or RMGI (Paolantonio M, et al. J Clin Periodontol 2004; 31:200-7)

7. Impact on Esthetics

8. Quality of substrate

- Enamel is important for the marginal seal of composite resin restorations
- Composite bonding to sclerotic dentin is not as strong as to normal or caries-affected dentin
- Attrition, abrasion, & erosion decrease enamel quantity and create sclerotic dentin

- Root cavities & exposed resorption defects have little or no perimeter enamel

9. Caries Activity

- Unless the underlying disease is controlled, even the highest quality restoration can develop secondary caries
- Determining that the disease is under control takes time (6 months +)
- Expensive restorations (e.g., cast gold, porcelain) should be deferred until caries control is verified

Class V

- When isolation, access, & visibility optimum, and margins on enamel: Composite Resin
- When isolation, access, & visibility optimum, but little enamel at margins: Resin-Modified Glass Ionomer
- If difficult isolation, access, or visibility: Amalgam

Cervical Abrasion

- When isolation, access, & visibility optimum, and margins on enamel: Composite Resin
- When isolation, access, & visibility optimum, but little enamel at margins: Resin-Modified Glass Ionomer
- If difficult isolation, access, or visibility: Amalgam

Crown Margin Repair

- When isolation, access, & visibility optimum, and margins on enamel: Composite Resin
- When isolation, access, & visibility optimum, but little enamel at margins: Resin-Modified Glass Ionomer
- If difficult isolation, access, or visibility: Amalgam

Class I

- Material of choice: Composite Resin
- Second choice: Amalgam
  - difficult isolation, access, or visibility
  - heavy occlusion
  - cusp replacement
  - little enamel (erosion or attrition)
  - patient cannot afford composite
- Other options: Porcelain Inlay, Cast Gold Inlay

Attrition

- Dentin cupping: Only composite resin is appropriate for restoration.
- To rebuild occlusion will require full mouth reconstruction.

Class II

- Composite Resin is minimally invasive
- Amalgam Second choice:
  - difficult isolation, access, or visibility
  - heavy occlusion
  - cusp replacement
  - little enamel (erosion or attrition)
  - patient cannot afford composite
- Other options: Porcelain Inlay, Cast Gold Inlay
- Proximal contact more difficult to create with composite than amalgam
- Bonded composite has a limited ability to stabilize adjacent week tooth structure

Class III & IV

- Material of choice: Composite Resin
- Alternative: all porcelain crown

Cusp Replacement/Protection

- Most economical choice: Amalgam
  - good if difficult isolation, access, or visibility
  - can serve later as build up under crown
- Best esthetic choice: Porcelain Onlay (or porcelain crown)

- Choice with best longevity: Cast Gold Onlay (or full crown)
- Alternative: Composite Resin
  - less resistant to wear & not as strong as metals or porcelain

Root Surface

- When isolation, access, & visibility optimum, and margins on enamel: Composite Resin
- When isolation, access, & visibility optimum, but little enamel at margins: Resin-Modified Glass Ionomer
- If difficult isolation, access, or visibility: Amalgam

Nebraska: We prefer to use amalgam if the restoration will be more than 50% of the distance between the buccal and lingual cusps, if the tooth has lost a cusp, the patient is a bruxer or has a high caries rate or poor oral hygiene or if proper isolation is impossible.

SIU:No protocols are required or prohibited to allow for a case by case apporoach. Students are taught the basic indications then follow proctoring faculty's instructions.

UMKC: No black and white guidelines, but composite is often recommended when the lesion is such that tooth structure can be saved by preparing for a composite restoration.

Marquette: Yes. There are several determinants in selecting on material over the other. Patient preference is a consideration. However, ability to adequately isolate for proper, effective bonding is the major determinant.

IV. Assessment

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment?

Creighton: Yes, numbers of procedures is a graded element, dollar amount is not considered.

Colorado: In the Comprehensive Care Clinic course a grading matrix is used to determine the semester grade. Productivity is part of one of the criteria in that matrix. The way we look at productivity is to evaluate students are using all opportunities and if they have a healthy patient pool. We also look at chair utilization time. If the productivity is low and the student have a low chair utilization time, we want to know the reason to make sure the student is busy and having enough clinical experiences. We don't have a dollar amount goal students have to reach.

Iowa: No

Minnesota: No

Nebraska: The students do have minimal requirements that are expected to be met, beyond that they are expected to be in clinic and be productive for all clinical sessions. Each clinic has a coordinator who assures the students are present and working. If a student does not have an

appointment, he/she will assist another student in that clinical group. In addition we have appointment clerks who strive to keep the students busy.

We did have a dollar production goal up until this year, but it is no longer in effect.

SIU: No

UMKC: No. Productivity is measured in axium and then assessed by a faculty mentor but does not play into the grade. Time units, however, are measured and used to determine a portion of their grade.

Marquette: No

ii. Do you believe that it should be?

Creighton: Yes, for numbers of procedures. We are preparing them to be successful in private practice with clinical skills and practice management skills. No for dollar amount.

Colorado: Yes. If this is to quantify students' clinical experiences, but not as a single factor in the final grade.

Iowa: No, productivity is graded in the gourth year curriculum, which we are not responsible for, we prefer to work on the quality of a student no the quantity of patient experiences in the D2 and D3 clinic

Minnesota: Not at this early stage in skill development. Emphasis should be on quality and not speed.

Nebraska: No

SIU: No

UMKC: No (monetary production)

Marquette: Yes

iii. How do you assess their productivity?

Creighton: Record the number of procedures successfully completed, then run reports. Benchmarks with associated grades are provided to the students before the academic year starts to communicate expectations

Colorado: Each procedure has a RVU (relative Value Unit) attached to it. The RVU is based on the difficulty and the amount of appointments needed to complete the procedure, such as Complete Dentures. We also give a RVU to procedures that are free of charge, but we really want the students to complete, such as Caries Risk Assessment, Deep Caries Protocol, Periodic Oral Evaluation (No Charge).

Iowa: During the junior clinical rotation we do make sure that students do an average number of procedures, approx. 20-30 procedures.

During the sophomore Operative dentistry clinics the students have to complete at least 1 class II amalgam restoration, 2 one-surface dental composite restorations, 1 one-surface GIC, 2 two-surface class II dental composite restorations. If these procedures are not completed in clinic, two of the same procedures have to be completed in simulation clinic on extracted teeth.

Minnesota: Through reports developed by IT for the AxiUm database, we compute for any given period of time (semester or cumulative):

- Operative Encounters,
- Efficiency (session equivalents/encounter),
- Total Restoration #,
- Total Amalgam #,
- Proximal Amalgam #,
- Anterior Composite #,
- Proximal Anterior Composite #,
- Posterior Composite #,
- Proximal Posterior Composite #,
- Indirect Restoration #.

Session equivalents are similar to RVUs. These productivity measures are used when evaluating curriculum effectiveness and clinic model innovation.

Nebraska: Students' financial productivity is tracked, but there is no specific requirement. Since we have had a new clinical system in place for only about a year, we need data to determine how well the system is functioning.

SIU: N/A

UMKC: Time units are the primary measure that is used to determine productivity. Actual monetary production is measured and entered into their personal chart on axium, but is not graded.

Marquette: Completion of competency exams (patient based skills exams) and Stage I / Stage II Case completions.

V. Administration

a. Attendance policy

i. Describe the attendance policy as outlined in your Academic Affairs manual.

Creighton: Below is the existing attendance policy; however, it is currently under revision in the Department Chairs Committee.

ATTENDANCE STANDARD

Creighton University School of Dentistry's primary obligation is the comprehensive and holistic education of the students. Implicit in the achievement of this goal will be the student's conscientious attendance of classes, laboratories, and clinic sessions.

At the start of every semester, each instructor of record publishes the course syllabus which includes the instructor's expectation for student participation in each course. It is the student's responsibility to note the expectations and fulfill them. Junior and senior students are required to have a minimum of 90 percent attendance at all scheduled clinic sessions including those of the Summer Clinic. Failure to maintain this attendance figure may require the student to attend addition clinic sessions during the following summer and may result in a delayed graduation.

The Office of Student Affairs determines authorized absences from didactic, laboratory and clinical courses according to the Policy on Excused Absences. Repeated, unexcused absenteeism may be considered by the Student Performance Committee. If absences occur for two consecutive weeks, the student will be considered as having withdrawn from the University. This is not to be considered, however, as revoking the regulation that requires the student to notify the Dean in person or in writing of his or her withdrawal. *Refunds are made to the student on the basis of the date the student has formally notified the Dean in person or in writing of withdrawal.*

Officially excused absences for University-sponsored affairs must be cleared with the Office of the Assistant / Associate Dean for Academic Affairs and the Office of Student Affairs by the responsible faculty moderator.

Reviewed and Revised: 02.27.17

The policy is enforced somewhat

The policy is felt to be fair

The policy is felt to be appropriate

Colorado: Attendance is expected but mandatory attendance is up to the discretion of the course director to enforce.

From our Student Professional Code of Conduct Policy-

Demonstrate total commitment to all educational opportunities as a student including attendance at all classes.

From our Academic Honor Code policy-

In all courses (including both didactic and laboratory) where class attendance is a mandatory requirement, student conduct standards do not allow for the use of any method to falsify actual attendance and students will remain in the classroom/lab for the entire duration of the class when required. The falsification of actual class attendance and the failure of the student to remain in the classroom/lab for the entire duration of the class when required both represent a violation of the Academic Honor Code.

ATTENDANCE POLICY:

Attendance is expected for all lectures and laboratory/simulation clinic sessions.

If absence is unavoidable, contact the course director(s)to obtain an excused absence.

The school defines absences in different categories: those the school are required by law to accommodate and absences that are accommodated at the school's discretion.

TITLE IX

The school defines absences in different categories: those the school are required by law to accommodate and absences that are accommodated at the school's discretion.

Excused absences protected by law
Students will be given the option to make-up any missed work due to the following types of excused absences, due to the discretion of the Course Director and/or Director of the Rotation, provided it is reasonable to do so and it does not fundamentally alter the curriculum. Documentation may be required to be submitted to the Academic Dean for central record-keeping.

• Medically-related absences that are documented as a disability through DRS and the student is provided with an authorization for accommodations
• Pre-approved absences due to the observance of protected religious holidays.
• Medically-related absences due to pregnancy for as long as deemed medically necessary by the student's health care provider. (Note this applies only to medically necessary absences associated with pregnancy and childbirth, it does not, for example, apply to childcare)
• Pregnant students needing assistance beyond what is offered should contact:

Information can be found at: http://www.ucdenver.edu/policy/TitleIX/Pages/default.aspx

• In situations where make-up work is allowed, course directors have the authority to determine whether make-up work will be completed before or after the assessment is administered to the rest of the class. If taken afterward, the course director has the authority to determine that it be completed as soon as the student's class schedule permits. All students who take a make-up assessment separately from the rest of the class will be required to honor the school's Student Ethics and Conduct Code.

Please refer to the Student Handbook for further information.

Policy is enforced by individual course directors

Policy is felt to be fiar

Policy is felt to be appropriate

Iowa: Lecture setting: mandatory attendance stated in Collegiate Academic and Professional Performance committee procedure manual.
Clinics: "D3 Clerkship Attendance Policy D3 students are required to be in clinic every day unless an absence has been approved in advance. Successful skill acquisition and knowledge development are dependent on consistently attending and actively participating in all clinical and didactic sessions. To provide you with some flexibility in scheduling, each student is permitted 4 full-day excused absences or 8 half days of excused absences for, but not limited to, the following reasons: • Personal emergencies • Family situations • Medical appointments • Illness • Funeral • Religious observance Time must be taken as a clinical session (not hour by hour) and no more than one full day will be allowed during a 5 week clerkship; no more than one full day from each of the disciplines in a 10 week block; and no more than two days during "superblock". Excused absences are a privilege and should not be thought of as "vacation days". They are not to be used for extensions of University holidays or saved until the end of the school year. Advance planning is recommended whenever possible. An Excused Absence Form should be routed through Axium: 1) Complete the "request" form in Axium 2) Use the "running man" to forward the request to: a. Clinic Clerk b. Clerkship Director 3) Clinic Clerk will review your schedule and approve your request if appropriate 4) Clinic Clerk will forward your request to the Clerkship Director using "running man" 5) Clerkship Director will approve your request if appropriate 6) Clerkship Director will forward your request to Dean of Students and back to the Clinic Clerk so all parties know the request has been approved. 7) Dean of Students will forward the approved or denied request to the D3 student. 8) Until you receive the completed form with all approvals, do not assume your absence has been approved. Absences will be tracked and you may not take more time off than the allotted four days without special permission from the Associate Dean for Student Affairs. If you are presenting a paper or poster and/or hold a national position in an organization, your attendance at a conference or national meeting will not count against the number of excused absences." I believe the D4 year has something of a similar nature.

Policy is not necessarily enforced

Faculty have varied opinions on fairness of policy, Dean of Education does not feel it is fair

i. Policy appropriateness: "'We need to be creative as our students are asynchronous learners"

Minnesota: **Doctor of Dental Surgery Attendance Policy**

I. Purpose:

The School of Dentistry has the responsibility of preparing its students both academically and clinically for the practice of dentistry. Successful skill and knowledge-based development requires continuous attendance in all classes and clinical sessions as designated by curriculum and clinic schedules.

II. Policy:

School of Dentistry students are expected to demonstrate professional behavior by attending all classes and clinics as indicated on School of Dentistry course schedules and the School of Dentistry academic calendar.

Students may be approved for time off from class or clinic for the following reasons.

1. Excused Absences
2. Family Leave
3. Vacation*
4. Personal Sessions*
5. Student Selectives*

*Vacation, personal sessions, and student selectives apply only to DDS3 and DDS4 students during clinical sessions.

Excused Absences

Student absences from class or clinic may be excused for the following reasons:

1. Physical or mental illness of a student or a student's dependent, including medical conditions related to pregnancy
    a. Students are required to submit a doctor's note to be excused from class or clinic and make-up any graded course component (exams, quizzes, practicals, etc.).
    b. Students experiencing challenges scheduling appointments with providers for physical or mental illness due to course and clinic scheduling should consult with the Director of Student Affairs to make arrangements for an excused absence.
2. Subpoenas
3. Jury Duty
4. Military Service
5. Recognized Religious Observances
    a. Recognized religious observances as determined by the Office of Equal Opportunity and Affirmative Action.
6. Emergency
    a. Unavoidable or legitimate circumstances preventing attendance as determined by the Office of Student Affairs (e.g., medical emergency of a family member). Flat tires and over-sleeping are not considered emergencies.

b. Faculty and administration reserve the right to request documentation for an excused absence due to emergency.

7. Bereavement, including travel for bereavement

8. National Board Dental Examinations (DDS4 only)1

9. Official School Business

Students who plan to be absent due to circumstances described above must submit a planned absence request at least ten days in advance to the Office of Student Affairs or a same-day absence request to the Registrar, following procedures outlined in the School of Dentistry Student Handbook.

Instructors may not penalize students with excused absences and must provide reasonable and timely accommodations to make up exams or other course requirements if the student:

- Was absent due to circumstances identified as excused in the reasons above or through family leave;
- Has complied with notification requirements; and
- Has provided any requested documentation.

Unexcused Absences – Didactic Courses

Students are expected to be in class as designated by School of Dentistry course schedules and the School of Dentistry academic calendar. Attendance may be included as a mandatory, graded component of a course.

Instructors are not required to offer make-up work to students who do not attend didactic courses and do not have excused absences.

Clinic Attendance

Students must be present in clinic a minimum of 90% of available sessions each academic year to ensure competency at the time of graduation. Students who present in clinic less than 90% of available sessions must meet with the Associate Dean for Academic Affairs to discuss their academic status and impact on their progress toward graduation. The Associate Dean for Academic Affairs may approve the student's additional absences or refer the student's situation to the appropriate progression sub-committee for further discussion. The sub-committee will have the authority to suggest a remediation plan and/or a program extension.

The number of sessions required to fulfill the 90% requirement will be determined by the Offices of Academic and Clinical Affairs.

Students will be granted 14 personal sessions and one vacation week each academic year. Personal sessions should be used for job interviews, doctor's appointments, daycare changes, etc. Students requesting personal sessions and/or use of a vacation week must follow notification procedures or be subject to denial of the absence and/or a referral to the School of Dentistry Code of Conduct Officer.

Students who are not present in clinic and do not have an approved absence will be charged a personal session and reported to the School of Dentistry Code of Conduct Officer. Students will remain enrolled in the School of Dentistry if they have a negative personal session balance at the time of graduation until their balance is zero, unless there is an approved exemption from the Associate Dean for Academic Affairs.

Students with more than five sessions of unexcused same-day absences will be required to submit documentation (e.g., doctor's note) for all same-day absences for the rest of the academic year. Students will be charged personal sessions if the required documentation is not submitted.

Details about Family Leave and Student Selectives are further described in the School of Dentistry Student Handbook.

III. Definition(s):

- Students: For the purposes of this policy, students are those enrolled in the doctor of dental surgery program.

• Excused Absences: Students who have followed absence notification procedures and received approval for a legitimate excused absences must be granted an opportunity to make-up exams or other course requirements.

• Clinic Session: A half day in clinic. Each clinic day is composed of an AM and PM session.

• Present in Clinic: Student scheduled in clinic must be available to see patients and easily contacted, for the entire session, even when a patient is not scheduled.

Is policy enforced: Yes, however some students have found ways to circumvent the policy when it comes to clinic attendance. The complaint against this comes largely from other students who complain that some are not following the rules.

A draft policy was attempted in the Summer of 2017. Student attendance was recorded in clinic with AxiUm. Any student assigned to clinic that did not have a patient entry was requested to obtain from the clinic faculty approval on an "attendance code" entry. The entry was made in the student's own dental record.

One semester of doing this made it clear that the policy placed additional demands on faculty at one of the busiest clinic times (near the end of the session), it was difficult for students to find open AxiUm computers to use, there were HIPAA concerns about using student dental records, and, most importantly, students complained that the policy was demeaning.

The policy was abandoned. Further policy innovations are being investigated.

Nebraska: "Attendance at all regularly scheduled classes and clinical sessions is required. There is no University policy permitting class cuts and attendance in class and clinic will be monitored. Each course director determines the method of monitoring attendance for his/her course. Failure to attend class or clinic could result in failure of a course.

> Planned absences should be worked out in consultation with course directors, appropriate clinical staff and patients as necessary.
>
> For situations involving unplanned absence from class or clinic, appropriate arrangements are made directly by the student with any patients scheduled and the College is to be called at 472-1301 to report the absence. The clinic receptionist will notify the registrar's office and the clinical clerks of the absence. Students are responsible for all course requirements regardless of the reason for the absence, so it is important that instructors are informed and that students maintain a clear understanding of what must be done to meet course requirements."

Policy is felt to be fair

Policy is felt to be appropriate

SIU: (REQUIRED IN ALL SYLLABI)

a. ATTENDANCE AT ALL LECTURES, LABORATORIES, QUIZZES AND EXAMS IS MANDATORY

b. PERMISSION TO BE ABSENT FROM A CLASS IS GIVEN EITHER ADMINISTRATIVELY OR AT THE DISCRETION OF THE COURSE DIRECTOR. DEPENDING ON THE TYPE OF ABSENCE REQUESTED, ADVANCE NOTIFICATION IS REQUIRED FOR PLANNED ABSENCES. STUDENTS ARE TO USE THE **STUDENT ABSENCE REQUEST FORM**, AVAILABLE FROM THE OFFICE OF ADMISSIONS AND STUDENT SERVICES, TO FILE SUCH REQUESTS. REFER TO THIS FORM FOR DETAILS ON THE PROCESS OF APPLYING FOR AN APPROVED ABSENCE. NOTIFICATIONS OF UNEXPECTED ABSENCE (SUCH AS ILLNESS) MUST BE CALLED TO THE COURSE DIRECTOR'S OFFICE PHONE OR E-MAILED TO THEIR SIUE E-MAIL PRIOR TO THE BEGINNING OF THE CLASS (BOTH OF THESE METHODS ARE DATE AND TIME STAMPED). IT IS THE STUDENT'S RESPONSIBILITY TO OBTAIN ALL MISSED CLASS MATERIAL.
c. IN THE EVENT OF AN ABSENCE A STUDENT MUST ALSO NOTIFY THE OFFICE OF ADMISSIONS AND STUDENT SERVICES @7170 OR 7171. THE ASSISTANT DEAN FOR STUDENT SERVICES OR THE ASSOCIATE DEAN FOR ACADEMIC AFFAIRS RESERVES THE RIGHT TO REQUEST A PHYSICIAN'S STATEMENT AT ANY TIME.
d. IF A STUDENT MISSES A QUIZ, EXAM OR OTHER WEIGHTED COURSE COMPONENT AS A RESULT OF AN ABSENCE (AS DESCRIBED ABOVE), APPROPRIATE REMEDIATION OF THE MISSED GRADED COMPONENT WILL BE DETERMINED BY THE COURSE DIRECTOR, BUT MAY INCLUDE:
    i. ESSAY OR SHORT ANSWER EXAM OR QUIZ
    ii. LIBRARY RESEARCH PROJECT
    iii. MULTIPLE CHOICE EXAM OR QUIZ
    iv. LABORATORY PROJECT OR PRACTICAL
    v. ORAL EXAMINATION
    vi. RECEIVE NO CREDIT FOR THE GRADED COMPONENT

*WHEN POSSIBLE, STUDENTS WILL BE NOTIFIED AT THE TIME OF THEIR ABSENCE REQUEST AS TO THE MEANS OF REMEDIATION THAT WILL BE ASSIGNED FOR THE MISSED COMPONENT.

Enforced at the course instructor of record's discretion

Policy felt to be fair

Policy felt to be appropriate

UMKC: Class of 2018: Attendance is required for clinic and rotations. All absences must be approved through the Office of Clinical Programs. Unplanned absences for illness, death in the family, and other like events must be reported to the Team Clerk and the Office of Clinical Programs at 816-235-2137, or

email stewarts@umkc.edu or wellslm@umkc.edu. The excused absence form must be completed upon return for the records. Excused absences will not be granted for travel/ days before/after break periods, studying, vacations, family reunions, etc. It is the student's responsibility to accurately complete the "Where Are You" form in the event of a patient cancellation or no-show. Falsifying the information or submitting the form for someone else is considered student misconduct and will be brought to the Honor Council. Requests for excused absences and rotation changes/swaps must be submitted a minimum of one (1) week in advance. Requests not submitted in advance or not accurately completed may not be approved. Approved rotation changes/absences must be made up no later than one week before the end of the semester to avoid receiving an unexcused absence. Unapproved rotations absences and/or changes will result in an unexcused absence, even if the student is present elsewhere and/or has someone take his/her rotation. The student must make up the rotation.

Class of 2019 (a change was implemented for this class)

Attendance is required for clinic and rotations. You are allowed 5 flex days (10 clinic sessions) of unexcused absence during the D3 Summer and Fall terms. More than 5 days will result in failure of the professional development course. Attendance · Clinical Flex Days should be used for weddings, interviews, externships, general/wellness medical & dental visits, personal days, funerals outside an immediate family member, car repairs, etc. Unused time will not carry over. For D3s this is 5 days (10 clinic sessions) total over the summer and the fall semester and 5 days (10 clinic sessions) total in the spring semester. For D4s this is 10 days (20 clinic sessions) total over the summer and fall semester and 5 days (10 clinic sessions) total in the spring semester. · "Excused Absences" include absences due to illness of the student, illness of an immediate family member that the student must care for, death of an immediate family member, medical issues (such as surgery, injury, pregnancy, etc.,) religious observance (where the nature of the observance prevents the student from being present during class), representation of UMKC in an official capacity, National Board examinations and licensing exams (testing dates only), and other compelling circumstances. Students seeking an excused absence must provide documentation upon request to substantiate the excuse. · Any absence will not relieve a student of the need to meet all educational requirements including clinical time (experiential) requirements. Students shall undertake appropriate make-up or alternative work to be provided by instructors of the courses in which absences were incurred.

It is the student's responsibility to accurately complete the "Where Are You" form in the event of a patient cancellation or no-show. It is also the student's responsibility to make certain the patient checks in for each visit to avoid being considered absent. Falsifying the information or submitting the where are you form for someone else is considered student misconduct and will be brought to the Honor Council. Requests for excused absences and rotation changes/swaps must be submitted a minimum of one (1) week in advance. Requests not submitted in advance or not accurately completed may not be approved. Approved rotation changes/absences must be made up no later than one week before the end of the semester to avoid receiving an unexcused absence.

Policy is enforced by course directors

Policy is felt to be fair

Policy is felt to be appropriate

Marquette: Students are expected to attend all lectures, laboratories, clinical assignments and related curricular activities in Marquette University School of Dentistry (MUSoD). Specific attendance requirements and consequences of unexcused absences are published in related course handouts, syllabi, and manuals.

Students with clinical responsibilities are expected to be present in the clinic and actively engaged in patient care activities, except when scheduled on block rotations and extramural assignments. There are no automatic legitimate absences from any scheduled lectures, laboratories, clinics or related curricular activities in MUSoD. Course Directors are expected to define legitimate student absences relative to their course in the course syllabus and explain how legitimate student absences will be handled. The Clinic Director is expected to define legitimate student absences relative to the clinic in the Clinic Operations Manual and explain how legitimate student absences will be handled. Absences for foreign mission trips will not be approved for any reason unless such mission trips are sponsored by MUSoD. Inappropriate absences from the clinic, block rotations or extramural assignments constitute professional misconduct.

Requests for planned absences of three (3) or more days must be approved by the Associate Dean for Academic Affairs.

Request for absences of one or two days must be approved by individual Course Directors, Group Leaders and Clinic Director, as appropriate, utilizing the Absence Request Form. Course Directors and Group Leaders and the Clinic Director are expected to exercise appropriate sensitivity to student requests for absences, especially as they apply to requests for absences to observe religious holidays and holy days.

Occasionally students are unable to attend scheduled curricular activities due to circumstances beyond their control, e.g. significant illness, jury duty, funeral. In such cases the student's absence will be approved and the student will not be penalized for missing scheduled activities, provided all of the following criteria are met:

I. The Course Directors, Group Leaders and Clinic Director, as appropriate, are notified by the student within 24 hours that the student will be or is absent and

II. The student meets within two (2) class days of returning to school with the Course Directors of all courses missed to determine what remedial work is necessary and

III. Documentation is provided, as requested by the Office of Academic Affairs.

Reasonable efforts will be made by Course Directors for students who have a legitimate absence to allow them to remediate. While students will not be penalized for legitimate absences, extended or multiple absences may require repetition of an entire course or courses up to and including a year of the curriculum.

Prolonged or repeated absences should be reported to the Office of Academic Affairs.

Policy is enforced somewhat (varies by course director and/or CPMG leader)

Policy is felt to be fair

Policy is felt to be appropriate, however better enforcement would be beneficial.

b. Millennial Students

Creighton: YES has offered faculty development

NO surveys

Specific: Videos embedded in lectures, links to You Tube videos on Blueline, online quizzes, having them write test questions for review

Behavioral lectures: Lecture in Community and Preventive Dentistry on Professionalism in school, professionalism in their social media lives.

Colorado: Opportunities are available both through the School and on Campus. We have started an iPAD initiative to bring technology into the classroom and to assist millennial student learning styles.

Course evaluations have written surveys

Problem (case) based and team-based learning styles are encouraged and incluse the use of technology

No behavioral lectures at this time.

Iowa: Summer faculty teaching development seminars (approx.. 1/3 attendance)

Evaluations taken in various forms, alumni surveys, dental student class learning surveys, Seniors are surveyed multiple times and ways (ADEA, Office of Student Affairs, Dean's informal meeting with student leaders/officers)
Interactive learning settings

D1 orientation, communications courses primarily focused on clinician-patient interactions but overlaps with student-faculty interactions

Minnesota: No faculty development programs

No surveys

Students are not a monolithic block. In a recent presentation at ADEA, we presented on an attempt at making the first Operative Preclinical course self-paced (manuscript in preparation). We found considerable heterogeneity in student learning styles and preferences. E.g., student preference for didactic material presentation were split between online Moodle lectures (48%), traditional face-to-face lectures (37%), and no preference (15%). Faculty involved in the course were aware of a decrease in student preparedness for laboratory sessions when left to their own self-discipline to view online content. [Hildebrandt GH. Self-Paced Versus Lock-Step Preclinical Simulation Training, J Dent Educ 2016; 80:221 (ADEA Annual Session, Denver, CO): Abstract #PO-148.]

Nebraska: Faculty development at The Medical Center, not our college

No surveys

We have no systemic evaluation of this, but anecdotally students seem to like interactive techniques.

Yes, Drs. Lange (Phycologist), Vogt (Dean for Student Affairs) and Froeschle (Group Practice Administrator of Comprehensive Care Clinical Model) do discuss faculty/student relationships.

SIU: The university has some seminars but the travel and schedule limits dental school's ability to attend

Alumni surveys, exit surveys

Technology integration, video demonstrations and reference material

Students have behavioral courses that address communication skills but no necessarily the specifics of student/faculty interactions

UMKC: Not specifically at the School of Dentistry, but there is a strong faculty development committee that offers many development opportunities, many pertaining to new technologies

Surveys- alumni

More interaction (use of clickers, interactive technologies via Top Hat

There is a Behavioral Science course and students are required to participate in role-playing exercises as well as write and reflect on clinical encounters. None specific to faculty interaction, more focused on patient and staff.

Marquette:

No faculty development

No surveys

Unknown special styles

Behavioral lectures- yes, students are provided with instruction on appropriate interaction amongst providers (student & faculty in the clinical setting.)

CONSORTIUM OF OPERATIVE DENTISTRY EDUCATORS

LSU Health NEW ORLEANS School of Dentistry

REGION III
NOVEMBER 1-3, 2017
New Orleans, LA

2017 Region III Meeting Attendees

UTHealth
The University of Texas
Health Science Center at Houston
School of Dentistry

Dr. Gary Frey
Dr. Juliana Barrows
Dr. Shelley Patel

UT Health
San Antonio
Dentistry

Dr. Joe Connor

Texas A&M
Health Science Center
Baylor College of Dentistry

Dr. Christine Beninger
Dr. George Cramer
Dr. Stan Cobb

The University of Tennessee
Health Science Center

Dr. Barry Owens
Dr. Bruce Hamilton

UMMC
School of Dentistry

Dr. Mitch Hutto
Dr. Steve Magee

The University of Oklahoma
College of Dentistry

Dr. Terry Fruits
Dr. Zac Dacus

LSU Health
New Orleans
School of Dentistry

Dr Tom Giacona
Dr. Dale Ehrlich
Dr. Mark Winkler
Dr. A.J. Liles
Dr. Raquel Baroni de Carvalho

2017 C.O.D.E. Region III would like to acknowledge and thank the sposors who have made generous contributions to this meeting.

Dentsply Sirona

Leslie DuPlooy

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C.O.D.E. Regional Meeting Reporting -National Meeting Information

The **2017 National Agenda** was established after a review of the suggestions contained in the reports of the 2016 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 as to what has changed and 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 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 publishable format** as an email attachment.

The required format and sequence will be:

CODE Regional Meeting Report Form*
CODE Regional Attendees form*
Summary of responses to the National Agenda
Individual school responses to the National Agenda
The Regional Agenda summary and responses

***(copies may be obtained from the CODE website: www.unmc.edu/code or within this document)

Send an electronic copy of the final regional report via an email attachment to the National Director (gary.stafford@mu.edu) within thirty (30) days of the meetings conclusion.

National CODE Meeting:

The meeting will be held Thursday, February 22nd, 2018 from 5:00 – 6:00 pm in the Parkside Room at the Drake Hotel, 140 East Walton Place in Chicago, IL. Any member who would like to present or who has suggestions for speakers should contact the National Director for more information.

2018 ADEA Section on Operative Dentistry and Biomaterials Meeting:

The meeting will be held during the ADEA Annual Session & Exhibition, March 17-20, 2018 in Orlando, FL.

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 university's directory listing on the CODE website at www.unmc.edu/code or by sending an email directly to the National Director at gary.stafford@mu.edu.

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

School name and complete mailing address

Individual names: (F/T Faculty), phone number and email address of F/T Faculty who teaches operative dentistry.

*This could be an individual who teaches 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 helps save time and effort in maintaining a complete National Directory and publishing the Annual National Report in a timely fashion.

All my best,

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C.O.D.E. 2017 National Agenda

I. Clinical Curriculum

UTHSC at Houston | School of Dentistry

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No) Yes
    i. What types of procedures? – Examples include:
        1. Extra/intraoral examination (Yes/No) Yes
        2. Periodontal probing (Yes/No) Yes
        3. Alginate impressions (Yes/No) Yes
        4. Photography (Yes/No) Yes
        5. Radiographs (Yes/No) No
        6. Local anesthetic (Yes/No) Yes
        7. Prophylaxis (Yes/No) Yes
        8. Retraction Cord Placement (Yes/No) No
        9. Others – Please be specific Rubber dam placement

b. Benchmarks for entering the pre-doctoral clinics
    i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No) No
    ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No) No
    iii. Will this policy change when INDBE is in place? (Yes/No) No
    iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? Yes, but only with regard to that specific discipline
    v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? Successful completion of Introduction to Clinic and Foundational Skills for Clinic courses.

c. What is the student/faculty ratio in your school's pre-doctoral clinic? On average 6-8 students/1 faculty
    i. Does case complexity play a role in determining this ratio? Daily assignment of faculty to students is done by clinical Group Practice Director in each practice group, so case complexity and other factors result in a flexible student/faculty ratio.

University of Oklahoma

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

i. What types of procedures? – Examples include:
   1. Extra/intraoral examination Yes
   2. Periodontal probing Yes
   3. Alginate impressions Yes
   4. Photography No
   5. Radiographs Yes
   6. Local anesthetic Yes
   7. Prophylaxis Yes
   8. Retraction Cord Placement No
   9. Others – Please be specific

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)

No, our students begin participating in clinical procedures prior to having to successfully complete NBDE1. However, all students must complete NBDE1 prior to entering the fall semester of their third year. Students who fail to pass the NBDE1 after three attempts or before the start of the fall semester of their third year (whichever comes first) are dismissed from the program.

ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)

No. Students must successfully complete the NBDE2 in order to meet the requirements to graduate from our College of Dentistry and receive a DDS degree. Students are expected to complete all requirements for DDS degree within a six year period of time from their initial enrollment. Any student who fails to fulfill all program requirements, which includes passing the NBDE2, in the stipulated time period will be dismissed from the program and will be ineligible for graduation.

iii. Will this policy change when INDBE is in place?

(Unknown)

iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?

YES-for each specific discipline

v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? –

For restorative procedures, they must pass local anesthesia/N2O course

c. What is the student/faculty ratio in your school's pre-doctoral clinic?

i. Does case complexity play a role in determining this ratio?

During the first three years, student/faculty ratio varies based on the specific disciplines guidelines. For Operative clinical restorative procedures, the ratio is as follows: second year students 3/1, third year students summer session 3/1, fall session 4/1, spring session 5/1.

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

Yes

ii. What types of procedures? – Examples include:

1. Extra/intraoral examination (Yes/No) Yes
2. Periodontal probing (Yes/No) Yes
3. Alginate impressions (Yes/No) Yes
4. Photography (Yes/No) No
5. Radiographs (Yes/No) Yes
6. Local anesthetic (Yes/No) Yes
7. Prophylaxis (Yes/No) Yes
8. Retraction Cord Placement (Yes/No) No
9. Others – Please be specific

- Taking a face bow and mounting casts
- Fabricating occlusal guards

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No) Yes

ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No) No

iii. Will this policy change when INDBE is in place? (Yes/No)

Not known at this time

iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?

No, but the failed course(s) must be repeated and successfully completed with a grade of "C" or better before the student can see patients in the failed discipline. In the meantime, a student may treat patients in the disciplines they passed in the pre-clinical years.

v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

Students must have current CPR certification, they must have completed the online HIPAA training, they must have attended the annual Quality Assurance Risk Management session presented by the Office of Clinical Affairs, their Tdap vaccination must be up to date, their hepatitis B titer must be completed, they must have completed the TB testing, and they must have their flu vaccine annually.

c. What is the student/faculty ratio in your school's pre-doctoral clinic?

It varies from discipline to discipline. Currently in D3 operative, the student/faculty ratio is 5-6/1 In F. Pros the ratio is 5/1, in R. Pros the ratio is 5-6/1, in Periodontics the ratio is 5-6/1, in Endodontics the ratio is 3/1 and in Pedodontics the ratio is 2/1. In D4 general dentistry, the ratio is 8-9 students/1 faculty member.

i. Does case complexity play a role in determining this ratio?

No, however on any given day, the faculty covering clinic in a particular discipline work together so that if one faculty member has a student with a more complex case requiring more of the faculty's attention, the other

faculty will help cover the other students assigned to the faculty member with the difficult case.

University of Tennessee College of Dentistry

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)
   i. What types of procedures? – Examples include:

      1. Extra/intraoral examination (Yes/No)
      2. Periodontal probing (Yes/No)
      3. Alginate impressions (Yes/No)
      4. Photography (Yes/No)
      5. Radiographs (Yes/No)
      6. Local anesthetic (Yes/No)
      7. Prophylaxis (Yes/No)
      8. Retraction Cord Placement (Yes/No)
      9. Others – Please be specific Dental dam placement

b. Benchmarks for entering the pre-doctoral clinics
   i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)
   ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)
   iii. Will this policy change when INDBE is in place? (Yes/No) Not known
   iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? Yes
   v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? N/A

c. What is the student/faculty ratio in your school's pre-doctoral clinic? 6:1
   i. Does case complexity play a role in determining this ratio? No

UTHSC at San Antonio | School of Dentistry

a. In your school, do students practice on one another in preparation for their clinical experiences? Yes
   i. What types of procedures? – Examples include:
      1. Extra/intraoral examination Yes
      2. Periodontal probing Yes
      3. Alginate impressions Yes
      4. Photography Yes
      5. Radiographs Yes
      6. Local anesthetic No
      7. Prophylaxis Yes
      8. Retraction Cord Placement No
      9. Others – Please be specific

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? No
ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? No
iii. Will this policy change when INDBE is in place? (Yes/No)
iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? Yes, students must pass all courses to advance. Remediation of courses may be allowed if approved by the Academic Performance Committee
v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?
    1. Hippa
    2. AxiUm training
    3. Infection control
    4. Rotations in surgery / periodontics and others

c. What is the student/faculty ratio in your school's pre-doctoral clinic?
Depending on the date anywhere from 5 to 14 in the clinic and normally 1 to 7 in the preclinical labs.
i. Does case complexity play a role in determining this ratio? No, except in the cases of unusually complex treatment such as esthetic crown lengthening.

University of Mississippi | School of Dentistry

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)
i. What types of procedures? – Examples include:
    1. Extra/intraoral examination **Yes – beginning in the D1 year in the fall**
    2. Periodontal probing **Yes – Periodontics course**
    3. Alginate impressions **Yes**
        a. Multiple courses throughout the D1 & D2 year
        b. Occlusal Disorders in the D3 year
    4. Photography **Yes**
        a. D3 year
        b. Coming year in D3 orientation
    5. Radiographs **No – Now on Dexter, however, almost all the students are eventually admitted by a classmate and the radiographs are taken at that time**
    6. Local anesthetic **Yes**
        a. D2 local anesthetic course
        b. D3 orientation
    7. Prophylaxis **Yes – Periodontics course**
    8. Retraction Cord Placement **Yes – some years during D3 orientation along with the anesthetic review**
    9. Others – **Fabricate occlusal splints Yes – D3 occlusal disorders course**

b. Benchmarks for entering the pre-doctoral clinics
i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)
ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)

iii. Will this policy change when INDBE is in place? (Yes/No)
iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?
v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

c. What is the student/faculty ratio in your school's pre-doctoral clinic?
i. Does case complexity play a role in determining this ratio?

LSU Health New Orleans | School of Dentistry

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes)
iii. What types of procedures? – Examples include:
1. Extra/intraoral examination (Yes)
2. Periodontal probing (Yes)
3. Alginate impressions (Yes)
4. Photography (Yes)
5. Radiographs (Yes)
6. Local anesthetic (Yes)
7. Prophylaxis (Yes)
8. Retraction Cord Placement (Yes)
9. Others – Please be specific

b. Benchmarks for entering the pre-doctoral clinics
iv. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (No)
v. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (No)
vi. Will this policy change when INDBE is in place? (No)
vii. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? YES
viii. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? None other than section "iv" above along with BLS Provider certification and medical clearance by LSUHSC.

c. What is the student/faculty ratio in your school's pre-doctoral clinic?
D2 Operative Clinic: 1:6
D2 Perio Clinic: 1:6
D3 Advanced Operative Clinic: 1:5
D3 OD Clinic: 1:3
D3 Fixed Pros Clinic: 1:5
D3 Removable Pros Clinic: 1:5
D3 Perio Clinic: 1:5
D4 Comprehensive Care Clinic: 1:7 (average)
Oral Surgery Clinic (D3s and D4s): 1:2
Endo Clinic (D3s and D4s): 1:5
Pedo Clinic (D3s and D4s): 1:4

i. Does case complexity play a role in determining this ratio?
It could. When it does a student asks a specific faculty member to be in clinic for a complex treatment/case.

II. Biological Aspects of Operative Dentistry

UTHSC at Houston | School of Dentistry

a. Pulp capping and pulp tissue management
   i. Material(s) used – Please be specific
      1. $CaOH_2$ (Yes/No) No
      2. ZOE (Yes/No) Yes
      3. RMGI (Yes/No) Yes
      4. MTA (Yes/No) Yes, but limited to occasional use in Endodontics clinic
      5. TheraCal LC (Bisco Dental) (Yes/No) Yes
      6. Biodentine (Septodont) (Yes/No) No
      7. Others (Yes/No) N/A
   ii. Technique(s) taught – Please be specific; for direct and indirect pulp capping scenarios, TheraCal LC is placed, usually followed by a thin layer of Vitrebond RMGI liner.

University of Oklahoma

a. Pulp capping and pulp tissue management
   i. Material(s) used – Please be specific
      1. $CaOH_2$ Yes (ultrablend)
      2. ZOE No
      3. RMGI Yes (vitrebond)
      4. MTA No
      5. TheraCal LC (Bisco Dental) No
      6. Biodentine (Septodont) No
      7. Others No
   ii. Technique(s) taught – Please be specific

Standard pulp tissue management for routine depth restorations:
-Our standard pulp protection under all amalgam restorations is the application of Gluma Desensitizer. We apply it for 20 – 30 seconds, rinse with water and dry the tooth prior placing the amalgam restoration. We have had very good success with eliminating most postoperative sensitivity with this technique.
-Our standard pulp protection for resins composite restorations is the application of an etch and rinse adhesive dentin bonding agent prior to placing the resin composite restoration.

-For deeper preparations that are not estimated to be within 0.5 mm of pulp but have less than 1 mm of healthy dentin remaining over the pulp, we apply a 0.75 – 1.0 mm thick layer of resin modified glass ionomer liner (Vitrebond, 3M).

Pulp Cap Procedure

Our criteria for the consideration of using a pulp cap include the following:

-Tooth must be vital (all questionable teeth should be tested for vitality prior to treatment)

-No periapical lesion observed on radiograph

-No history of spontaneous pain

-No history of abnormal responses to stimuli (cold, hot, electrical)

-No history of prolonged pain to normal stimuli (cold, hot, sweet)

-Will not be an abutment tooth for prosthesis

-In the case of a direct pulp cap, the following also apply:

-Limited to small "pin-point" exposures.

-Exposed pulpal tissue appears vital, and any bleeding is easily controlled.

Pulp Cap Materials and Technique:

Assuming the qualifying criteria for pulp cap procedures listed above are met, the protocol for a direct or indirect pulp cap are as follows:

-In preparations in which there is a pulp exposure, or we estimate that there is less than 0.5 mm of dentin remaining over the pulp, we apply a very thin layer of calcium hydroxide (Ultrablend,Ultradent), and then cover that with a 0.75 – 1.0 mm thick layer of resin modified glass ionomer (Vitrebond, 3M).

Indirect pulp caps are utilized in teeth that are good candidates for this procedure based on the diagnostic signs and symptoms for that tooth. We prefer to remove as much of the carious tooth structure as possible. If the situation meets our criteria for the utilization of a pulp cap, an indirect pulp cap is preferred to the direct pulp cap when the thin layer of carious tissue remaining is fairly firm (flaky or leathery).

Baylor | Texas A&M University College of Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ (Yes/No) Occasionally
2. ZOE (Yes/No) No
3. RMGI (Yes/No) Yes
4. MTA (Yes/No) Occasionally
5. TheraCal LC (Bisco Dental) (Yes/No) Yes

6. Biodentine (Septodont) (Yes/No) No
7. Others (Yes/No) No

ii. Technique(s) taught – Please be specific

Direct and indirect pulp capping techniques are taught. For cases where the tooth is asymptomatic and tests vital and has an exposure <0.5 mm in diameter with hemorrhage from the exposure site easily controlled and rubber dam isolation was in place, TheraCal LC is placed and cured followed by placement of a suitable restorative material. An indirect pulp cap with TheraCal LC is placed when a pulp exposure is imminent if excavation is continued but all soft decay is removed. The tooth is then restored as before with a suitable restorative material.

Stepwise decay removal technique is taught in pediatric cases.

University of Tennessee College of Dentistry

b. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ (Yes/No)
2. ZOE (Yes/No)
3. RMGI (Yes/No)
4. MTA (Yes/No) (Endo)
5. TheraCal LC (Bisco Dental) (Yes/No) (Endo)
6. Biodentine (Septodont) (Yes/No)
7. Others (Yes/No)

ii. Technique(s) taught – Please be specific (Infected dentin is removed under dam, if no exposure it is based; if exposure, refer to Endo)

UTHSC at San Antonio | School of Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ Yes
2. ZOE No
3. RMGI - Vitrebond
4. MTA No
5. TheraCal LC (Bisco Dental) No, but it is planned.
6. Biodentine (Septodont) No
7. Others Ultrablend Plus

ii. Technique(s) taught – Please be specific

1. 60 second Consepsis scrub, dry, dycal .5 mm liner near pulp, vitrebond cover then light cure, adhesive then final restoration.
2. 60 second Consepsis scrub, dry, .5 mm Ultrablend plus, light curel adhesive, then final restoration

University of Mississippi | School of Dentistry

a. Pulp capping and pulp tissue management
  i. Material(s) used – Please be specific
    1. $CaOH_2$ (Yes/No)
    2. ZOE (Yes/No)
    3. RMGI (Yes/No)
    4. MTA (Yes/No)
    5. TheraCal LC (Bisco Dental) (Yes/No)
    6. Biodentine (Septodont) (Yes/No)
    7. Others (Yes/No)
  ii. Technique(s) taught – Please be specific

LSU Health New Orleans | School of Dentistry

a. Pulp capping and pulp tissue management
  i. Material(s) used – Please be specific
    1. $CaOH_2$ (Yes)
    2. ZOE (No)
    3. RMGI (Yes)
    4. MTA (Yes in Endo only)
    5. TheraCal LC (Bisco Dental) (Not at this time)
    6. Biodentine (Septodont) (No)
    7. Others (Yes/No)
  ii. Technique(s) taught – Please be specific

Direct and Indirect – LSU clinic

*If required , control hemorrhage with sterile cotton pellet and sodium hypochlorite or sterile water.

*CaOH (Dycal,Life)- thin, small layer placed over a slight amount of carious dentin adjacent to the pulp or pulp exposure.

*Resin Modified Glass Ionomer Base (RMGI,Vitrebond) – Thin layer placed covering and extending beyond the CaOH (SEAL)

*Adhesive System (SBMP) – etch, prime and bond (SEAL)

*Place restoration – composite or amalgam

III. Materials and Techniques

UTHSC at Houston | School of Dentistry

a. Provisionals
   i. Material(s) used – Please be specific: Systemp (intracoronal) and Integrity (crown/onlay coverage)
   ii. Technique(s) taught
      1. Discuss various techniques
         a. Traditional
            i. Describe They are taught both direct and indirect
         b. CAD/CAM (Yes/No) There has been a very few cases where provisionals have been made with paradigm blocks.
         c. 3D Printing (Yes/No) Being researched but have not heard of a successful placement as of yet.

b. Direct Pin Placement
   i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?
      2. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

Direct pin placement is still taught pre-clinically, manifesting both in lecture and laboratory exercise learning.

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? For a true repair of a defective margin of an amalgam restoration that does not require complete replacement, repair is done most typically with amalgam.
   ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? Repair with composite resin.
d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? Primarily based on classic indications, practitioner judgment, and patient desires. Vast majority of direct restorations being placed are composite resins; amalgams are most typically considered when fluid control/isolation severely compromised or for posterior build-ups where esthetics are not a concern.

University of Oklahoma

a. Provisionals
   i. Material(s) used – Please be specific
   ii. Technique(s) taught
      1. Discuss various techniques

a. Traditional
   i. Describe:
   Putty pre-op impression with Integrity (Dentsply) resin providioanl restoration.

b. CAD/CAM
   No
c. 3D Printing
   No

b. Direct Pin Placement
   i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?
      1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.
      Clinical instructors have the option of recommending pin retention or bonded retention. Pin retention is taught in one session of the operative preclinical course. Many of the our Fixed Prosthodontic instructors still prefer pin retention for foundational core restorations, but many of our fourth year comprehensive care instructors prefer bonded retention for amalgam or resin core restorations. There is no "consensus" on this topic at our school, with differences in opinions occurring with different instructors and different situations.

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?
   Yes. If the area to be repaired is conservative in size, repairs are preferred.

   ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?
   Yes. If the area to be repaired is conservative in size, repairs are preferred.

d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?
   General guidelines are provided in our operative preclinical course for utilization of various types of restorative materials. Amalgam is recommended for larger restorations in posterior teeth, especially in cases of heavy occlusal function (Bruxing/Clinching) restorations in areas where adequate isolation for adhesive bonding is impossible.

Resin is recommended for restorations that are considered to be in an area of esthetical concern for the patient, and are conservative or moderate in size.

Baylor | Texas A&M University College of Dentistry

a. Provisionals
   i. Material(s) used – Please be specific
      - Caulk acrylic and Integrity™ (Dentsply Caulk)
      - Aluminum crowns relined with Caulk acrylic are used occasionally.
   ii. Technique(s) taught
      1. Discuss various techniques
         a. Traditional
            i. A custom template is fabricated from the patient's study cast and cold cure Caulk acrylic is used in the template to form the interim restoration. In the D4 year and in select D3 cases with close faculty supervision, Integrity (Dentsply Caulk) crown and bridge resin is used to fabricate single unit provisional restorations. The interim restorations are usually cemented with non-eugenol containing temporary cement such at Temp-Bond NE (Kerr).
         b. CAD/CAM (Yes/No)
            No, not at this time.
         c. 3D Printing (Yes/No
            No, not at this time.

b. Direct Pin Placement
   i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?
      (The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.)
      Yes, we are still teaching direct pin placement to augment resistance and retention forms for amalgam and adhesively bonded composite materials, but only as a last resort when conventional adjuncts to retention and resistance form are not possible. We do not currently teach bonded amalgam restorations.

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?

Generally speaking, we do not repair defective amalgam margins with composite resin but rather replace the total restoration exhibiting a defective margin(s). In the clinic, however, it is at the discretion of the attending faculty member overseeing the procedure to make the determination as to whether it is better to repair or replace a defective amalgam with a defective margin(s) assuming that the restoration was originally placed here at the school.

ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

If the composite has been placed here at the school, it is at the discretion of the attending faculty member overseeing the procedure to determine if the defective composite restoration should be repaired or replaced.

d. Clinical Guidelines – Amalgam/Resin

i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

Yes. Generally speaking, the recommendation for larger Cl I and Cl II and complex restorations on molars (and possibly premolars when esthetics is not a primary consideration) would be amalgam. It is at the discretion of the attending faculty member overseeing the procedure, however, final approval of the restorative material used for a procedure should take into account the patient's preferences once the pros and cons for various restorative materials are discussed. Additionally, for Cl V restorations below the gingiva where moisture control is poorly achieved, amalgam is the restorative material of choice.

University of Tennessee College of Dentistry

a. Provisionals

i. Material(s) used – Please be specific

ii. Technique(s) taught (Direct)

1. Discuss various techniques

a. Traditional

i. Describe (ZOE temporary)

b. CAD/CAM (Yes/No)

c. 3D Printing (Yes/No)

b. Direct Pin Placement

i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials? (Not taught formally in labs; use is declining in clinic)

1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

c. Restoration Repair

i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?

ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? (Yes)

UTHSC at San Antonio | School of Dentistry

a. Provisionals
   i. Material(s) used – Please be specific
   ii. Technique(s) taught
      1. Discuss various techniques
         a. Traditional
            DESCRIBE:
            ii. IRM in Endodontic access preparation
            iii. Fuji II or Fuji IX
            iv. Cavit in non vital teeth to fill access prep
            v. Integrity or Jet Acrylic
         b. CAD/CAM Yes 3Shape Trios scanners are used extensively (mostly by DS4s)
         c. 3D Printing No

b. Direct Pin Placement
   i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?
      1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.
         We teach TMS pin placement in our preclinical lab course both in ivorene and extracted natural teeth.

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? Repair is taught at the school with amalgam or composite on a case-by-case basis.
   ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? Repair is considered acceptable

d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

1. Amalgam is recommended if the operating site cannot be controlled, if the patient prefers or cannot afford the fee associated with composite. Core restoration are preferred in amalgam.
2. Composite is recommended in esthetic cases, where the preparation is less than 1.75 mm deep, or the patient has indicated a preference. Cuspal coveragage composites are approved on a case-by-case basis.

University of Mississippi | School of Dentistry

a. Provisionals

i. Material(s) used – Please be specific

1. **Jet acrylic (Lang Dental) [MMA]**
2. **Structur (Voco) [Bis-Acryl Composite]**
   Jet Acrylic by Lang, Structur by Voco (Pappa)

ii. Technique(s) taught: **direct using vacuum formed matrix, direct using PVS matrix, indirect made in laboratory with Jet acrylic, indirect made in the lab with milled PMMA**

1. Discuss various techniques

a. Traditional- **direct using vacuum formed matrix, direct using PVS matrix, indirect made in laboratory with Jet acrylic**

i. Describe: **Impressed matrix or vacuum form matrix with Jet acrylic (methyl methacrylate).**
Students use their preformed matrix to fabricate provisionals directly in the mouth after the preparation has been approved. They may also fabricate them indirectly and have them ready to reline on the patient.

b. CAD/CAM: **YES**

Yes - Preparations or cast of them can be scanned and milled PMMA provisionals are fabricated in the laboratory

c. 3D Printing: **YES – Additive Manufacturing Technologies applicable to dentistry in advanced fixed topics in dentistry. (see attached table 1).**
Note: Table did not come with document.

b. Direct Pin Placement

i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice. **One pin per cusp that is replaced. Other forms of retention to include: slots, grooves, boxes, coves, offsets-steps, dovetails and bonding.**

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? **Requires a total restoration replacement.**
   ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? **Requires a total restoration replacement**.

d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? **A totally dry field must be obtained in order to use composite restorations. Use of Iso-lite or Iso-dry or rubber dam is determined prior to restoration.**

LSU Health New Orleans | School of Dentistry

a. Provisionals
   i. Material(s) used – Please be specific

*JET (PMMA)
*SNAP (Poly-R'Methacrylate)
*INTEGRITY (BisAcryl)
*Protemp (Bis-GMA)
*PVS Putty/Futar D (fast)
*Thermoplastic sheets
*Polycarbonate crowns
*Stainless Steel or Aluminum shell crowns

   ii. Technique(s) taught
      1. Discuss various techniques
         a. Traditional (Yes)
            vi. Describe

a)Eggshell from study model/wax-up using Jet, Snap, Integrity, or Protemp using a putty matrix or polypropylene clear thermoplastic sheets on a VacuForm ('suck-down").
b)Direct fabrication using modified putty matrix impression prior to tooth prep with either Jet acrylic or Integrity
c) Direct fabrication using Futar D in TripleTray impression prior to tooth prep with either JET, SNAP or INTEGRITY/PROTEMP.
d)Preformed polycarbonate crowns or Stainless Steel or Aluminum shell crowns with JET or SNAP acrylic reline.

         b. CAD/CAM (Yes) CEREC OmniCam prep acquisition using biogeneric or biocopy proposal mode with milling of a PMMA block for Temporary.

c. 3D Printing (Not at this time. Prs Dept interested)

b. Direct Pin Placement
   i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?
      1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

LSUSD teaches direct pin placement in vital teeth to augment resistance and retention form for amalgam as well as select adhesively bonded composite resins. Preference is to use composite resin if a bonded full coverage crown or onlay is the final restoration, and, amalgam if a luted full coverage cast metal crown or PFM crown is the final restoration.

c. Restoration Repair
   i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?
   Total replacement of defective amalgam
   ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?
   Yes in most cases. Depends on the defect.

d. Clinical Guidelines – Amalgam/Resin
   i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?
   No specific guidelines. Selection of amalgam or composite resin material is dependent on faculty evaluation.

IV. Assessment

UTHSC at Houston | School of Dentistry

a. Clinic Productivity
   i. Is the clinic productivity of your student a graded element in their clinical progress assessment? Only in the aggregate, year-long sense – there are a minimum number of clinical experiences with each discipline expected in order to successfully promote students to the next educational level/graduation. Productivity itself is not graded. It has been discussed.
   ii. Do you believe that it should be? Not sure how to interpret this question. If it regards the aggregate accumulation of clinical experiences to gain

competency, then many faculty agree with this. If this question, by contrast, regards productivity as far as clinical revenue is concerned, this is perhaps more controversial. Our faculty are somewhat divided on this with most shying away from doing so.

iii. How do you assess their productivity? The students productivity is from an essential experience standpoint only, we do not assign a dollar value to their individual weekly/monthly production. But the Group Practice directors can certainly tell you what their practices production is (this information is disseminated to GPD's and chairs) and who is the most productive in their practice.

University of Oklahoma

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment? Clinical productivity does affect the student's grade somewhat, due to the fact that they do have to meet certain minimal clinical experience units to complete clinical courses. Once the minimum number of clinical experience points is met, the quality of their work, based on daily grades and exam grades, will dictate their actual grade for a course.

ii. Do you believe that it should be? To some extent. We think that students should be required to reach some minimum level of exposure to a variety of clinical experiences during their dental education.

iii. How do you assess their productivity? We track their clinical experiences during their career at the school by recording "Relative Value Units" awarded for various types of clinical experiences.

Baylor | Texas A&M University College of Dentistry

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment? Not so much in the D3 year, but productivity is a graded element in the D4 clinical progress assessment.

ii. Do you believe that it should be?

As we all know, the more clinical experience a student has in dental school, the better clinician the student will likely become. To that end, the number of clinical experiences (quantity) as well as quality of the performance on clinical experiences should be assessed.

iii. How do you assess their productivity?

RV (Relative Value) points are awarded to various procedures according to the average time that it should take for a student to complete the given procedure.

University of Tennessee College of Dentistry

a. Clinic Productivity
   i. Is the clinic productivity of your student a graded element in their clinical progress assessment? (No)
   ii. Do you believe that it should be? (No)
   iii. How do you assess their productivity? (Axium)

UTHSC at San Antonio | School of Dentistry

b. Clinic Productivity
   i. Is the clinic productivity of your student a graded element in their clinical progress assessment? Yes
   ii. Do you believe that it should be? Yes, we feel that more experience is better than less.
   iii. How do you assess their productivity? AxiUm points are reported every month. 1600 points are needed to pass although students who accumulate more than 2100 points may be given higher than a 4.0. The production grade is then averaged with skills assessment grades.

University of Mississippi | School of Dentistry

a. Clinic Productivity
   i. Is the clinic productivity of your student a graded element in their clinical progress assessment?
   Clinic Productivity is measured in RVUs and attendance.
   ii. Do you believe that it should be?
   Yes
   iii. How do you assess their productivity?
   By assigning Relative Value Units to each procedure code. As they complete each procedure, this credit is given to the student. Students are asked to be present in clinic at all open clinic times. If they have a patient, this fulfills the attendance policy as does rotations and school sanctioned events. If the student does not have a patient, they are expected to assist with clinical activity. They receive credit for attendance in clinic, but no RVU's.

LSU Health New Orleans | School of Dentistry

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment? Yes … completion of requirements is PART of the final grade.
ii. Do you believe that it should be? Yes
iii. How do you assess their productivity? Number of restorations, surfaces treated, and classification of restoration (Class 1-6 in Operative).

V. Administration

UTHSC at Houston | School of Dentistry

a. Attendance Policy
i. Describe the attendance policy for your school's students.
1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.
Excused absences are permitted only if the student does not miss more than 25% of the total number of class meetings, preclinical lab sessions, or the contact-hour equivalent (not including the final examination period) for the specific course or courses in which the student is enrolled at the beginning of the semester.
* Missing more than 25% of scheduled course sessions at one time will require the student to take a leave of absence from the program.
* Any student missing more than 25% of scheduled preclinical laboratory sessions will be at risk of having grade deductions or potentially failing the course, whether or not the absences are considered excused.
ii. Is the policy enforced? Not sure. Policy one year old
iii. Do you feel that this policy is fair? Yes; perhaps generous
iv. Do you feel that the policy is appropriate? Yes

b. Millennial Students
i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? Yes
ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? No
iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students? Lay it out on a silver platter and spoon feed them. LOL

In reality, it seems that there are small groups within the larger group within which have different techniques work. I have some that plain lecture works, some small group, some self-instruction, it is almost a mix-mash. Nothing seems to work for them all.

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? We do have some learning helps available if they are having problems, one of our former Deans has a specific learning course he teaches to those in need, but they have to ask for the help.

University of Oklahoma

i. Describe the attendance policy for your school's students.
   1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

ATTENDANCE IS MANDATORY

Classroom and Laboratories

Exceptions can be made for legitimate excuses acceptable to the course directors. The methods of enforcing the attendance policy will be carried out at the departmental level. Students will be informed of departmental procedures for checking attendance at the beginning of each course. Unexcused absences may result in grade reduction or failure, at the discretion of the department chairperson and/or course director. A physician must document any absence due to illness from a major exam or required activity.

Clinics

Attendance in clinic is required unless the student is excused by the Director of Clinics (dental students) or the Clinic Coordinator or Site Coordinator (dental hygiene students). If not treating a patient, dental students will be expected to be assisting in clinic or in the laboratory. Dental hygiene students will be expected to assist in clinic.

Sanctioned Excused Absences

The College has determined that students may be excused from class and/or clinic without penalty for one of the following reasons with prior approval from the Dean's Office:

1. The student is officially representing the College of Dentistry at an event such as AADR, ASDA, ADA, ADEA, ADHA or other school-sponsored functions.
2. The student is required to appear for jury duty.
There may be other reasons for which the dean may excuse an absence.
Please note: Even when an absence is excused, students are expected to notify each course director in advance and arrange for satisfactory completion of any work that will be missed.

ii. Is the policy enforced?

Policy is enforced in some areas, and not in others. Operative department does not track attendance in lectures. However, attendance in the pre-clinic lab sessions is recorded by daily grade forms collected during each session.

iii. Do you feel that this policy is fair?

Yes

iv. Do you feel that the policy is appropriate?

Yes

c. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

Extensively.

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

Not sure what interactions the question is referring to. Interactions between faculty and students are evaluated by course evaluations which address all facets of the course.

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

Probably. Many do not, or cannot, or will not take notes during a lecture. Many do not expect to have to read from a textbook. Some (not all, but many) simply want, and expect, a "step by step" recipe for a procedure without any background knowledge of why they are completing each step.

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

Not to our knowledge.

Baylor | Texas A&M University College of Dentistry

a. Attendance Policy

i. Describe the attendance policy for your school's students.
   1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

Attendance Guidelines
Texas A&M University College of Dentistry

Texas A&M University College of Dentistry requires all students to maintain satisfactory attendance. At the beginning of a course the course director must inform all students in writing of the attendance policy for that course. Faculty members electing to keep attendance records must specify this fact in the course syllabus and must follow the guidelines established below. This policy is vigorously supported by the Administration.

1. **All students will be assigned a seat number according to their roster number, and this will be the assigned seat in each lecture room for that academic year.**

2. **The roll will be taken by seat numbers at the beginning of each class period.**

3. **Students arriving in class after the roll has been taken have the responsibility to notify the instructor at the end of the class period.**

4. **Tardiness may be counted as an absence at the discretion of the instructor responsible for the course. Class begins promptly on the hour and students are expected to be in their assigned seats at that time.**

5. **Instructors may use attendance as a factor in determining grades. The class must be informed of this fact in writing at the beginning of the course. The Director of Student Affairs will determine whether an absence is excused or unexcused.**

6. **Those departments using attendance as a factor in determining grades must maintain a written record of attendance.**

7. **Special consideration of absences may be given when the student (a) is on official duty for the school, (b) is incapacitated for health reasons, or (c) presents acceptable justification. The Director of Student Affairs will determine whether an absence is excused or unexcused.**

8. **Attendance at scheduled clinic/block sessions is mandatory unless the student is excused by the course director. If not treating a patient, the student will be expected to remain on college premises during clinic hours.**

Procedures for Reporting Absences

***Unanticipated absences*, e.g. personal illness, family emergency, etc. must be reported to the Office of Student Affairs. In the case of unanticipated absences necessitating cancellation of patient(s), it is the student's responsibility to contact their PAA, for patient notification, and the Office of Student Affairs.**

***Anticipated absences*, e.g. advanced program interviews, doctor appointments, etc. should be discussed with appropriate faculty prior to the time of the absence so arrangements can be made as needed. The absence should be reported by the students to the Office of Student Affairs and, if cancellation of patient appointments is involved, to their PAA.**

Refer to the *Leave of Absence Guidelines* for information on short and long-term leave

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Leave of Absence Guidelines

Any student enrolled in the College may request from the Associate Dean for Academic Affairs a leave of absence for cause. Any student who is granted a leave must officially clear key offices of Texas A&M University College of Dentistry, in keeping with institutional procedures. The purpose is to provide a mechanism by which students can re-enroll in the College after they return from the leave of absence.

Emergency leaves of absence can be arranged with the Director of Student Affairs or the Associate Dean for Student Affairs for up to 10 school days. All missed work must be made up and completed in a satisfactory manner. Leaves of absence longer than 10 days (including accidents and illnesses) must fully comply with the "Leave of Absence Request Procedure" listed below. Failure to follow this procedure in full will result in the student's re-enrollment conditions being stipulated by the Student Promotions Committee.

Students taking a leave of absence will re-enter the curriculum no later than the point at which the leave began, and students may be required to repeat a portion of the curriculum. Students who are on leave from A&M TAMHSC College of Dentistry for more than one calendar year may be required to repeat all or a significant portion of the curriculum.

Leave of Absence Request Procedures:

a. A student may request a leave of absence from Texas A&M University College of Dentistry by submitting the Leave of Absence Request Form to the Associate Dean for Academic Affairs. The student will be asked to state:

(1) The reason the leave is being requested (i.e., ill health, financial burdens, family problems, personal problems, reconsideration of career or life goals, etc.).
(2) The inclusive dates (i.e., beginning and ending) of the leave.

b. For students enrolled as a regular student, the Associate Dean for Academic Affairs will refer the leave request to the Associate Dean for Student Affairs for review and a recommendation. The Associate Dean for Student Affairs will review the leave request and the student's academic record, and will recommend to the Associate Dean for Academic Affairs whether the leave should be granted and any conditions which must be met for the student to re-enroll. For students who are on academic probation or enrolled as a special student, the Associate Dean for Academic Affairs will refer the leave request to the Student Promotions Committee.
The Student Promotions Committee will recommend to the Associate Dean for Academic Affairs whether the leave should be granted and, if so, the point in the curriculum where the student will re-enter and any necessary remediation activities following re-enrollment.

c. The Associate Dean for Academic Affairs will review the recommendation and will notify the student in writing of the action on the student's request, including any conditions which must be met by the student. A copy of the Associate Dean's written notice to the student will be forwarded to the Office of the Registrar for filing in the student's record.
d. If the leave is granted, the student must personally complete clearance procedures through the Office of the Registrar.

e. Students who have been approved for a leave of absence may have their patients reassigned.

f. In cases where the leave of absence extends for more than 60 days, the student must confirm his or her plans to re-enter by notifying the Associate Dean for Academic Affairs in writing at least 45 days prior to the ending date of the leave of absence. The Associate Dean will then notify the Associate Dean for Student Affairs of the quarter and year the student will re-enroll. Students seeking reinstatement will be required to provide verification that all conditions for reinstatement have been met.

g. Students who fail to confirm their re-enrollment date in accordance with this policy or students who do not notify the Associate Dean for Academic Affairs of a change in plans may not be allowed to re-enroll in the College. Students must also complete all institutional procedures required for reinstatement as specified by the College and the Associate Dean for Student Affairs.

ii. Is the policy enforced?

It is up to the Course Director.

iii. Do you feel that this policy is fair?

Yes, the policy appears to be fair even though it is not consistent from course to course.

iv. Do you feel that the policy is appropriate?

It would seem more appropriate if attendance were mandatory for all classes. It would be in the student's best interest to be present for all classes since much can go on in a classroom setting that can be beneficial to learning even if the material is presented on another medium. Also, it can reduce the amount of time an instructor must spend answering questions concerning material presented in a class where the student was not present.

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

Yes, our Office of Faculty Development has offered programs on this topic. Additionally, our Department of Restorative Sciences has presented programs related to teaching/dealing with the new generation of students to our departmental faculty.

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

One focus group was assembled and surveyed, but there was no follow-up with faculty.

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

The students appreciate faculty demonstrations of techniques used in the preparation and restoration processes. They also appreciate having lectures recorded on Camtasia. Students also like case studies, faculty sharing their experiences and problem solving in teams. The students tend to learn in bits and pieces but a mastery of in-depth knowledge appears to be lacking.

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

No

University of Tennessee College of Dentistry

a. Attendance Policy
   i. Describe the attendance policy for your school's students.
      1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.
   ii. Is the policy enforced? (Yes)
   iii. Do you feel that this policy is fair? (Yes)
   iv. Do you feel that the policy is appropriate? (Yes)
b. Millennial Students
   i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? (Yes)
   ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? (No)
   iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students? (visual learning, frequent breaks, computer based notetaking)
   iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? (Not sure)

Policy and Procedures Student Attendance

(Last Revised July 9, 2014)

While each college develops its own methods for tracking class attendance and for defining conditions for excused absences, UTHSC adheres to federal regulations that require verification of class attendance for all students receiving federal financial aid. These regulations dictate that a student MUST attend the classes for which he/she is awarded financial aid.

The College of Dentistry expects that students attend the various educational opportunities provided for them as a part of the curriculum of the college. The College considers attendance mandatory for certain educational experiences. Students will be informed, in writing, where college policy requires class attendance
In the College of Dentistry, attendance is required for all laboratories and clinical clerkships. Course directors have the discretion of requiring attendance for lectures. They will inform students at the beginning of the course, in writing, of any attendance requirements and consequences of lack of attendance. Students are responsible for all assigned work in all courses in which they are enrolled, regardless of any attendance requirements.

Student Policy Regarding Absences Excused Absences

Excused absences are granted through the Office of Academic Affairs for all classes, including clinic. For clinical excused absences, the student must, also, call and let their PCC and any scheduled patients know of their unavailability to keep the appointment. Excused absences allow students to miss class and/or clinic without penalty. Examples of justifiable reasons include, but are not limited to, complications related to pregnancy; serious medical problems; death in the family; automobile accident; jury duty and other judicial matters; military service; recognized religious holy days; and official representation for the University, or College of Dentistry.
Students unable to attend class or clinic must call the Office of Academic Affairs (4485114). Students unable to attend clinic must also call their Patient Clinic Coordinator before 8:00 a.m. the day of the class or clinic and also via Axium. The only exception is if the event causing the absence occurred after 8:00 a.m. and prior to arrival to school. Then call as soon as possible. If clinic is missed, the student should, also, immediately notify their patient of the inability to keep a clinical appointment. A voice mail system will be available at this number (448-5114) that automatically records the date and time of the message. Students should clearly state their name, class, and reason they are calling. All messages will be checked at 8:30 each morning. Any student who misses a scheduled course or clinic session, must provide documentation, including medical, jury duty, etc. to the Office of Academic Affairs (and clinical affairs for clinic absences) within five working days of the resumption of matriculation to obtain an excused absence. Medical documentation must be obtained from the University Health Service, or the student's health care provider. Please note that an excused absence does not excuse a student from assigned clinic or clinic blocks (patient treatment). It is the student's professional responsibility to obtain a replacement for any assigned block rotation, and notify the departmental block coordinator of the change.

Students who cannot provide proper documentation will not receive an excused absence and thus may not be afforded an opportunity to make-up missed examinations, quizzes or other assignments. For these students, course directors have the discretion of requiring alternative assignments or examinations to ensure competency. All decisions regarding the feasibility of providing required educational experiences, in an alternative manner or form, will be made by the course director, with input from the departmental chair.

Unfortunate circumstances, such as automobile problems. traffic conaestion, over sleeping and other issues of a similar nature, funerals for non-family members and issues of a personal nature are not considered justifiable reasons for an excused absence from required class attendance. In general. students will not be given excused absences from scheduled classes for such reasons as vacations, weddings, National Board Dental Examinations. Graduate Record Examinations. etc.. or trips not authorized by the College of Dentistry. However. since every possibility cannot be anticipated. exceptions may be qranted at the discretion of the Office of Academic Affairs and/or the Dean. Students not eligible for excused absences are still bound by the attendance requirements of the course(s) from which they were absent.

Administrative Exemptions

An Administrative exemption may be given to students planning to take time from the curriculum for reasons other than those outlined such as interviews and other extenuating circumstances. Administrative exemption from required attendance will be granted by the Office of Academic Affairs upon receipt of sufficient justification. Students are required to request exemption and provide justification to the Office of Academic Affairs in advance of anticipated absences from the college. The Office of Academic Affairs will then inform the course directors of anticipated absences. In cases where an anticipated absence involves a scheduled examination, the student is required to work with the course director to determine a date and time for re-scheduling. When advance notification is not possible, a request for administrative exemption and justification must be received within five workinq days of the resumption of matriculation. Unless there is an emergency, administrative exemptions will not be granted after the fact. Fourth-year students that have required interviews for residency programs or for other career opportunities will be afforded the opportunity to obtain administrative exemptions, but it requires that the Office of Academic Affairs receive advanced notice prior to leaving the dental school and that arrangement has been made to make up any scheduled assignments.
Students who do not have an administrative exemption from attendance may not be afforded an opportunity to take missed quizzes or other assignments. Course directors have the discretion of requiring alternative assignments or examinations to ensure competency, as dictated by individual circumstances for students with un-excused absences. All decisions regarding the feasibility of providing required educational experiences, in an alternative manner or form, wilt be made by the course director, with input from the departmental chair.

Students in the D-3 and D-4 years and hygiene students with clinical assignments are allowed 6 half-days from clinic per semester for personal business. The following days away from COD clinics are not included; rotations in Arkansas, Jackson, the Hope Smiles elective, Clinical Hygiene rotations and any other approved rotation. D-3 and D-4 students are allowed a maximum total of two weeks (10 business days) for externships. Sick days without a doctor's excuse count towards the 6 half-day total. Personal days may not be carried over to the next academic semester or year or "saved. "

Examination Policy

Students are expected to be present for all scheduled examinations (as indicated on the official class schedule). Excused absences will be available only from the Associate Dean of Academic Affairs and will in general only be aiven in the case of serious illness that requires hospitalization. or death of an immediate family member (mother. father. sister .brother). Exceptions will be considered by the Dean of the Colleae.

Students who are absent from an examination for reasons other than an emerqencv will incur a one-letter qrade (7.5%) reduction in their qrade for that examination and will be required to take the missed examinations as soon as

possible after they return, but no later than two business days after their return to class.

Contacting Course Director upon Return to School

In the absence of extenuating circumstances, as determined by the Office of Academic Affairs, a student who has been absent, regardless of the cause of the absence, has the responsibility and obligation to contact the course director(s) within five working days of the resumption of matriculation. Failure of the student to contact the course director(s). regardless of the validity of the absence. may result in an inability of the student to make up or otherwise account for missed lectures. laboratories, clinics. quizzes. or other activities.

Missing Clinical Block Assignments

D-3 and D-4 students are periodically scheduled for block assignments and are required to attend those sessions. In the event of an anticipated absence, it is the student's professional responsibility to obtain a replacement for any assigned block rotation, and notify the departmental block coordinator of the change. In the event of illness, the student should follow the protocol for reporting their illness by informing the Office of Academic Affairs (448-5114) which block they will be missing due to illness.

Sustained Illness

Sustained physical or mental illnesses, medical complications and pregnancy and/or delivery may present unique problems in terms of obtaining an excused absence from required attendance. In these cases, a 'Leave of Absence' may be granted by the Dean, depending upon the circumstances of each case and alternative arrangements considered by the departments working in conjunction with the Office of Academic Affairs.
The administration of the College of Dentistry will make every effort to work with students in these cases. However, because of the unique nature of the curriculum, e.g., required attendance for all laboratories and clinical clerkships, exposure to dental materials, the necessity of sequential course scheduling, and patient care responsibilities, prolonged absences may preclude uninterrupted matriculation. Limited institutional resources and sound pedagogy may preclude the offering of specific courses, or portions of courses, in an alternative manner or form, for which any student is justifiably absent.

In the event that an alternative educational program is necessary and can be devised following a 'Leave of Absence,' the student will be required to provide a medical clearance from their health care provider stating that they may return to full-time study. They will be required to perform the same fundamental and essential elements of the curriculum at the same level as his or her peers. No additional consideration will be given beyond the construction of an alternative curriculum. All students will be evaluated for promotion and graduation using the same basic criteria.

If an alternate educational program cannot be arranged following a 'Leave of Absence,' the student may be considered for readmission for the next academic year, assuming that they were

in good academic standing and are otherwise qualified as a student and that sufficient space exists to accommodate them in the ensuing class.

Personal Problems

Students may experience personal problems at some point in their dental education. The College of Dentistry will make every effort to provide reasonable accommodations, however in the event that an individual student's educational needs cannot be met through reasonable accommodations, the student will be given the opportunity to withdraw from program, without prejudice. The student may be considered for readmission for the next academic year, assuming that they were in good academic standing and are otherwise qualified as a student and that sufficient space exists to accommodate them in the ensuing class.

UTHSC at San Antonio | School of Dentistry

a. Attendance Policy

i. Describe the attendance policy for your school's students. Attendance at our lecture and lab restorative routinely exceeds 95%.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

VI. Attendance is mandatory. Attendance is required for all lectures so that you may hear points of emphasis, ask questions, and allow instructors to assess whether you understand the material that is being presented. A short quiz covering the material presented in the previous lecture and assigned readings will be given at 8:00. Turning in that quiz will record your attendance. If you are absent three times, you must arrange to meet with the Didactic Course Director(s) Dr. Joseph Connor or Dr. Shannon Roberts and you will be required to submit a written summary of the answers to the learning objectives from each of the sessions for which you were counted absent. Attendance and attention during lecture is considered one aspect of professionalism. Chronic tardiness or absence, leaving early or inattention in class will be taken into consideration when assigning final grades. It may even result in the assignment of a failing grade.

VII. n/a

VIII. Each Operative Dentistry Lecture session begins promptly at 8:00 unless otherwise indicated in your schedule. On the days of laboratory skills assessments the lecture may follow the lab. Students who must be absent from class should report the absence prior to the start of class. Students can access the online reporting system to report absences, which will link to all Course Directors/Rotation Directors. The link is located on the Dental School Webpage in the 'Current Students' section. Using your UTHSCSA username and password to log in, click on the Absence Reporting link. Complete all of the information on the pop-up including: first and last name, year in school (DSI-DSIV), start date of absence, end date of absence (optional, if known), and reason for the absence. Once sent by the student, the information will be routed to the Course Director/Rotation Director.

ii. Is the policy enforced? Yes students who miss more that three lectures are required to turn in written answers to learning objectives.

iii. Do you feel that this policy is fair? Yes

iv. Do you feel that the policy is appropriate? Yes

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? WikiClinic (See below)
ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? Yes
iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?
iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

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TITLE: Mitigating the Dental July Effect

Statement of the problem

The term "July Effect" refers to a "perceived increase in the risk of medical errors and surgical complications that occur when… medical school graduates begin residencies." [1] Dental schools experience the same perceived effect in the first months of clinical experience despite concerted efforts to mitigate this phenomenon. This project describes the development and multiple uses of WikiClinic, a website developed at the UT School of Dentistry. The site provides clinical information to students and faculty in real time on computers and hand-held devices. It is utilized by students particularly in the first months of clinic and it helps to reduce errors and increase confidence in inexperienced providers. The current and developing uses of WikiClinic include calibration of faculty, providing detailed instructions for multi-step clinical procedures, providing information on grading criteria for clinical examinations, and other relevant topics. It has potential to further advance the way that dentistry is taught by providing relevant information to both faculty and students as it is needed at the point of care in the clinic. The concept is applicable to nursing, medicine and allied professional schools.

Discussion

[1] https://en.wikipedia.org/wiki/July_effect

"Wiki Wiki Web" was the name given to the first program of its type by the inventor Ward Cunningham in 1994. He chose the name using the Hawaiian word for quick.[2] "Wiki" now refers to any website that allows collaborative editing of its content and structure directly from a web browser.[3] It can be compared to an open access "file cabinet" that serves as a repository of shared knowledge[4]. The technology developed over the following decades to be used by individuals, corporations, and schools. Wikipedia by far the largest wiki and the fifth most visited site on the web now receives over thirteen million page views each day.[5]

Wikis have found a place in medical education. A systematic review published in the Journal of Medical Internet Research in 2015 examined 25 Medical wikis and addressed the ways they are used in medical education.[6] A wiki based program was described in the dental literature in the Journal of Dental Education in 2011 under the name Dental Procedure Education System. [7] The focus of dental literature has been on the impact of social media or so-called Web 2.0 that includes blogs, facebook, twitter, YouTube, and others. For reasons that I will discuss the overall penetration of wikis in medical and dental literature has been relatively slow.

The program "WikiClinic" was developed by a third-year dental student with a degree in Computer Engineering. It has been in use at the UT Health School of Dentistry since 2012. He created the site on his private server as an aid to fellow students in orientation to the clinic. The original design of the site focused on three things: where to go in the clinic for instruments and supplies, management of paperwork, and clinical processes that students encountered in the first weeks of care. The site has been in use at the school for the past 5 years and has been visited by students more than 15,000 times

The inventor remained the sole administrator during the creation of the website. Upon his graduation in 2014 he was offered a part-time position with the school where he continued to develop and refine the site until he departed the area in 2016 to start his private practice. Significantly the hosting of the website was transferred to the University computers where it eventually drew the attention of faculty members who recognized the potential of the site.

While Wikis were invented to allow open access to users, there are a number of circumstances where access to edit Wikis must be restricted. Unlike Wikipedia, that allows visitors to make changes, contributions, or corrections at will,[8] administrative privileges in medical and dental

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[2] Andrews, Lorrin (1865), A dictionary of the Hawaiian language to which is appended an English-Hawaiian vocabulary and a chronological table of remarkable events(PDF), Henry M. Whitney, p. 514

[3] *Encyclopædia Britannica*, **1**, London: Encyclopædia Britannica, Inc., 2007, retrieved April 10, 2008

[4] Godwin-Jones R. Emerging technologies: Blogs and wikis: Environments for on-line collaboration. Lang Learn Tech 2003; 7(2)12–16

[5] https://www.quora.com/How-many-users-visit-Wikipedia-daily

[6] Brulet A, Llorca G, Letrilliant L, Medical wikis dedicated to clinical practice: a systematic review. J Med Internet Res. 2015 Feb 19;17(2)

[7] Salajan F. Mount, G, Leveraging the Power of Web 2.0 Tools: A Wiki Platform as a Multimedia Teaching and Learning Environment in Dental Education, *J Dent Educ.* 2012 76:427-436

[8] https://www.merriam-webster.com/dictionary/wiki

Wikis must be restricted since the information contained in the website will be used at the point of care. It must be accurate, current, and reflect what is taught at the school. It must also preserve intellectual property rights of creators of content. So,up to this point, students have not been allowed to edit, add, or delete content. Administrative rights have now been granted only to select faculty members who assure that information is reliable.

Our students however, have a significant role in identification of content that would help them in the clinic. Our students have received hundreds of hours of lectures on a variety of subjects each of which may contain dozens of facts that they need to know in order to perform dental procedures. Students have complained that searching through thousands of Powerpoint slides in courses that they took a year or more ago seldom provides them with precisely what they need. Collaboration between professors and students to create clear and relevant content in an accessible and searchable format is the overarching goal.

We have developed a strategy that addresses the interests of students and the need of professors to assure accuracy of content. UT Health School of Dentistry has a robust Teaching Honors Program that allows students to earn distinction upon graduation by attending classes and completing projects that establish their skills as dental educators. Our Teaching Honors Program students have been asked to coordinate with course directors to identify suggested content and to standardize the way that it is presented. Once approved by the course director, content will be placed on the site by paid individuals with experience in programming.

A significant advantage of Wiki technology is calibration of faculty members in treatment planning decisions, clinical techniques, and grading. Faculty who provide clinical coverage for students or residents **need** to know what their students are **supposed** to know. With the advances in technology and materials and our knowledge of the biologic sciences, few dentists can remain up to date in all areas of dentistry. As experts in our own areas we rely on our own experience and knowledge to inform our own clinical decisions. We know what we teach but don't know what is taught by experts in other areas. Our lack of calibration results in confusion among students who may receive contradictory guidance.

The correct use of cements, bonding agents, and other materials and devices requires specific steps to be taken with meticulous attention to detail. There are more than 15 steps involved in bonding of a post in an endodontically treated tooth. Having instructions shown on the screen in the dental operatory provides enormous advantage that translates as improved outcomes. WikiClinic has potential to reduce clinical errors, improve clinical quality, decrease confusion associated with the first weeks in clinical care, make better use of treatment time, and enhance the training of pre-doctoral students. The faculty will know what the students have been taught and the students will know the expectations of their faculty.

The major innovation upon which this recommendation is based is the expansion of the role of faculty and students in the creation of content that may fundamentally change the way that dentistry is taught at the school. Surveys have been sent to third year dental students to assess their degree of confidence in performing clinical procedures that they may be asked to perform in the first months of intensive clinical experience. The survey will be repeated at the end of the first semester with the intention of assessing the value of the Wikiclinic site in increasing

confidence of students. A similar survey was sent to faculty members that will allow us to compare student and faculty confidence before and after using WikiClinic. Statistical analysis will be performed to assess the significance of data.

The introduction of WikiClinic as a major organizational change has required the accomplishment of significant objectives. The first step, after identifying the potential of the program, was gaining the support of senior leadership in the organization. The Chair of the Department of Comprehensive Dentistry lent his enthusiastic support to further development after a one-on-one briefing. It was followed by an in-depth interview with students to determine how the program was being used and the ways in which the site to be improved Feedback from students was used to update the WikiClinic section on Operative Dentistry as "proof of concept".

The improved content was outlined in a demonstration to the Dean of the School of Dentistry, who gave his support for wider use of the program in other departments. Subsequently a one-hour presentation was made to all faculty at the annual "Faculty Advance." The presentation drew the interest and support of faculty at large but follow on one-on-one meetings with key faculty were required to solicit contributions to content.

Program directors of graduate programs were particularly interested in improving referrals to graduate clinics. Many patients who were referred to periodontics, oral surgery, prosthodontics, endodontics and other clinics were unable to accept the more expensive treatment plans that were proposed in these clinics. By creating information sheets for patients and providing instructions to students outlining referral protocols, it offers ways to increase treatment plan acceptance. Patients will be required to verify that they have been advised of increased fees before they accept an appointment. Patients whose treatment needs cannot be met at the school may be given the names of community clinics may meet their treatment needs.

As with any program that involves significant change, the process must be carefully managed and even then, the outcome is uncertain. Faculty are already fully committed doing what they are doing to ` Feedback thus far has indicated that faculty may be reluctant adapters.

University of Mississippi | School of Dentistry

a. Attendance Policy

i. Describe the attendance policy for your school's students.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

ATTENDANCE POLICIES - UMC
https://documents.umc.edu/ViewPolicy.aspx?pid=E-SOD-PRG-GEN-PO-00005

Clinic:
85% clinic attendance is required to receive a passing grade in 650, 675. The method of accounting for clinic attendance is outlined in the Clinic Operating Manual. The grades for 650 and 675(attendance component) are awarded as follows:

*** <85% attendance F**
*** 85 to 89% attendance C**
*** 90 to 94% attendance B**
*** 95% or greater attendance A**

Students are given credit for attendance if their absence involves a university-sanctioned event. Up to nine one-half day clinic sessions of national board prep for D4 students and two days per interview for out of town post-graduate program interviews are included in this policy. These are the only absences a student is given credit for attendance.

Failing grade in 650 – student receives an F (numeric grade of 50) for 650 and this grade is considered by the Student Evaluation and Promotion Committee (SEPC). If the SEPC recommendation is to allow the student to continue into the summer session on academic probation, the student must have 95% or greater clinic attendance for the summer session to have probation status removed. The remedial grade if probation status is removed will be 70. If a student does not have sufficient clinic attendance to have probation status removed at the end of the summer session, a remedial grade of F (numeric grade of 50) will be reported to the SEPC and the student will be subject to repeat of the year or dismissal.

Failing grade in 675 – student receives an F (numeric grade of 50) for the attendance component of 675 and this grade is considered by the SEPC. If the SEPC recommendation is to allow the student to extend into the summer session on academic probation, the student must attend five times the number of clinic sessions that kept the 675 attendance percentage below 85% to have the probation status removed. The remedial grade when probation status is removed will be 70.

Special circumstances involving clinic absence: student notifies the clinic dean who will decide if the special circumstance warrants waiving the attendance requirement for that absence. This will be considered only if the student already has more than the number of absences which result in a failing grade in 650 or 675.

Class:
Students are expected to attend all classes. Arriving late for or leaving early from class 20 minutes beyond the bounds set by the course coordinator will be counted as an absence.

If a student is absent from a class, the student must contact the course coordinator by UMMC email prior to the next class session to make up the missed class. Any additional remedial assignments for the missed class will be at the discretion of the course coordinator. Failure to complete a missed class assignment in the time designated by the course coordinator will result in a failing grade (50) for that assignment. Failure to report an absence to the course coordinator prior to the next class session or failure to successfully complete any remedial assignment in the time designated by the course coordinator will result in a penalty of three points off the course final grade for each occurrence.

Rotations and Special Events:

For student rotations and certain special events, 100% attendance is required. Remediation is required if a student is absent for a rotation session or a required special event. Depending on the session or event missed, that may involve hours in the rotation, service hours as determined by the clinic dean, or other consequences as explained in the syllabus if the session or event is part of a course.

ii. Is the policy enforced? **Yes**
iii. Do you feel that this policy is fair?
Yes, however most times burden is transferred to course coordinator.
iv. Do you feel that the policy is appropriate?
Yes there needs to be an agreed upon policy in place.

b. Millennial Students
i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?
ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?
iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?
iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

LSU Health New Orleans | School of Dentistry

a. Attendance Policy
i. Describe the attendance policy for your school's students.
Please quote the actual attendance policy as outlined in your Academic Affairs manual.

LSUSD Didactic and Pre-clinical Courses:
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 reduction of one letter grade for that course. Each department will determine general policy for monitoring attendance in assigned course(s). There are no excused absences with this policy. The only exception is an APPROVED ABSENCE as described herein.

LSUSD Attendance - Clinical
"The LSU School of Dentistry attendance policies for didactic, pre-clinical and clinical courses are included in the LSUSD STUDENT HANDBOOK OF POLICIES AND PROCEDURES. It states:
"Dental students are required to attend all scheduled clinic sessions as a requirement of each specific clinical course. There are no excused absences. The only exception is an approved absence as described herein. The Dean or the Associate Dean for Academic Affairs may grant a petition for a short approved absence in the case of illness, participation at a professional meeting, or any emergency, with the explicit understanding that the student will arrange with the faculty involved to satisfactorily complete all course expectations."

However, for the 1087 clock hour Senior Comprehensive Care Clinic Course the Administration allows this in the Course outline/Syllabus:
"For this course you are therefore expected to participate in clinic 100% of your scheduled time. Attendance is more than signing a roster or approving an attendance code in Axium. You must also actively contribute to your clinical education by treating a patient directly or by assisting a fellow student. Attendance will be monitored, and

verified by the team leader through various signed forms (attendance and assisting).

As previously stated, this is course is a transition into private practice. As such, this course will allow 8 clinical days (16 clinical sessions) of personal time you can use when you are sick, studying for Board exams, vacation. If necessary, an additional four (8 clinical sessions) clinic days off is available for externships, job/ residency interviews, etc. which requires written documentation given to the Course Director. NO exceptions.

Violation of this attendance policy will result in a grade of "1" for: Ethical conduct; Communication in a professional manner; and Efficient Clinic Utilization. Also, this violation could result in a possible reduction in your final course grade by one Letter grade."

ii. Is the policy enforced?
Didactic and Pre-clinical Courses: Yes …. Enforced by the Course Directors/
Clinical Courses: Spotty … Again depends on Course Directors. The Senior Comprehensive Care Clinic Course depends on its Team Leaders to document attendance.

iii. Do you feel that this policy is fair? Students do … Faculty has mixed opinions.

iv. Do you feel that the policy is appropriate? Students do … Faculty has mixed opinions.

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? Yes

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? Yes

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students? Hard to tell … students seem to enjoy shorter lessons with technique videos

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? Yes …. In Class Orientation at beginning of each year, Professional Development Courses, and Clinical Course orientation.

Fall 17

Consortium of Operative Dentistry Educators (CODE)

2017 National Agenda

Prepared by:

Gary L. Stafford DMD – National Director

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Regional Meeting Reporting/National Meeting Information

The 2017 National Agenda was established after a review of the suggestions contained in the reports of the 2016 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 as to what has changed and 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 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 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.unmc.edu/code or within this document)

Send an electronic copy of the final regional report via an email attachment to the National Director (gary.stafford@mu.edu) within thirty (30) days of the meetings conclusion.

National CODE Meeting:

The meeting will be held Thursday, February 22nd, 2018 from 5:00 – 6:00 pm in the Parkside Room at the Drake Hotel, 140 East Walton Place in Chicago, IL. Any member who would like to present or who has suggestions for speakers should contact the National Director for more information.

2018 ADEA Section on Operative Dentistry and Biomaterials Meeting:
The meeting will be held during the ADEA Annual Session & Exhibition, March 17-20, 2018 in Orlando, FL.

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.

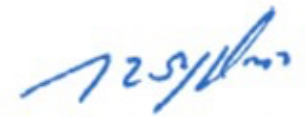
You may update your university's directory listing on the CODE website at www.unmc.edu/code or by sending an email directly to the National Director at gary.stafford@mu.edu.

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

1. *School name and complete mailing address*
2. *Individual names: (F/T Faculty), phone number and email address of F/T Faculty who teaches operative dentistry.*
    a. This could be an individual who teaches 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 helps save time and effort in maintaining a complete National Directory and publishing the Annual National Report in a timely fashion.

All my best,



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2017 National Agenda

Region IV- Great Lakes Summary

I. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

i. What types of procedures? – Examples include:

1. Extra/intraoral examination (Yes/No)
2. Periodontal probing (Yes/No)
3. Alginate impressions (Yes/No)
4. Photography (Yes/No)
5. Radiographs (Yes/No)
6. Local anesthetic (Yes/No)
7. Prophylaxis (Yes/No)
8. Retraction Cord Placement (Yes/No)
9. Others – Please be specific

Summary:
Overall, most schools have students practice on one another in preparation for their clinical experiences. (No on retraction cord- 5 schools), (Photographs-no 4 schools), (Radiographs-4 (dexter)), sealants (2), nightguards, bleaching trays, rubber dam, facebow, border molding. Some schools have experienced students not wanting to participate (medical history) due to privacy issues, fear, etc.

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)

Summary:
Yes (6 schools) by the clinical entry
No (1 schools) end of D2 year the students enter clinic (but pass by D4 year)

ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)

NO (5) D4 year
Not a graduation requirement (1-WVU)
Requirement for graduation (6)

iii. Will this policy change when INDBE is in place? (Yes/No)

Not sure (6),
Will be requirement to enter D4 year (1)

iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?

Overall, yes. (remediations may be necessary)

v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

BLS, vaccinations, TB test, examination on clinical policy/procedures, clinical orientation session

Summary:

c. What is the student/faculty ratio in your school's pre-doctoral clinic?

6:1 average (6)
8:1 maximum (5)
10:1 average (1)
12:1 max (1)
preclinical lab- 12:1 (2); 10:1 (6)

i. Does case complexity play a role in determining this ratio?

Yes (5)
No (2)
-Chairs for CAD/CAM, more individualized cases (3:1), prosthodontics

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ (Yes/No) Yes 6 No 1
2. ZOE (Yes/No) Yes 3 No 4
3. RMGI (Yes/No) Yes 7 No
4. MTA (Yes/No) Yes 3 (2 endo) No 4
5. TheraCal LC (Bisco Dental) Yes 2 (1 pedo) No 5
6. Biodentine (Septodont) Yes 1 (endo) No 6
7. Others (Yes/No) MioMTA (pedo)

Summary:

ii. Technique(s) taught – Please be specific

- Indirect pulp cap is taught, clear margin, CAOH covered by RMGI and then restorative material
    - Caries needs to be removed from the DEJ.
- Direct pulp-MTA then, restorative treatment
- Pulp testing and radiographs are recommended (2)
- Rubber dam
- No preclinical exercise (1)
- Extracted teeth or carious plastic teeth (2)

III. Materials and Techniques

a. Provisionals

i. Material(s) used – Please be specific

Summary: MMA Jet, Bis-acryl (integrity), Alike, Trim, Provisa, SNAP, ProtempPlus

ii. Technique(s) taught

1. Discuss various techniques
   a. Traditional
      i. Describe

Summary: Indirect and direct technique, PVS matrix, vacuum-formed template, performed provisionals

b. CAD/CAM (Yes/No) Yes 4 No 3

c. 3D Printing (Yes/No) No 7 Yes 0

b. Direct Pin Placement

i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

Summary: Remove a cusp, MODB amalgam with pin; slots, max pins, amalgam pin. Many schools have a preclinical activity. Clinically, depends on faculty coverage/understanding/comfort.

c. Restoration Repair

i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?

Summary: On occasions, (to save the tooth) amalgam and GI repairs. Replace entire restoration-2 schools

ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

Summary: Stained margin, can replace with resin and depends on caries extension Also, depends on size of restoration and difficulty. Overall, no school has set protocol. Depends on faculty decision. If crown is indicated, there is a greater tendency to replace entire restoration.

d. Clinical Guidelines – Amalgam/Resin

i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

Summary: No, limitation of materials and determined by clinical faculty. Subgingival, posterior = amalgam (Yes there are guidelines, but faculty often make the decisions). Amalgam is preferred for cores. Location. Extent of restoration, isolation considerations. Patient preference. Margins on enamel, no cuspal coverage.

IV. Assessment

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment?

Summary: *RVUs, risk assessment is part of that, some courses, start checks part of grades, progress is tracked procedurally (WVU), (utilization, accountability, points and productivity = broken into % for the grade).*

ii. Do you believe that it should be?

Summary: No (3), Yes (3), Maybe (1)

iii. How do you assess their productivity?

Summary: Look at codes to assess productivity, CPUs are used to measure, WVUs, time management (in axiUm)

V. Administration

a. Attendance Policy

i. Describe the attendance policy for your school's students.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

Summary: Students attendance is required for most schools. Professionalism requirement is part of some school's grades. Attendance excused or unexcused is determined by the administration (3 schools) or course directors (4 schools).

ii. Is the policy enforced? Yes No

iii. Do you feel that this policy is fair? Yes No

iv. Do you feel that the policy is appropriate? Yes No

Summary: The school representatives were split on the enforcement, fairness and if the policy was appropriate.

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

Summary: small group learning, case-based learning, clickers, phones, transitions course (study skills, time management, motor skill development)
No: 3 schools
Yes: 3 schools (Seminars-) Teaching Scholars program which has the topic of millennial students. Faculty meetings to identify at risk students

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

Summary: no
Course evaluations for faculty
Exit student interviews

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

Summary: Flipped classrooms, online presentations, tooth atlas, live demonstrations, discussion regarding failure, active learning, Increased instructors (help sessions), visual learning methods,

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

Summary: Ethics and Professionalisms, positive environment policies,

2017 National Agenda

Region IV- Great Lakes Individual School Responses

VI. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

i. What types of procedures? – Examples include:

1. Extra/intraoral examination (Yes/No)
2. Periodontal probing (Yes/No)
3. Alginate impressions (Yes/No)
4. Photography (Yes/No)
5. Radiographs (Yes/No)
6. Local anesthetic (Yes/No)
7. Prophylaxis (Yes/No)
8. Retraction Cord Placement (Yes/No)
9. Others – Please be specific

Buffalo	In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)- **YES** What types of procedures? – Examples include: Extra/intraoral examination (Yes/No) **YES** Periodontal probing (Yes/No) **YES** Alginate impressions (Yes/No) **YES** Photography (Yes/No) **NO** Radiographs (Yes/No) **NO** Local anesthetic (Yes/No) **YES** Prophylaxis (Yes/No) **YES** Retraction Cord Placement (Yes/No) **NO** Others – Please be specific **(Face-bow record, practicing sealants without acid etch to remove the sealant after assignment, caries risk assessment, diet analysis)**
Case Western	No responses given
Detroit Mercy	In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No) What types of procedures? – Examples include: Extra/intraoral examination (Yes/No) Periodontal probing (Yes/No) Alginate impressions (Yes/No) Photography (Yes/No)

	Radiographs (Yes/No) Local anesthetic (Yes/No) Prophylaxis (Yes/No) Retraction Cord Placement (Yes/No) Others – Please be specific: **Sealants and Rubber dam Isolation on each other**
Indiana	**In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)** **What types of procedures? – Examples include:** • **Extra/intraoral examination (Yes/No)—as part of my oral diagnosis and treatment planning course given in the 2nd semester of D1 year. They work in a group with 2 other students and are assigned to one another in axiUm so that they can officially record the experience and fill out associated forms** • **Periodontal probing (Yes/No)—D1's do this as part of a Risk assessment course and again in the prophy clinic at the conclusion of the D1 year.** • **Alginate impressions (Yes/No)—D1's do this in their first semester as part of their Introduction to Clinics course.** • **Photography (Yes/No)** • **Radiographs (Yes/No)—They work on "dexter" heads in the radiology clinical space. However, many of them do this on one another as one of their first clinical experiences at the start of their D3 year. This is not required.** • **Local anesthetic (Yes/No)—The students work in groups of 3 and have been assigned each other's chart in axiUm. They go through most of the types of injections, giving a small amount without epinephrine. They do this as part of the local anesthesia course at the conclusion of their D1 year. They must complete a certain amount of injections with direct supervision over their second year prior to starting in the clinics in their 3rd year.** • **Prophylaxis (Yes/No)—They have a prophy clinic at the conclusion of their D1 year where they are assigned to another student and go through the full process.** • **Retraction Cord Placement (Yes/No)—They do this as part of the applied prosthodontic principles course offered at the end of the D2 year.**

	• **Others – a. Facebow record. The students record a facebow record and transfer it and mount the models (as part of the applied prosth principles course** o **border molding on one another (part of the applied prosth principles course**
Michigan	No responses given
Midwestern	**a.** In your school, do students practice on one another in preparation for their clinical experiences? No - no procedures at all ii. What types of procedures? – Examples include: 1. Extra/intraoral examination (Yes/No) 2. Periodontal probing (Yes/No) 3. Alginate impressions (Yes/No) 4. Photography (Yes/No) 5. Radiographs (Yes/No) 6. Local anesthetic (Yes/No) 7. Prophylaxis (Yes/No) 8. Retraction Cord Placement (Yes/No) 9. Others – Please be specific
Ohio State	**a.** In your school, do students practice on one another in preparation for their clinical experiences? (Yes) iii. What types of procedures? – Examples include: 1. Extra/intraoral examination (Yes) 2. Periodontal probing (Yes) 3. Alginate impressions (Yes) 4. Photography (Yes) 5. Radiographs (Yes) 6. Local anesthetic (Yes) 7. Prophylaxis (Yes) 8. Retraction Cord Placement (No) 9. Others – Please be specific A. Night Guards B. Sealants C. Border Molding D. Caries Risk Assessment including Saliva Check Test and CariFree Swab for bio-load test. E. Head and Neck Exam. F. Medical History G. Intra-oral dental exam and charting. H. Plaque Score

	I. OHI J. Oral Cancer Screening k. Vital signs l. At home bleaching with shade selection m. Shade Selection n. Ear Bow transfer and centric relation record o. Smile Analysis p. Rubber Dam Placement q. Selective coronal polishing
Pittsburg	**a.** In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No) iv. What types of procedures? – Examples include: 1. Extra/intraoral examination (Yes/No): **Yes** 2. Periodontal probing (Yes/No):**Yes** 3. Alginate impressions (Yes/No):**Yes** 4. Photography (Yes/No):**No** 5. Radiographs (Yes/No): **No** 6. Local anesthetic (Yes/No): **Yes** 7. Prophylaxis (Yes/No): **Yes** 8. Retraction Cord Placement (Yes/No):**No** 9. Others – Please be specific: **Obtaining medical history and taking vitals.**
UIC	**a.** In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No) v. What types of procedures? – Examples include: 1. Extra/intraoral examination (Yes/No) 2. Periodontal probing (Yes/No) 3. Alginate impressions (Yes/No) 4. Photography (Yes/No) 5. Radiographs (Yes/No) 6. Local anesthetic (Yes/No) 7. Prophylaxis (Yes/No) 8. Retraction Cord Placement (Yes/No) 9. Others – Please be specific: Rubber Dam Isolation, Alginate impressions, Comprehensive Oral Exam, caries detection, pulp testing, periodontal examination, home bleaching, facebow mounting.
West Virginia	**a.** In your school, do students practice on one another in preparation for their clinical experiences? (Yes/No)

	i. What types of procedures? – Examples include: 1. Extra/intraoral examination (Yes/No)Intro To Patient Care Course 2. Periodontal probing (Yes/No) Intro To Patient Care Course 3. Alginate impressions (Yes/No)Occlusion Course 4. Photography (Yes/No)In 2nd yr course with ortho instructor 5. Radiographs (Yes/No)Complete on Mannequin (DEXTTR) 6. Local anesthetic (Yes/No) TWICE before clinic- once in Anesthesiology course, again in Intro To Patient Care Course 7. Prophylaxis (Yes/No) Intro To Patient Care Course 8. Retraction Cord Placement (Yes/No) Intro To Patient Care Course- done with anesthesia and cord packing in same session 9. Others – Please be specific Taking and recording in Axium of Medical history, dental history, drug history form, Orofacial Exam (Hard and Soft tissues- complete orofacial exam form and odontogram in axium. Caries risk. Bleaching/trays.
Western Ontario	No responses given

a. Benchmarks for entering the pre-doctoral clinics
   i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)
   ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)
   iii. Will this policy change when INDBE is in place? (Yes/No)
   iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?
   v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

Buffalo	i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No) **YES** i. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No) **NO** i. Will this policy change when INDBE is in place? (Yes/No) **YES** v. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? **YES, failing students need to remediate the course/courses and successfully pass before attending the clinic.**

	v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? **Student should be in good standing.**
Case Western	No responses given
Detroit Mercy	i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No) **Pass it By May as DS2** i. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No) **Pass it by March DS4** i. Will this policy change when INDBE is in place? (Yes/No) **Don't know** v. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? **Yes, with new model student will have exam periodically (gatekeeper) to check their progress, any student performing under will be asked to retake it until pass grade is earned.** v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? **CPR, Immunizations TB test**
Indiana	**a. Benchmarks for entering the pre-doctoral clinics** **ii. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)—The D2 students must take it by March 1st of their D2 year, but do not have to pass it by then. They must, however, pass it by July 6th to move on with their class.** **iii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)—The students must take it by December 1st of their 4th year.** **iv. Will this policy change when INDBE is in place? (Yes/No)—This will possibly change; it is currently under discussion.** **v. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?—Yes, all D1 and D2 courses must be passed.** **vi. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?—BLS must be current; immunizations up to date for credentialing.**
Michigan	No responses given

Midwestern	**a.** Benchmarks for entering the pre-doctoral clinics vii. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? Yes viii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? No ix. Will this policy change when INDBE is in place? The plan is to have D3 students take INBDE toward the middle to end of D3 year. So it will not be a requirement to enter the clinics x. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? Yes xi. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? No other academic requirements at present. Immunizations must be complete. There is a plan to have D2 students take a week long series of performance exams at the end of D2 year. Passing the test would be a requirement for entry into clinic. The plan will be implemented in Spring Quarter 2018
Ohio State	**a.** Benchmarks for entering the pre-doctoral clinics xii. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes) xiii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (No) xiv. Will this policy change when INDBE is in place? (Probably) xv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? (Yes) xvi. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? Current on inoculations including flu vaccination, current BLS/CPR Certification, and current TB test.)

Pittsburg	**a.** Benchmarks for entering the pre-doctoral clinics xvii. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No): **Yes** xviii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No): **No** xix. Will this policy change when INDBE is in place? (Yes/No): **Yes** xx. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? **Yes** xxi. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? **Successful completion of second year which includes Operative Dentistry III. Operative Dentistry III is a sim-clinic course in which a student has to complete amalgam and composite preparations and restorations on a typodont.**
UIC	i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No) ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No) Is a requirement for graduation. ii. Will this policy change when INDBE is in place? (Yes/No) v. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? Yes v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? None. Attend the first week of mandatory clinic orientation.
West Virginia	**a.** Benchmarks for entering the pre-doctoral clinics xxii. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic? (Yes/No)But, is a benchmark for entering the 4th year. Taken at end of 2nd yr/start of 3rd yr, but have to PASS to enter 4th yr. If not passed, time gone by until passing achieved determines which class they rejoin…3rd or 4th yr. xxiii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic? (Yes/No)Taken prior to graduation, but is not a requirement for graduation. xxiv. Will this policy change when INDBE is in place? (Yes/No) Class of 2021 will have option to take, Class

	of 2022 will not have option. Will likely be a passing requirement/benchmark to enter 4th year. xxv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic? Yes xxvi. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic? Must pass an examination on clinical policies and procedures. Up to date on vaccinations; TB testing, annual flu vaccine now required.
Western Ontario	No responses given

b. What is the student/faculty ratio in your school's pre-doctoral clinic?

vi. Does case complexity play a role in determining this ratio?

Buffalo	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic? **Average 6:1** i. Does case complexity play a role in determining this ratio? **Sometimes**
Case Western	No responses given
Detroit Mercy	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic? **Pre-doc clinic** **Total of 120 DS4 and DS3 students 6 DHs2 in clinic (20 DS4 and DS3,1 DHs2)** **2 Clinic directors** **6 Clinic Leads (1 Clinic lead/20DS4 and 20DS3,1DHS2 students)** **18 General Dentists** **6 endo specialtist** **6 prosth specialist** **6 Perio specialist** **6 dental hygienist** **1 CAD/CAM specialist** **Simlab** **Total of 288 DS1 and DS2 students** **1 Director for DS1 Integrated course 2 course directors for 2 DS2 courses** **4 co-directors** **20 bench instructors**

	Ideally ratio 5 students to 1 bench instructors **Sometimes on religious holidays, sickness, that ratio goes down to 10 student to 1 bench instructor** i. Does case complexity play a role in determining this ratio? **yes**
Indiana	a. What is the student/faculty ratio in your school's pre-doctoral clinic?—There are no regulations on this and it is often anywhere from 8:1 to 12:1 or 14:1. All clinical faculty believe this to be a big problem, as there are currently no limitations in place for this. Interestingly, the dental hygiene program has accreditation requirements in place for a 6:1 ratio and no more. vi. Does case complexity play a role in determining this ratio?—Absolutely not as there is no way to monitor, predict, and prepare for complex cases as someone unfamiliar with the students and their patients is responsible for faculty scheduling.
Michigan	No responses given
Midwestern	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic? 1 faculty per 7 - 8 students ii. Does case complexity play a role in determining this ratio? No
Ohio State	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic? (Ideally 1:6) ii. Does case complexity play a role in determining this ratio? (No)
Pittsburg	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic**? For prosthodontic cases we try to set the limit at six patients per prosthodontic instructor. For restorative procedures there is no limit but the average is approximately five patients per restorative instructor. Team leaders will see as many patients as scheduled in the clinic as there is no limit for comprehensive oral exams, limited oral exams and treatment plans.** ix. Does case complexity play a role in determining this ratio? **No**
UIC	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic? Approximately 6/1. Does case complexity play a role in determining this ratio? It does not change for our comprehensive clinics, but we have designated chairs for digital dentistry, implants and

	complete dentures that has a more individualized attention to the patient and student (3/1).
West Virginia	**a.** What is the student/faculty ratio in your school's pre-doctoral clinic? 1:6 max usually, can be as many as 10, as little as 2 (on an off day) depending on procedure/ amt of students booked in clinic. If faculty has smaller #, they usually pick up students doing mannequin procedures or serve as a second grader for a performance assessment. (Pre-clinic or lab is much higher…usually 1:10-20) Does case complexity play a role in determining this ratio? Yes, depends on type of procedure student is completing (ie. Fixed, denture adjustments, treatment planning.) Treatment plans limited to 3. Denture adjustments...unlimited? Hygiene exams: anywhere from 13 to 22 students to 1 faculty, (sometimes 2, usually 1).
Western Ontario	No responses given

VII. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$ (Yes/No)
2. ZOE (Yes/No)
3. RMGI (Yes/No)
4. MTA (Yes/No)
5. TheraCal LC (Bisco Dental) (Yes/No)
6. Biodentine (Septodont) (Yes/No)
7. Others (Yes/No)

Buffalo	**a.** Pulp capping and pulp tissue management ii. Material(s) used – Please be specific 1. $CaOH_2$ (Yes/No) **YES** 2. ZOE (Yes/No) **NO** 3. RMGI (Yes/No) **YES** 4. MTA (Yes/No) **NO** 5. TheraCal LC (Bisco Dental) (Yes/No) **NO** 6. Biodentine (Septodont) (Yes/No) **NO** 7. Others (Yes/No) **NO**

Case Western	No responses given
Detroit Mercy	**a.** Pulp capping and pulp tissue management iii. Material(s) used – Please be specific 1. $CaOH_2$ (Yes/No) **used in simlab/clinics** 2. ZOE (Yes/No) **used in simlab/clinics** 3. RMGI (Yes/No) **used in simlab/clinics** 4. MTA (Yes/No) **introduced in lectures** 5. TheraCal LC (Bisco Dental) (Yes/No) **introduced in lectures** 6. Biodentine (Septodont) (Yes/No) **Don't know** 7. Others (Yes/No)
Indiana	**a.** Pulp capping and pulp tissue management iv. Material(s) used – Please be specific 1. $CaOH_2$ (Yes/No) Yes – for direct & indirect pulp capping. Not recommended unless cavity preparation has < 0.5 mm of remaining dentin thickness. Endo seems to be moving away from $CaOH_2$ due to its irritating effect. Will need to discuss alternatives. 2. ZOE (Yes/No) Mentioned in class for use as a sedative temporary restoration. However, a two-step indirect pulp capping procedure (i.e., one that requires a subsequent visit to place a permanent restorative material) is not routinely used in clinic. May occasionally be used if endodontic diagnosis is uncertain. 3. RMGI (Yes/No) Yes – used as a liner in deep cavity preps, either alone, or over $CaOH_2$ in direct or indirect pulp capping procedures. 4. MTA (Yes/No) Mentioned in D2 class. Not available in clinic. Endo does not use (primarily due to cost & preference for Biodentine). 5. TheraCal LC (Bisco Dental) (Yes/No) Not mentioned in D2 class (but, we need to update...). Not available in clinic. Endo does not use. 6. Biodentine (Septodont) (Yes/No)

	Not mentioned in D2 class. Not available in Comp Care clinic. But, Endo does use. 7. Others (Yes/No) None.
Michigan	No responses given
Midwestern	**a.** Pulp capping and pulp tissue management v. Material(s) used – Please be specific 1. $CaOH_2$ Yes 2. ZOE No 3. RMGI Yes 4. MTA Direct pulp cap only, not indirect 5. TheraCal LC Included in didactic content, not used clinically 6. Biodentine (Septodont) Included in didactic content, not used clinically 7. Others (Yes/No)
Ohio State	**a.** Pulp capping and pulp tissue management vi. Material(s) used – Please be specific 1. $CaOH_2$ (Yes) 2. ZOE (Yes but not often)) 3. RMGI (Yes) 4. MTA (Yes but rarely and not in pre-doc clinic) 5. TheraCal LC (Bisco Dental) (No) 6. Biodentine (Septodont) (No) 7. Others (No)
Pittsburg	**a.** Pulp capping and pulp tissue management vii. Material(s) used – 1. $CaOH_2$ (Yes/No): **No** 2. ZOE (Yes/No):**Yes** 3. RMGI (Yes/No):**Yes** 4. MTA (Yes/No):**Yes** 5. TheraCal LC (Bisco Dental) (Yes/No):**No** 6. Biodentine (Septodont) (Yes/No):**No** 7. Others (Yes/No):**No**
UIC	**a.** Pulp capping and pulp tissue management viii. Material(s) used – Please be specific 1. $CaOH_2$ (Yes/No) 2. ZOE (Yes/No)

	3. RMGI (Yes/No) 4. MTA (Yes/No) 5. TheraCal LC (Bisco Dental) (Yes/No) 6. Biodentine (Septodont) (Yes/No) 7. Others (Yes/No)
West Virginia	**a.** Pulp capping and pulp tissue management ix. Material(s) used – Please be specific 1. $CaOH_2$ (Yes/No)Indirect or pinpoint direct 2. ZOE (Yes/No) IRM taught in pre-clinic, but don't use in clinic 3. RMGI (Yes/No) Vitrebond used with Dycal or theracal with sandwich technique 4. MTA (Yes/No)Endo 5. TheraCal LC (Bisco Dental) (Yes/No)Indirect, and pinpoint 6. Biodentine (Septodont) (Yes/No Endo-residents 7. Others (Yes/No)Pedo- uses Neo- MTA. Is MTA material that is mixed o desired consistency- can be liner type consistency, or compressible.
Western Ontario	No responses given

x. Technique(s) taught – Please be specific

Buffalo	**The technique is to place the calcium hydroxide over the exposure, then place glass ionomer over the calcium hydroxide prior to restoring. Depending on the type of exposure the tooth may be temporized with GI (calcium hydroxide in place). Preoperative requirements: pre-operative radiograph, no apical pathology, no pain in the tooth. rubber dam isolation.**
Case Western	No responses given
Detroit Mercy	ii) Technique(s) taught – Please be specific **CaOH2,RMGI, used under no pain,pathology,clean margin, DEJ, Zoe used as temp in clinics,**
Indiana	i. Technique(s) taught – Please be specific • In general, we advocate indirect pulp capping for caries lesions approaching the pulp: Clean the periphery of the preparation & ensure the cavosurface margins are caries-free. To avoid pulp exposure, leave a small amount of demineralized dentin over the pulp. Place $CaOH_2$

	(conservatively) in the deepest portion; cover the $CaOH_2$ & the immediately surrounding dentin with GI or RMGI to seal the dentin & protect the $CaOH_2$. Place the final restorative material. We do not advocate re-entry into the preparation later to complete caries removal or check for dentin bridge formation. • We advocate the same procedure for direct pulp capping of small mechanical or carious exposures. Again, we do not advocate re-entry into the preparation to complete caries removal or check for dentin bridge formation. • For both direct & indirect pulp capping, we recommend that the tooth must be vital, with no history of lingering or spontaneous pain, and no periradicular pathology. Therefore, pre-operative pulp testing and a PA radiograph are encouraged. Adequate field control (i.e., rubber dam isolation) is required whenever possible. • We do mention Stepwise Caries Excavation & Partial Caries Removal techniques in our D2 course. Both are two-visit techniques, with incomplete caries removal & placement of a temporary restoration at the first visit, followed by subsequent partial or complete removal of the temporary to place the permanent restoration. However, we do not advocate these procedures in clinic. And personally, I find that teaching all three techniques tends to confuse the students. • We also discuss the Atraumatic Restorative Technique (ART) in class. This is less confusing; and the students do perform this procedure during their mission trips.
Michigan	No responses given
Midwestern	i. Technique(s) taught – Please be specific Calcium hydroxide over small exposure or pink dentin RMGI liner over the calcium hydroxide Bonding materials for composite restoration Composite
Ohio State	i. Technique(s) taught – Please be specific We teach infected caries removal with a clean margin, and trying to avoid a pulp exposure. We do pulp vitality testing. Pulp treatments taught are use of $CaOH_2$ when within .5 mm of pulp or for a direct pulp cap. Then place an RMGI base.

Pittsburg	i. Technique(s) taught – Please be specific: **For indirect pulp treatment, we recently eliminated Dycal and now tell the students to place a RMGI base prior to restoring the tooth. For direct pulp treatment when there is no bleeding or the bleeding can be stopped, the procedure is to place MTA over the exposure and place a RMGI base prior to restoring the tooth. In situations where the pulpal bleeding persists, an endodontic procedure is indicated.**
UIC	i. Technique(s) taught – Please be specific: If Direct pulp capping: control bleeding with saline solution and a cotton pellet, calcium hydroxide is placed on the exposure site and then covered by RMGI followed by the restorative material. Reentry is discouraged. Our philosophy supports partial caries excavation which leads us to do indirect pulp capping with no reentry. The protocol for indirect pulp capping is the same as direct pulp capping: Ca(OH)2 on pulp transparency proximity covered by RMGI, followed by placement of the final restoration without reentry.
West Virginia	i. Technique(s) taught – Please be specific Blushing or indirect pulp cap, or small pinpoint exposure– place liner followed by restoration. Theracal or Dycal covered by Vitrebond. Larger exposure- consult endo dept- may place MTA and provisional material, or complete endo access. Pedo Dept uses neo-MTA for pulp capping and apexogenesis. Pulp testing as instructed, and under rubber dam isolation.
Western Ontario	No responses given

VIII. Materials and Techniques

a. Provisionals
- i. Material(s) used – Please be specific
- ii. Technique(s) taught

1. Discuss various techniques
   a. Traditional
      i. Describe
   b. CAD/CAM (Yes/No)
   c. 3D Printing (Yes/No)

Buffalo	

	iii. Material(s) used – (Please be specific): **PMMA (Fixed partial denture) and BisAcryl (single crowns)** iv. Technique(s) taught: **Both direct technique and indirect-direct technique** 1. Discuss various techniques a. Traditional i. Describe: **<u>Direct technique:</u> using the PVS impression or vacuum matrix, provisionals are fabricated by PMMA or BisAcryl material.** **<u>Indirect-direct technique:</u> Fabricating a shell (from the PVS impression) and later relining the shell with PMMA or BisAcryl material. Vacuum matrix is also used.** b. CAD/CAM (Yes/No) **YES** c. 3D Printing (Yes/No) **NO**
Case Western	No responses given
Detroit Mercy	**a.** Provisionals v. Material(s) used – Please be specific: **Alike temporary crown and bridge resin,Temphase temporary crown and bridge material, Pre-formed polycarbonate crown** vi. Technique(s) taught: **Cast need to be ready for template (vacuuform) before working on patient** 1. Discuss various techniques a. Traditional i. Describe b. CAD/CAM (Yes/No) c. 3D Printing (Yes/No) **Only used for trial for studies**
Indiana	**a.** Provisionals vii. Material(s) used – Please be specific Direct Provisional Material: 1. <u>IRM Eugenol Free</u> 2. <u>Other: Glass Ionomer, …</u> Indirect Provisionals: 3. <u>Snap -</u> 4. <u>Pro-Temp</u> 5. <u>Pre-formed Metal (lined or unlined)</u> 6. <u>Polycarbonate (line or unlined)</u> viii. Technique(s) taught 1. Discuss various techniques

	a. Traditional: i. Snap and Pro-Temp: Pre-preparation impression with PVS or alginate. Snap or Pro-Temp lined. Impression placed over prepared tooth to form Provisional. Margins and occlusion adjusted and then cemented. ii. Preformed metal provisional sized and adjusted with crown and collar scissors or discs to approximate margins. Lined with Snap or Pro-Temp and placed over prepared tooth. Margins and occlusion adjusted and then cemented. Can also be used as mold for missing tooth or insufficient crown and then carry on as in (i) above. • Polycarbonate Crown preformed provisional sized and adjusted with burs and discs. Margins and occlusion adjusted, then cemented or relined as above with Snap or Pro-Temp and then cemented b. CAD/CAM (Yes/No) Yes. We have the capability but have not used the CAD to make provisionals in the undergrad clinics. We have occasionally used it to manufacture provisionals in the grad Oper and grad Prosth clinics. c. 3D Printing (Yes/No) No capability at this time.
Michigan	No responses given
Midwestern	**a.** Provisionals Material(s) used – Please be specific Bis Acrylic (Versa Temp) and PMMA (Alike) are taught Technique(s) taught 2. Discuss various techniques a. Traditional i. Describe - use of PVS matrix for provisional matrix b. CAD/CAM - used for restorations not for provisionals c. 3D Printing No
Ohio State	**a.** Provisionals ix. Material(s) used – Trim, Jet, and Provisa. x. Technique(s) taught 1. Discuss various techniques a. Traditional i. Describe – Use an external matrix form. b. CAD/CAM (Yes for long term provisionals using Lava Ultimate.) c. 3D Printing (No in clinic but available in in house fixed lab)

Pittsburg	**a.** Provisionals xi. Material(s) used – Please be specific: **Jet acrylic** xii. Technique(s) taught 1. Discuss various techniques a. Traditional i. Describe**: Students are to have stents when they arrive in the clinic to be used to fabricate Provisionals.** b. CAD/CAM (Yes/No): **Yes. We have started to use CAD/CAM in the clinic for crowns. We also have milling units to fabricate the prosthesis. Therefore, most Cerec crowns are completed in one day.** c. 3D Printing (Yes/No): **No. We do not utilize 3-D printing at this time. However, one of our faculty members won the ADEA Gies Award for fabrication of a RPD framework utilizing 3-D printing.**
UIC	**a.** Provisionals xiii. Material(s) used – Please be specific: Students are taught techniques for fabrication of provisional restorations using methyl-methacrylate (JetSet-4 - Lang) or Bis-acryl (Integrity – Dentsply Caulk). xiv. Technique(s) taught 1. Discuss various techniques a. Traditional Describe: The techniques that are introduced in pre-patient care courses include: use of a PVS matrix, a vacu-formed clear matrix, or a shell technique. The use of polycarbonate crown forms is also introduced though custom provisional restorations are preferred. i. b. CAD/CAM (Yes/No) – Not used for fabrication of provisional restorations in pre-doctoral clinics or pre-patient care courses. Telio is used in PG prosth. c. 3D Printing (Yes/No)
West Virginia	**a.** Provisionals xv. Material(s) used – Please be specific Crown and bridge-Integrity/ Ultratemp cement. Inlay/Onlay –Telio CS xvi. Technique(s) taught 1. Discuss various techniques a. Traditional

	i. Describe ESF impression, prep/impress, Integrity over prep with ESF impression (direct) or clear matrix (indirect). Adj as necessary, cement with Ultratemp. b. CAD/CAM (Yes/No)Just starting in October/November at CRET Innovation Center c. 3D Printing (Yes/No)Not yet
Western Ontario	No responses given

xvii. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

Buffalo	**Pins are used whenever a cusp is missing. They are rarely used in anterior teeth. Restoration of complex amalgams with pins are included in the pre-clinical operative curriculum.**
Case Western	No responses given
Detroit Mercy	**a.** Direct Pin Placement xviii. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials **TMS for cuspal build up introduced in lecture and placed in simlab as exercise only for amalgam restorations, not for adhesively bonded composite materials.Other secondary retention taught are,lugs troughs, grooves.** 1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.
Indiana	**a.** Direct Pin Placement xix. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

	1. In the first year operative course we have the students (on ivorine) prepare an MODB amalgam preparation (MB cusp removed) on a mandibular first molar and have them place a minim pin in the area of the missing MB cusp to improve retentive form. This is accomplished under rubber dam isolation. They then restore with amalgam. This can be a final restoration or a foundation/build up for an indirect final restoration. We also instruct in other mechanical methods of retention form including slots, grooves, boxes, etc. This information is reinforced in the second and third year operative courses. Pin kits are available in the undergraduate clinics. They are not used as much as in previous decades. At least one-half the graduating class does not get opportunity to place a pin clinically while in school. Probably due to **a)** reliance on resin bonding for retention **b)** RCT and use of the pulp chamber for retention and **c)** extraction and placement of implant for badly broken down teeth. IUSD seems to be tending towards fewer heroic efforts especially with premolars.
Michigan	No responses given
Midwestern	**a.** Direct Pin Placement xx. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials? 1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice. Pins are included in didactic content, not used in clinic, not an exercise in preclinical simulation
Ohio State	**a.** Direct Pin Placement xxi. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials? Still teaching but no used frequently in clinic.
Pittsburg	**a.** Direct Pin Placement

	xxii. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials? **There is a project in our pre-clinical amalgam course which teaches the placement of pins as a retentive component of an amalgam restoration. For this exercise, students must place pins in a mounted natural tooth. In our clinic, we utilize the Stabilok system. However, very few of our restorative instructors use pins as a retentive supplement.** 1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice**. I believe that in certain clinical situations placement of a pin is a good option to increase retention of a restoration or core built up.**
UIC	**a.** Direct Pin Placement In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials? There is one IDS/lecture session and one pre-patient care clinic session regarding pin-retained restorations. Pin retained restorations are very rarely placed in patient care clinics. Resin composite is the material of choice for buildups, when indicated, prior to indirect restorations.
West Virginia	**a.** Direct Pin Placement xxiii. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials? 1. The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice. Amalgam: Pin placement as well as other auxiliary retention is taught in pre-clinic amalgam/operative course. Pins may be placed in clinic at the discretion of the supervising faculty. Maxpin system used. Also use amalgabond plus. Composite: no pins

	Students pre-clinically complete exercise for pin placement with complex amalgam preparation and restoration for PA. Also do flattened natural tooth exercise where place retentive pin, amalgampin, slot.
Western Ontario	No responses given

xxiv. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?

xxv. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

xxvi. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

Buffalo	i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? **Depending on the size of the amalgam (if it's large) and repair necessary (small), repairs are allowed with amalgam restoration with appropriate retentive forms or glass ionomers in case of class V. Depends on the clinical situation and judgement of the supervising faculty.** ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? **Repairs are allowed with resin depending on the extent of caries and the size of the restoration. Depends on the clinical situation and judgement of the supervising faculty. Total etch technique is used.** **b.** Clinical Guidelines – Amalgam/Resin xxvii. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? **Amalgam is the material of choice when a tooth cannot be <u>isolated</u> properly for moisture control. <u>Esthetic concern</u> is also a factor for anterior teeth and composite is the choice. Amalgam is selected over composite on posterior <u>large size</u> restorations when the extent of preparation is <u>subgingival</u>.**
Case Western	No responses given

Detroit Mercy	**a.** Restoration Repair xxviii. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? **At Detroit Mercy Dental, students are expected to replace the restoration. Repair may be done in an isolated incidence** xxix. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? **At Detroit Mercy Dental, students are expected to replace the restoration. Repair may be done in an isolated incidence** **b.** Clinical Guidelines – Amalgam/Resin xxx. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? **At Detroit Mercy dental, students are expected to restore large size restorations (cuspal build-up) using amalgam and minimally invasive preps are restored using resin composite**
Indiana	**a.** Restoration Repair xxxi. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? IUSD allows the repair of a defective amalgam with composite resin. How margin defects are handled is determined by the clinical attending based on location, size, isolation, use of the tooth in the treatment plan, etc. xxxii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? Yes, IUSD allows the repair of a defective composite with a composite resin. How margin defects are handled is determined by the clinical attending based on location, size, isolation, use of the tooth in the treatment plan, etc. **b.** Clinical Guidelines – Amalgam/Resin Does your school have guidelines as to when amalgam vs composite resin restorations are placed? No formal undergrad published guidelines. Clinical attending faculty make determination of material usage based on clinical judgment.

Michigan	No responses given
Midwestern	**a.** Restoration Repair xxxiii. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? Usually total restoration replacement for defective amalgam xxxiv. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? Repair allowed on a case by case basis **b.** Clinical Guidelines – Amalgam/Resin xxxv. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? Yes, amalgam is supposed to be used when moisture control can not be achieved, and is recommended for posterior teeth where the gingival margin is apical to the CEJ. But this depends upon faculty who tend to follow their own clinical judgement rather than guidelines.
Ohio State	**a.** Restoration Repair xxxvi. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? Both depending on faculty recommendation but usually repair with amalgam. If a crown is going to be placed and the restoration was not placed in our clinic within the last two years, the restoration will be replaced. xxxvii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? Both depending on faculty recommendation. **b.** Clinical Guidelines – Amalgam/Resin xxxviii. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? Yes.
Pittsburg	**a.** Restoration Repair xxxix. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? **We have no specific protocol for this issue but leave the decision to the**

	restorative instructor on the clinic floor. Some instructors will practice conservative dentistry and allow a defective margin to be repaired. Others will want the entire restoration replaced. xl. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? **We have no specific protocol for this issue but leave the decision to the restorative instructor. In this scenario, if the remaining composite restoration is fine most instructors will just have the student repair the defective margin with composite material.** **b.** Clinical Guidelines – Amalgam/Resin xli. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? **No. However, in many cases our students do not educate their patients sufficiently as to the advantages and disadvantages of each type of material. Many of our students do not let the patient make the decision which is the opposite of what they are told in the composite course lecture. Students are too entrenched with the idea that posterior teeth should be restored with amalgam and anterior teeth with composites. This characteristic may come from the pre-clinical amalgam course director who is very pro amalgam.**
UIC	**b.** Restoration Repair i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? Although it is not in our restorative department philosophy yet, we do repair amalgams in occasions when the restoration will not be able to be replaced once removed. We repair with amalgam by making a preparation within the amalgam with retention features like dovetails, or coves. In few instances, we have also repaired amalgam margins with GI.

	ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? We do consider repair depending on the reason. If the restoration is failing due to caries and the carious lesion is superficial or there is a stained margin we will attempt repair by cleaning the defective margin/area and following the total etch technique and placement of a flowable composite. If the carious lesion requires extension for convenience form, the restoration will be replaced. It is a case by case decision. **c.** Clinical Guidelines – Amalgam/Resin i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? We do have a restorative philosophy document that is in the process of revision. **Amalgam** is indicated for: - the moderate to large restoration of Class I and II defects when the faciolingual width of the cavity preparation is no greater than half of the distance between the primary grove and the cusp tip. -When rubber dam isolation is not possible for composites. -On a tooth that serves as an abutment for a removable partial denture. Amalgam is the preferred restorative material for clinical situations that exceed those identified for posterior composites. The primary indications for use of **resin composite** for direct posterior restorations are to achieve a more esthetic result and to conserve healthy tooth structure. Resin composite should not be viewed as an amalgam substitute. Resin composite has clear indications that determine the most appropriate application in posterior teeth based on the best available evidence and an understanding of the physical and mechanical limitations. These include: 1. Restoration of primary Class I and II lesions requiring conservative cavity preparations when the margins will be located in enamel 2. Esthetically important premolars and molars

	• The tooth to be restored MUST be isolated by placement of a rubber dam • Gingival cavosurface margins MUST be located on intact enamel • Cuspal replacement with resin composite is NOT appropriate • Centric occlusal stops should be on enamel.
West Virginia	**a.** Restoration Repair ii. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement? Minor repairs done at the discretion of the supervising faculty (no specific protocol). Depends on the scenario. Repair more likely when restoration is very large, replacement if is small. Glass ionomers/ RMGIs in class Vs. iii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement? Repairs permitted- taught that must HFl etch the composite (phosphor etch not strong enough) and bond. **b.** Clinical Guidelines – Amalgam/Resin iv. Does your school have guidelines as to when amalgam vs composite resin restorations are placed? Amalgam is preferred for posterior cores if there is adequate retention. Otherwise, is at the discretion of the supervising faculty. Amalgam if isolation is an issue.
Western Ontario	No responses given

IX. Assessment

a. Clinic Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment?

ii. Do you believe that it should be?

iii. How do you assess their productivity?

Buffalo	**a.** Clinic Productivity iv. Is the clinic productivity of your student a graded element in their clinical progress assessment? **In some courses** v. Do you believe that it should be? **NO** vi. How do you assess their productivity? **CPUs**

Case Western	No responses given
Detroit Mercy	**a.** Clinic Productivity vii. Is the clinic productivity of your student a graded element in their clinical progress assessment? **No, wasn't factored in until now however it will be with the new model** viii. Do you believe that it should be? **No** ix. How do you assess their productivity? **Indirectly by CPU's**
Indiana	**a.** Clinic Productivity x. Is the clinic productivity of your student a graded element in their clinical progress assessment? xi. *Yes, for the most part. All? Of our clinical competencies have a minimal number of procedures as a prerequisite for the competency exam. In a number of course, those minimal number of procedures are the course requirement and grade. Operative clinic grade depends on the cumulative number of 2000 code procedures done. We do have a set number of expected Comp Care points per semester, although that can be lowered depending on the class's achievement and patient availability. This point total does allow students a great deal of flexibility in the procedures they accomplish in a semester.* Do you believe that it should be? *Yes, in one way or another. Individual's raise to meet what is expected. With no expectations, achievement/ productivity would likely diminish. Expectations of procedures, attendance, production in dollars, etc give them a bar to reach/ exceed.* xii. How do you assess their productivity? *We currently do it by points and procedures as a measure of their production.*
Michigan	No responses given
Midwestern	**a.** Clinic Productivity xiii. Is the clinic productivity of your student a graded element in their clinical progress assessment?

	Not yet - but is under consideration currently xiv. Do you believe that it should be? It should be part of progress, but not weighted heavily xv. How do you assess their productivity? Case completions, case complexity, contact time with patients
Ohio State	**a.** Clinic Productivity xvi. Is the clinic productivity of your student a graded element in their clinical progress assessment? Part of their grade. This has been changing. The productivity is determined evaluating a student's utilization, accountability, relative value points earned, and money produced. xvii. Do you believe that it should be? Yes xviii. How do you assess their productivity? Production total (student's utilization, accountability, relative value points earned, and money produced) for the semester.
Pittsburg	**a.** Clinic Productivity xix. Is the clinic productivity of your student a graded element in their clinical progress assessment? **Not clinical productivity but the number of patient appointments.** xx. Do you believe that it should be? **Yes.** xxi. How do you assess their productivity**? We do not directly assess their productivity from a monetary aspect. However, we do assess the number of patients that they treat during their clinic time. This does not include any patients seen when they are on rotations. When the patient is seated in the dental chair, the student receives a Start Check approval in axium from their instructor. The Start Check is given regardless of the procedure to be rendered. For example, a denture adjustment is given the same Start Check as a crown preparation. The number of Start Checks per semester is a component of the grading rubric for the course.**
UIC	**a.** Clinic Productivity i. Is the clinic productivity of your student a graded element in their clinical progress assessment? Students are graded on

	educational experiences utilizing a relative value unit system, RVU, rather than productivity. In this way, services without a fee value such as risk assessment and preventive care is captured and measured. xxii. Do you believe that it should be? Our belief is that educational value is not always measured via financial productivity, and thus we do not believe in this mechanism as an assessment and grading tool. xxiii. How do you assess their productivity? We utilize detailed reports which indicate procedures by code and combine RVU acquisition and varied experiences via code distribution to assess "productivity".
West Virginia	**a.** Clinic Productivity xxiv. Is the clinic productivity of your student a graded element in their clinical progress assessment? Yes-procedural—NOT financial. There are benchmarks for 3rd and 4th yr for # of procedures and number of performance assessments expected, and minimum experiences required for graduation as well as WVUs---weighted value units. For each clinical session, time management is evaluated. Productivity is part of a time management evaluation--- completing what is expected in the time allotted for the student's level of experience xxv. Do you believe that it should be? In regards to the manner above, yes. Need minimum # of experiences necessary to achieve competency, which is different for different students. xxvi. How do you assess their productivity? Part of their evaluation in Axium at the end of each clinical session, and axium tracks number of each procedures to evaluate reaching benchmarks as well. Team Leaders monitor and encourage students to help ensure they achieve expected minimum experiences
Western Ontario	No responses given

X. Administration

a. Attendance Policy

i. Describe the attendance policy for your school's students.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

ii. Is the policy enforced?

iii. Do you feel that this policy is fair?

iv. Do you feel that the policy is appropriate?

Buffalo	**a.** Attendance Policy v. Describe the attendance policy for your school's students. 1. Please quote the actual attendance policy as outlined in your Academic Affairs manual. **Attendance and Absence Policy of University at Buffalo** Attendance at scheduled classes, laboratory sessions, clinical assignments (including rotations), and examinations is mandatory. Absence from any of these activities can negatively affect knowledge, skills and grades. The School acknowledges, however, that occasional absences will occur and that some of these will be unpredictable. Fairness requires that students know the absence policies for their classes, and that to the maximum extent reasonably feasible there be alternatives permitting students to make up required course activities from which they are justifiably absent. The responsibilities of faculty and students are: Every Course Director shall provide to students a course syllabus during the first week of class that specifies attendance policies and dates and times for classes, exams and all other required activities. Instructors shall provide reasonable alternatives to students for required course activities from which they are justifiably absent. Instructors shall observe University policy when scheduling class activities, which states that classes are to meet at the time and on the campus published in the schedule, unless changed with the consent of the entire class. Students may be justifiably absent from classes due to religious observances, illness documented by a physician or other appropriate health care professional, public emergencies,

	documented personal or family emergencies and conflicts with University sanctioned activities. University sanctioned activities include, but are not limited to, presentations and other official representation at professional meetings, and BOCA outreach events. Course directors may require students to provide certification of such activities by an appropriate senior administrator, e.g., the Associate Dean for Academic Affair s or Associate Dean for Student Affairs (DDS) or the Associate Dean for Advanced Education or Program Director (Advanced Education). Students are responsible for the prompt completion of any alternative assignments. The student is responsible for notifying the instructor in writing with as much advance notice as possible of required absences, preferably at the beginning of the course. Students must also notify the Clinic Group Director (DDS) or the Program Director (Advanced Education), if the absence includes clinic, and the appropriate dental unit, if the absence includes a clinical rotation. Students are responsible for informing their assigned patients of appointment cancellations and re-appointments in a timely manner. It is recognized that absences, especially for illness, emergencies, or University sanctioned activities, may not be known at the beginning of the semester. Dental students who are absent from school because of illness, injury or other extreme circumstance should contact the Office of Student Affairs (829-2839) (DDS) or their Program Director (Advanced Education) as soon as possible so that administrative representatives can inform instructors of their absence. Illness of more than two days' duration may require medical documentation. **Other Absences** Unfortunate circumstances such as automobile problems, traffic congestion, faulty alarm clocks, etc. are not considered justifiable reasons for absence. In such cases, students are bound by the attendance requirements of the course(s) and/or clinic(s) from which they were absent, and the Course Director has the discretion to decide on an individual basis whether to allow remediation. **Patient Care Considerations**

	Absences involving clinic or rotation assignments are subject to patient care considerations. If the clinic or rotation director determines that an anticipated absence will negatively affect patient care, such absence may not be approved. Similarly, permission for such absence may be denied by a clinic group director (DDS) or a Program Director (Advanced Education) if it is determined that the student is significantly deficient in his or her clinical requirements. vi. Is the policy enforced? **YES** vii. Do you feel that this policy is fair? **YES** viii. Do you feel that the policy is appropriate? **YES**
Case Western	No responses given
Detroit Mercy	**a.** Attendance Policy ix. Describe the attendance policy for your school's students. 1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.**Will send the document** x. Is the policy enforced? **Yes** xi. Do you feel that this policy is fair? **Yes** xii. Do you feel that the policy is appropriate? **Yes**
Indiana	Indiana University: The DDS attendance policy for courses in which students are enrolled will be left to the discretion of the course directors. The syllabus must clearly state the attendance policy for each course. As professionals, students are expected to be present and punctual for classes and clinical activities. • **Student Absence** o It is understood that students must occasionally be absent from class for unavoidable personal reasons. Students are expected to contact the Office of Admissions and Student Affairs at oasamail@iupui.edu or 317-274-8173 as early as possible to report an absence. OASA will then notify course directors regarding the absence and its general nature. It is the responsibility of the student to coordinate missed assignments or makeup quizzes with course directors and other involved faculty in a timely fashion. A student who is absent and fails to communicate with course directors in a timely manner regarding missed assignments is accountable for any negative outcomes based on the attendance policy of the course director. OASA only determines whether an

absence is excused or unexcused when an assessment is involved. Please see the section below, "Assessment Absence," for the appropriate procedures when an absence causes a student to miss an assessment.

- **Assessment Absence:**
  - Except for extenuating circumstances, students are prohibited from missing any type of assessment unless excused by the Associate Dean for Admissions and Student Affairs. If the request for an excused absence is determined to be valid, the course director(s) will be notified and the student will be required to make arrangements for alternate assessment date(s). In the event of a recurring pattern of illness, the student may be required to provide documentation from the health care provider of record to the Associate Dean for Admissions and Student Affairs.
  - Below is a list of acceptable and unacceptable reasons for missed assessment(s). This list is not exhaustive and each case will be considered by the Associate Dean for Admissions and Student Affairs. [Source: OASA 5/12/15]

Acceptable Reasons for Assessment	Unacceptable Reasons for Assessment Absence
Illness	Holiday Plans
Military Duty	Travel Arrangements
Jury Duty	Alarm Clock Malfunctions
Death in the immediate family	Wedding Planning
Victim of recent serious crime	Sport and Leisure Activities
Quarantine	Lack of Child Care
	Vacations (including those pre-

- **Absence Due to Participation in Student and Service Organizations**
  - Students who are in good academic standing (e.g., no probation, professional misconduct) are encouraged to participate in local, regional or national student organizations such as ASDA, ADEA, AADR, SPEA or in service-related activities for IUSD. When travel is involved, students must complete a Student Travel Form (see the **Student Travel** section of this handbook and **Appendix P**.)
- **Attendance and Religious Holidays**
  - IU respects the right of all students to observe personal religious holidays and will make reasonable

accommodation, upon request, for such observances. Any student who is unable to attend class or participate in any examination, study or course requirement on such days due to religious beliefs will be given the opportunity to make up the work that was missed or do alternative work that is intrinsically no more difficult than the original assignment or examination. If possible, students should submit the IUPUI religious observance request form to the Office of Admissions and Student Affairs by the end of the 2nd week of the semester so that any potential accommodations can be arranged. OASA will send notification of the approval to faculty and clinical directors. It should be noted that while campus policy requires faculty to make reasonable accommodations for missed assignments or examinations in observance of religious holidays, it is NOT campus policy for faculty to make accommodations when students wish to travel to share a holiday with family and/or friends.

- **Clinical Attendance**
  - Clinic attendance levels will be determined and monitored by the Office of Clinical Affairs. Students falling below the required level of productivity and participation are subject to disciplinary action, up to and including dismissal. When students are accused of or caught violating provisions of the Clinical Manual, the Associate Dean of Academic and Clinical Affairs has the right to suspend students from all clinical activity pending final results of the professional conduct and appeals processes. Given that violations of policies and procedures governing the clinics can impact patient health, impair student safety and impact school liability, clinical suspensions are not subject to appeal. However, before the Associate Dean of Academic and Clinical Affairs can suspend students from all clinical activity, he or the Associate Dean for Admissions and Student Affairs must interview them to hear their explanation of the problem(s).

xiii. Is the policy enforced?

Indiana University:Most faculty would say *no.*

xiv. Do you feel that this policy is fair?

Indiana University: *Overall most of the faculty do not like the attendance policy because it is places the course directors in a position which they appear as the "bad guy" and the majority of the*

	effort relies on the course directors to make accommodations for these students. xv. Do you feel that the policy is appropriate? Indiana University: *Again, most faculty would like more support from the administration on the attendance policy. The system is too lenient for students. Currently, IU is experimenting with a new program. Top Hat is a classroom engagement software that we are piloting this semester with 6-7 faculty. Top Hat is a student response system allows faculty to upload PowerPoint presentations into the platform and create questions to engage students during a class session. During class, students respond using any device available to them (e.g. smart phone, tablet, laptop). Another feature of Top Hat is its point-in-time attendance management feature, which allows faculty, at any time during the presentation, to take student attendance. The attendance "window" is open for a set amount of time, which is determined by the faculty. One way in which this feature could potentially improve student attendance, is to tie the point-in-time attendance capture to a grade. Top Hat seamlessly integrates with the Canvas LMS, so a professor could potentially assign a point value to the attendance portion of the class and link the attendance statistics from Top Hat to a graded assignment in Canvas.*
Michigan	No responses given
Midwestern	**a.** Attendance Policy xvi. Describe the attendance policy for your school's students. 1. Please quote the actual attendance policy as outlined in your Academic Affairs manual. The College of Dental Medicine – Illinois (CDMI) has the responsibility to prepare its students both academically and clinically for the practice of dentistry. Successful knowledge- and skill-based development requires continuous attendance in all classes, instructional sessions and simulation clinic assignments, as designated by the curriculum schedules. The Dental Medicine coursework is rigorous and students should be aware that one (1) week equals ~10% of an entire course content or simulation clinic experience. CDMI students are expected to demonstrate professional behavior in complying with this attendance policy by attending all classes and

	imulation clinic sessions as indicated on their schedules. Students must lso separately follow the "Policy Regarding Absence from Mandatory Attendance Events" found in the "IBSS Common Course Policy". CDMI is not responsible for students' missed time and Course Coordinators are not required to provide individual make-up sessions or any coursework, simulation clinic experiences, assessment or examination that a student has missed due to an absence. It is at the liscretion of the Course Coordinators to allow a student to make-up nissed course work, assessments or examinations. **Students should be ware that protracted absences may result in the interruption nd/or delay of the student's coursework, and may impact progress nd advancement through the program.** **Didactic Sessions** Students are expected to be in attendance for ALL scheduled didactic essions. Course Coordinators have the prerogative to require ttendance at certain non-repeatable and/or essential didactic sessions. **Simulation Clinic Sessions** Attendance at all simulated sessions (e.g. simulation clinic sessions, tandardized patient experiences) is **mandatory.** Attendance is tracked y Course Coordinators, based on information received from the aculty. Students are required to be in attendance for the entire duration f the session. Students who wish to leave early must obtain permission rom the session coordinator. Observed trends in late arrivals and/or arly leaves could lead to a recorded absence. Protracted or frequent absences may lead to an "Unsatisfactory" grade n Professionalism and overall course failure, with consequent impact n academic progress. Attendance records will be examined at the conclusion of each quarter and taken into consideration when letermining final course grades. **Clinical Rotations** All Clinical Rotations scheduled for the MultiSpecialty Clinic (Dental nstitute) are mandatory. Attendance and assessments will be erformed during each of the clinical sessions. The assessments will be graded Pass/Fail. There will also be a Professionalism component due o the simulated patient care component of the rotations. **Notification of Absences**

	The student MUST report his/her absence by e-mail, directly to the Course Coordinators, as soon as possible. **Notification of an absence does not imply approval for the absence.** Course Coordinators are responsible for notifying the students' supervising faculty member and the Office of Academic Affairs about the absence. Students are accountable for reporting absences and failure to self-report an absence as described herein may result in the generation of a written report and an unsatisfactory grade in Professionalism. Students must include the following information in the email, when reporting an absence: 1. First and last name. 2. Year of study 3. Reason for the absence 4. The expected date of return to the University. The student is required to submit a physician's note-report (from a non-family member) if ill on the day of an examination or absent more than two (2) consecutive days. It is the responsibility of the student to ensure that the physician's note-report reaches the Course Coordinator within 48 hours. If an examination or test is conducted during an absence, it is at the discretion of the Course Coordinator to determine if a make-up examination will be conducted. If the request for a make-up examination or test is granted, there will be an automatic 10% deduction of overall points/score for that missed examination or test. The format (e.g. essay, short-answer, or oral) of such examination will be determined by the Course Coordinator. Missed simulation clinic performance assessments MUST be made up by the end of the quarter. **Multiple Absences** Absences from lectures, labs or simulation clinic sessions may be considered sufficiently serious to warrant a report related to unprofessional behavior. Protracted or frequent absences may lead to an overall course failure, with consequent impact on academic progress. The Student Academic Progress Committee may review absences of any student to determine any compromise to the integrity and continuity of the student's education. Numerous absences may be cause for additional action by the administration of the College and/or the University. Consequences include required remediation, leave of absence or dismissal.

	xvii. Is the policy enforced? More or less, yes. It is up to the course directors to enforce xviii. Do you feel that this policy is fair? Yes xix. Do you feel that the policy is appropriate? No, most of the faculty want to have mandatory attendance for lectures, pre clinical simulation clinic and for clinics. The administration is reluctant to state a mandatory and tracked attendance
Ohio State	**a.** Attendance Policy xx. Describe the attendance policy for your school's students. 1. Please quote the actual attendance policy as outlined in your Academic Affairs manual. Attendance policy is attached at the end of this document. It is 7 pages long. xxi. Is the policy enforced? yes xxii. Do you feel that this policy is fair? yes xxiii. Do you feel that the policy is appropriate? Needs to be stricter.
Pittsburg	**a.** Attendance Policy xxiv. Describe the attendance policy for your school's students. Please quote the actual attendance policy as outlined in your Academic Affairs manual. **"The faculty and administration of the School expect every student to attend all scheduled lectures, seminars, laboratory sessions and clinic assignments, except in the event of illness, emergency, or approved School sponsored activity.** **Regular class attendance is a student obligation, and a student is responsible for all work, including tests and written work, of all class meetings. Excessive absenteeism, as determined by the course director, could have an adverse effect on a student's performance. The course director will describe, in writing, his or her class attendance policies at the beginning of the course. Pursuant to this policy, in a course where attendance is mandatory and utilized in the grading process, a faculty member must have a systematic method of monitoring student attendance and a stated process for factoring excessive absences into the**

	student's grade or any recommended remedial activity. Students should notify their course instructors and the Office of Student Affairs (412-648-7471) of illness, death in the family, or other unusual circumstances that may necessitate being absent from classroom, laboratory or clinical assignments of one day or longer." xxv. Is the policy enforced? **Mostly, yes but some cases need to be dealt with on an individual basis.** xxvi. Do you feel that this policy is fair? **Yes** xxvii. Do you feel that the policy is appropriate? **Yes**
UIC	**a.** Attendance Policy xxviii. Describe the attendance policy for your school's students. 1. Please quote the actual attendance policy as outlined in your Academic Affairs manual. Attached xxix. Is the policy enforced? For most of the situations, we follow our attendance policy. For lectures, we do not always take attendance during lecture times. We do it randomly through quizzes, class exercises or participation activities. We have discussed to use our automated response software in our college. xxx. Do you feel that this policy is fair? Yes xxxi. Do you feel that the policy is appropriate? Yes
West Virginia	**a.** Attendance Policy xxxii. Describe the attendance policy for your school's students. (Mostly 1st and 2nd year) 100% attendance is required to all lectures and labs. Only University excused absences or approved trips for school functions are exceptions; prior notice must be given for school functions/trips. 3rd and 4th year- 95% attendance is required. It is tracked in axium. If student has 95 % up until last semester, they can miss more as long as meeting benchmarks/minimum requirements. If any term a student does not have 95%, they must have 100% each term thereafter.

	1. Please quote the actual attendance policy as outlined in your Academic Affairs manual. See attached xxxiii. Is the policy enforced? Yes- syllabi reiterate circumstances of absence. xxxiv. Do you feel that this policy is fair? Yes xxxv. Do you feel that the policy is appropriate? Yes
Western Ontario	No responses given

b. Millennial Students

xxxvi. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

xxxvii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

xxxviii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

xxxix. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

Buffalo	**a.** Millennial Students xl. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? **No formal faculty development program is offered. However, faculties are calibrated to teach in a standardized manner through general information sessions and faculty meetings.** xli. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? **NO** xlii. Are there any special teaching techniques or styles that seem to work better with the new generation of students? **Flipped classroom structures, video lectures, incorporation of digital teaching tools, exams via Examsoft and small group sessions are playing an effective role.** xliii. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? **Yes. There are numerous sessions within courses plus Standardized Patient m-OSCES that detail this important topic. Also, several lectures for professionalism.**

Case Western	No responses given
Detroit Mercy	**a.** Millennial Students xliv. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? **No** xlv. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? **Yes, the results are out with mixed opinions about the new model.** xlvi. Are there any special teaching techniques or styles that seem to work better with the new generation of students? **We tried flipped classroom, tooth atlas but students seem to like the traditional method over contemporary** xlvii. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? **Yes**
Indiana	**a. Millennial Students** xlviii. **Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?—They have done various ones in the past at our fall faculty conferences and they encourage faculty to gain information from the center for teaching and learning (CTL) at the university. For the most part, some faculty obtain new ideas from programs such as the ADEA annual session. However, it's a big enough issue that more should be done to educate faculty on a somewhat regular basis.** **That said, myself and 3-4 other faculty members have looked into the medical school model at IU for incoming students. They offer a "transitions" course for students at 3 intervals; beginning, 2nd to 3rd year, and then again from 4th year to residency. They seek to prepare students and this current generation for success by acclimating them better to the rigors and new climate they will experience. As a result, we just began our own pilot**

	program this year for transitioning beginning DDS students. xlix. **Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?—Usually there are not any surveys taken other than evaluations unless a faculty member is specifically attempting to look at outcomes for the new program or teaching style they developed. We did this when we incorporated ipad technology in the lab for teaching pre-clinical students.** **I am currently working with 2 students that are doing the ADEA fellowship program. They've been working with me on ideas for the transitions course. For their project, we submitted an ADEA abstract based on surveys we had students complete; the D2's who had no special program and the D1's who completed it. Thus far, the results are positive and promising from what faculty can see.** **Findings/Conclusion: The study revealed 33.3% of students believed that the amount of time spent on laboratory work was more than expected. Additionally, 47.1% of respondents stated that time spent on didactic work was more than expected. Based on the preliminary findings, our hypothesis may be supported that there is a need for a transitions program, as many students felt that the curriculum demanded more of them both didactically and within the laboratory than they expected. Further research will examine the benefits that the class of 2021 may experience given participation in a transitions pilot program.** i. Are there any special teaching techniques or styles that seem to work better with the new generation of students? *Yes, many faculty believe that they respond best when they are expected to not only attend, but participate in the class sessions. While we no longer have formal small groups in our curriculum, think, pair, share activities still stimulate good discussion and use of video scenarios grab attention and interest. Our course surveys support this. The more we can provide experiential learning the better. They also as expected would do better with shorter learning sessions of 50 mins then our curriculum set up in 3 hr blocks.*

	ii. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? **Indiana University:** *Yes, a number of us participated in a formal "transitions" component during the T520 course this year. This focused on expectations, didactic/hand-skill strategies, pitfalls and professionalism as key conceptual differences of health professions education distinct from other curricular environments.*
Michigan	No responses given
Midwestern	**a.** Millennial Students l. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? A few sessions li. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? No, not unless individual faculty do it independently lii. Are there any special teaching techniques or styles that seem to work better with the new generation of students? Not sure liii. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? Yes there is a communications course which focuses around communication with faculty, patients, other health professionals
Ohio State	**a.** Millennial Students liv. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? Yes. At Faculty Forum Meetings.

	lv. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? No. lvi. Are there any special teaching techniques or styles that seem to work better with the new generation of students? Very visual, do not read or write well. lvii. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? Maybe at orientation.
Pittsburg	i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? **Yes. We have had a few speakers address this issue during faculty development seminars.** ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? **No** ii. Are there any special teaching techniques or styles that seem to work better with the new generation of students? **Yes. Some newer concepts for teaching include POGIL (Process Oriented Guided Inquiry Learning), the flipped classroom and the use of Panopto to video record lectures. When I first tried to incorporate POGIL into my course the students gave a sigh of disgust. The students from past experiences did not think it was valuable tool. My opinion on one huge way many instructors fail is that they do not convince or even tell the students why their course is important or relevant. Students will respond positively to a course if they understand it's value. If the course is useless students will likewise react negatively. I believe any course we have the students take should meet one of the following three goals. 1) educate the students so they can graduate and be prepared to practice general dentistry 2) give the best possible treatment to our patients 3) help the students to pass the board examinations. My personal experience is students appreciate stories applicable to situations they will face later in the clinic, private practice or life. Students enjoy to hear both good and bad experiences a person has been exposed to as a clinical dentist.**

	v. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? **Not related to student/faculty interaction.**
UIC	**a.** Millennial Students lviii. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? Six years ago our DMD curriculum changed to a case-based learning curriculum with small group setting lead by facilitators. All faculty who participated in the new curriculum had the opportunity to receive training regarding their role as facilitators. The teaching format has focused on small group activities, more interactive didactic sessions and student huddles before starting a preclinical activity. lix. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? No lx. Are there any special teaching techniques or styles that seem to work better with the new generation of students? With the new curriculum, we try to replace large lectures for interactive didactic (ie. Using clickers). We also do flipped classrooms and peer teaching. Students show preference for prerecorded lectures. lxi. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? Students receive a variety of lectures in ethics and professionalism were they discuss different scenarios regarding student/faculty interaction. Also our Academic Dean is working on "positive Environment Policy to enhance the interaction amongst all members of the College of Dentistry. This policy has been created with the input from our Students Leadership meetings.
West Virginia	**a.** Millennial Students lxii. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students? Teaching scholars program

	lectures on this topic, for those who participate. Otherwise, only discussion at departmental meetings and faculty retreats. (Teaching scholars program is part of Faculty Development-- WVU Health Sciences Center, ? if there are others for other campuses) lxiii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions? No. There is a senior curriculum survey—students complete upon graduation where they may provide comments/input about anything/everything. lxiv. Are there any special teaching techniques or styles that seem to work better with the new generation of students? Active vs. passive learning, case-based learning, use of interactive technology. Increased Instructor availability seems in demand. Students desire real life demos for skills (preps). Making it personal (relate material to them) lxv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting? Professionalism discussion at new student orientation. Professionalism discussed throughout classes. Also, course DENT 725 Professional Communications- go through patient scenarios and discuss how to communicate with patient and faculty. Discuss Code of Conduct—respect of peers, faculty, and staff.
Western Ontario	No responses given

Regional Meeting Report Form

Region: IV, Great Lakes Region

Host University, Address, and Dates of the 2017 Regional Meeting:

Host University	Address	Dates of Meeting
The Ohio State University College of Dentistry	305 W. 12th Ave, Columbus Ohio 43210	October 12th and 13th 2017

Chairperson and Contact Information for the 2017 Regional Meeting:

Chairperson	University/Address	Phone/email
Michele L. Kirkup	Indiana University School of Dentistry 1121 W. Michigan Street Indianapolis, IN 46202	317-274-5576 mkirkup@iu.edu

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

Contact Person, Host University, and Dates of the 2018 Regional Meeting:

Contact Name Phone/email	Host University/Address	Dates of Meeting
Swati Chitre **313-494-6783** **chitresd@udmercy.edu**	University of Detroit Mercy School of Dentistry	Tentative: October 5 and 6, 2018

Regional Meeting Attendee's Form

Name	University	Phone	email
Michele Kirkup	**Indiana University School of Dentistry**	317-278-5576	mkirkup@iu.edu
Adriana Semprum	**The University of Illinois at Chicago College of Dentistry**	312-996-1811	asemprum@uic.edu
Kim Diefenderfer	**Indiana University School of Dentistry**	317-274-3715	kediefer@iu.edu
Brooke Adams	**Indiana University School of Dentistry**	317-439-2256	bnadams2@iu.edu
Paul Reifeis	**Indiana University School of Dentistry**	317-278-1858	pereifei@iu.edu
Swati Chitre	**University of Detroit Mercy School of Dentistry**	313-494-6783	chitresd@udmercy.edu
Upoma Guha	**University of Buffalo School of Dental Medicine**	716-829-6281	guhau@buffalo.edu
Ron DeAngelis	**University of Pittsburgh School of Dental Medicine**	724-991-5602	rjd43@pitt.edu
Tammy Chipps	**West Virginia University School of Dentistry**	304-293-1245	tchipps@hsc.wvu.edu
D. Stanley Sharples	**The Ohio State University College of Dentistry**	614-688-5808	sharples.3@osu.edu
Janet Bolina	**The Ohio State University College of Dentistry**	614-292-3316	bolina.1@osu.edu
Lisa Lang	**The Ohio State University College of Dentistry**		lang.513@osu.edu

Sarah Mikhail	**The Ohio State University College of Dentistry**		mikhail.9@osu.edu
Rafat Amer	**The Ohio State University College of Dentistry**		amer.23@osu.edu
Sharmeen Chaudhry	**The Ohio State University College of Dentistry**		chaudhry.36@osu.edu
Robert Rashid	**The Ohio State University College of Dentistry**		rashid.1@osu.edu
Dawne Stefanik	**The Ohio State University College of Dentistry**	614-688-4762	stefanik.12@osu.edu
Shilpa Shah	**The Ohio State University College of Dentistry**		shah.755@osu.edu
Gabriela Weiss	**The Ohio State University College of Dentistry**		weiss.178@osu.edu
Kelly Rustico	**The Ohio State University College of Dentistry**		rustico.2@osu.edu
Matthew Messina	**The Ohio State University College of Dentistry**		messina.55@osu.edu

Suggested Questions for 2018 National Agenda

1. How many faculty are available to teach operative dentistry pre-clinical lab and didactic courses?
2. How do you maintain the faculty calibration for all full time and part time faculties who teach the operative pre-clinical laboratory?
3. Do you teach post-placement for endodontically treated tooth in operative courses? Which type of post systems are preferred in your school?
4. Is there any OSCE exam in the operative course in your school?

5. Are clinical procedures given a finite length of time wherein the procedure is expected to be completed? For example - 1 - 1.5 hour for Class II composite

6.

    a. Other than performance examinations, are procedures in preclinical simulation given a finite length of time for completion? If yes, how long is the specified time for the following:

        i. Class II amalgam
        ii. Class II composite
        iii. Full crown preparation

    b. If yes, is there an assessment at the end of the specified time?
    c. Is this assessment a factor in the project or course grade?
        i. If yes, at what point does this time requirement begin? When the student does their first preparations / restorations or closer to entering the clinic?
7. Do you have dental student candidate participate in bench testing for dental prior to entry?
8. What type of caries detection programs/products are utilized:
    a. Preclinical
    b. Clinical
    c. Teaching for the Clinical Boards?
9. Grading scale and remediation policy? Do you think it needs to be changed? Remediation range? How many attempts?
10. Addressing the mental health of students. Fit for participation
11. How does your school allow for accommodations for students with learning disability? For examinations and/or practical?
12. Grades or Points for ergonomics, time management during the clinical sessions

Regional Nominee for Presenting at the 2018 CODE Annual Meeting (Please Include Topic)

Name	Topic	Contact Info

Please return all completed enclosures to:

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

Associate Professor and Chair
Department of General Dental Sciences
Marquette University School of Dentistry
1801 W. Wisconsin Ave.
Rm 336C
Milwaukee, WI 53233

414.288.5409
gary.stafford@mu.edu

Deadline for return: 30 days post-meeting

Please send the requested documents via email with attachments

Attachments for Attendance Policy for Schools

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry Student Attendance #02-01

Applies to: Dental hygiene and dental students

OPERATING PROCEDURE

Issued: 05/09/2016

An operating procedure for dental hygiene and dental student attendance is essential for a common understanding of the responsibilities of students, staff members, course and/or clinic directors, the College's Associate Dean for Academic Affairs, and the Academic Progress Committee. Furthermore, it must ensure accurate and timely communication of student absences to appropriate staff members and course and/or clinic directors so as to support student learning and facilitate appropriate patient care. University policy permits each college to develop its own student attendance operating procedures (University Faculty Rules 335-9-21).

The intention of this operating procedure is to define the expectation for attendance, the circumstances where dental hygiene and dental student absences are excused (allowing the student to make up graded work) and the process for notification regarding absences. Attendance at all course activities and clinical assignments allows students to maximize their educational experience and provide better care of our patients. This operating procedure is designed to empower students, reduce the impact on course and/or clinic directors, increase timely and accurate communication, and increase consistency by defining which types of absences are excused. Moreover, this operating procedure will benefit students, staff members and course and/or clinic directors by simplifying the process of communicating student absences. Multiple absences may impede a student's progress through the curriculum and delay the student's completion of the program. Generally, course and clinical activities occur Monday through Friday from 7:30 am – 4:30 pm, although various out of class assignments, assigned external rotations, and remediation opportunities may have schedules that precede or extend beyond these regular hours.

Definitions

Term	Definition
Planned Absence	An absence that could be reasonably anticipated by the student (e.g., medical appointment, National Dental Board Examination testing, wedding).
Unplanned Absence	An absence that could not be reasonably anticipated by the student (e.g., acute illness, transportation difficulties, oversleeping)
Excused Absence	Absence for which a student will be allowed to make up any graded work missed during the absence without penalty
Unexcused Absence	Absence for which a student may be allowed to make up graded work missed during the absence but may negatively affect the student's grade at the discretion of the course director, as stated in the course syllabus.
Scheduled Course/clinic Activities	Activities whose date and time are listed in the course syllabus distributed to students before or on the first day the course meets.
Immediate Family Member Adapted from the University Office of	Spouse; domestic partner; mother; father; sister; brother; biological, adopted or foster child; stepchild; legal ward; grandparent; grandchild; mother-in-law; father-in-law; sister-in-law; brother-in-law; daughter-in-law; son-in law; grandparent-in-law; grandchild-in-law; or corresponding relatives of the student's partner; other persons for whom the student is legally responsible; and anyone who stood in loco parentis to the student as a child.

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry Student Attendance
#02-01

Applies to: Dental hygiene and dental students

Human Resources Paid Leave Program Policy 6.27	

Procedure Details

1. Class Attendance:
    a. Dental hygiene and dental students are expected to attend all **scheduled course/clinic activities** as determined by the course director and/or clinic director and as stated in the respective course syllabus.
    b. When a course director determines that a dental hygiene or dental student stops attending a course, the Associate Dean for Academic Affairs should be notified as soon as possible (University Faculty Rules 335-9-21).
2. Student Absences
    a. General
        i. It is the responsibility of the dental hygiene or dental student, as directed by the course and/or clinic director to which the work pertains, to work with appropriate course and/or clinic directors and staff members to complete all missed work and clinic responsibilities due to an absence.
        ii. If a dental hygiene or dental student fails to complete all missed work and/or clinic responsibilities as outlined by the course and/or clinic director before the end of the term, the student may receive an incomplete (I) or failing grade in the course depending upon the extent and nature of the missed work and/or clinic responsibilities.
        iii. If recreating a course activity that a dental hygiene or dental student misses for excused or unexcused reasons would be difficult due to cost, availability of equipment or other reasons, the course director may provide an alternative activity that will meet the educational objectives of the original activity.
        iv. If a dental hygiene or dental student is on a rotation to an external clinical experience, such as for the OHIO Project, the student will follow the schedule of that external clinic. For **planned absences** that involve a student's attendance at an external clinic, it may be possible for the student to reschedule his/her rotation through the clinic scheduler/OHIO Project assistant if done early enough.
        v. Excessive absences, planned or unplanned, may result in a dental hygiene or dental student being unprepared and therefore unable to move forward in the curriculum or to graduate. This determination will be made by the Academic Progress Committee.
    b. Planned Absences
        i. General
            1. Whenever possible, dental hygiene and dental students must schedule these events or activities at times that do not conflict with required course/clinic responsibilities. A planned absence in which a student could

reasonably schedule so as not to conflict with a significant graded course activity will not be excused.

2. For all planned absences, the Office of Student Affairs must be notified as far in advance as possible but at least 2 weeks before the planned absence, except for religious holidays as indicated below.
3. The Office of Academic Affairs will consult with course and/or clinic directors to determine the courses for which planned student absences would not be excused. An example might be courses that are densely scheduled in a short period of time.

ii. Excused Absences

1. College-related business – When dental hygiene or dental students attend events or activities on behalf of the college, their absence is excused. Examples may include presenting student research results at IADR/AADR, ADHA, or ADEA meetings, attending a national conference for a national student organization, participating at an event or activity at the request of the college administration. Participation of a dental hygiene or dental student in these activities must be approved by the Chair of the Division of Dental Hygiene or the Office of Academic Affairs respectively, in consultation with the directors of the affected courses before the event occurs.
2. Interviews – As dental hygiene and dental students prepare for careers after graduation from the college, they may need to attend interviews at locations outside of the College of Dentistry. Students will be granted **excused absences** by the Associate Dean for Academic Affairs (in consultation with the Chair of the Division of Dental Hygiene for dental hygiene students) for a reasonable number of interview days based upon individual circumstances, such as the type of post-graduate opportunity and timing of the interview days.
3. National Board Dental Examinations – Dental students are required to pass Part I of the National Board Dental Examination as a condition of their continued participation in clinical activities and they must pass Part II for graduation. Therefore when dental students take the national board exams, their absence is excused. Dental Hygiene student are not excused from class to take the National Board Dental Hygiene Exam unless they have permission from course directors when no other options are available.
4. Religious Holidays – It is the policy of The Ohio State University and the intent of the College of Dentistry that students be granted excused absences from class, clinics, and exams to observe religious holidays.
    a. The Office of Academic Affairs will consult with the dental hygiene or dental student, the student's course and clinic directors, and the Division of Dental Hygiene for dental hygiene students to determine which religious holidays will be excused.

b. Notification of the absence should be made no later than one month before the beginning of the term in which the religious holiday is to be observed by the student.

5. Civic/Military Duty/Subpoenas – When dental hygiene or dental students are required to participate in military activity and/or civic responsibilities (e.g., absence resulting from receiving a subpoena or from jury duty that cannot be rescheduled), they will be granted an excused absence, or a leave of absence if more appropriate, as determined by the Associate Dean for Academic Affairs. Absence due to voting in local, state, or national elections will not be excused.
6. If a dental hygiene or dental student is in good academic standing, a planned absence for other reasons may be excused as determined by the Associate Dean for Academic Affairs in consultation with the student's course and/or clinic director and the Chair of the Division of Dental Hygiene for dental hygiene students.

c. Unplanned Absences
   i. General
      1. Dental hygiene and dental students may need to be absent from class/clinic responsibilities unexpectedly. For such an absence to be excused, students must notify the Office of Student Affairs as soon as possible.
      2. Excused Absences
         a. Personal illness – When a dental hygiene or dental student becomes ill and unable to attend class/clinic due to this illness, they should seek medical care. Documentation from an appropriate health care provider may be required by the Office of Student Affairs for the absence to be excused.
         b. Family illness – When **immediate family members** who are dependent upon the student for their care are ill, it may be appropriate for the student to be absent to care for the immediate family member. Documentation of the dependence of the immediate family member may be required by the Office of Student Affairs for the absence to be excused.
         c. Personal/Family Emergency – Documentation of the reason for this absence may be required by the Office of Student Affairs. Examples of this could include, but are not limited to, the following:
            i. Transportation issues not in the control of the student (e.g., car accident)
            ii. Death of immediate family member
            iii. Unexpected childcare issues
      3. Other reasons for an **unplanned absence** may be excused as determined by the Associate Dean for Academic Affairs in consultation with the student's course and/or clinic directors and the Chair of the Division of Dental Hygiene for dental hygiene students.

d. Unexcused Absences (planned and unplanned) The consequences for missing class sessions or activities without an excused absence are determined by each course director and provided in the course syllabus. These consequences could include, but are not limited to, the following:
    i. If a student misses more than a specified number of course activities as stated in the course syllabus without excused absences and fails the course, then the student must retake the course at the next offering, i.e., there would be no opportunity for remediation.
    ii. If a student misses a graded activity in the course without an excused absence, the student may participate in the graded activity at a later date but the score may be reduced as specified in the course syllabus.
    iii. If a student misses more than a specified number of course activities without excused absences, the student would not receive bonus course points or could lose course points as stated in the course syllabus.

3. Notification Protocol
    a. The student will notify the Office of Student Affairs, preferably using their OSU email account, or by phone if necessary, for any absences as soon as the student is aware that they will not be in attendance.
    b. The Office of Student Affairs will inform the appropriate staff members, course and/or clinic directors, and the Chair of the Division of Dental Hygiene for dental hygiene students of any absences on a timely basis. Examples of those individuals include:
        i. Clinic director – for students scheduled for clinical sessions
        ii. Course director(s) – for the course(s) from which the student will be absent
        iii. Clinical rotation desk – if the student is assigned to a rotation
        iv. Clinic scheduler/OHIO Project assistant
    c. Notification of the absence will include the days for which the student is expected to be absent and whether the absence is excused or unexcused.
    d. The Office of Student Affairs will inform the Associate Dean for Academic Affairs if a dental hygiene or dental student is absent for more than five days in a semester.
4. Appeal Process for Extenuating Circumstances
    a. If a dental hygiene or dental student deems that an absence should be excused but does not fall within the categories of excused absences listed above, he/she may submit an appeal.
    b. This appeal must be submitted in writing to the Associate Dean for Academic Affairs no later than five College of Dentistry business days after the student returns to the college for the appeal to be considered.
    c. The Associate Dean for Academic Affairs, in consultation with the appropriate course director/clinic director/staff, and Chair of the Division of Dental Hygiene for dental hygiene students, will determine if the absence is excused.
    d. If the appeal is not approved, the absence will remain unexcused and the consequences of the **unexcused absence** will remain in effect.

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry Student Attendance #02-01

Applies to: Dental hygiene and dental students

Responsibilities

Position or Office	Responsibilities
Associate Dean for Academic Affairs	1. Review and revise the student attendance operating procedure as needed. 2. Notify course and/or clinic directors and staff members of revisions to this operating procedure 3. Review course syllabi to ensure that this operating procedure is referenced and the specific attendance requirements for the course are clearly defined 4. Consult with appropriate course directors and the Chair of the Division of Dental Hygiene (for dental hygiene students) for planned and unplanned student absences as described above 5. Receive notification from the Office of Student Affairs if a student is absent more than 5 days within an academic term 6. Review and render decisions (with consultation of appropriate course directors and the Chair of the Division of Dental Hygiene for dental hygiene students) on student appeals for excused absences
The Office of Student Affairs	1. Inform and advise students on appropriate use of the student attendance operating procedure 2. Receive all notices of absences (planned and unplanned) from dental hygiene and dental students 3. Inform appropriate course/clinic directors, on-site staff members, and the Chair of the Division of Dental Hygiene of all student absences in a timely manner 4. Inform the Associate Dean for Academic Affairs of student appeals or if a student is absent for more than five days within an academic term
Chair of the Division of Dental Hygiene	1. Inform the Associate Dean for Academic Affairs of the absences for college-related business events or other reasons that are excused for dental hygiene students 2. Receive notices of planned and unplanned absences from Office of Student Affairs
Clinic Scheduler/OHIO Project Assistant	1. Receive notices of planned and unplanned absences from Office of Student Affairs 2. Inform appropriate rotation staff of all student absences in a timely manner
Student	1. Be aware of and follow this student attendance operating procedure
Course and/or clinic directors	1. Incorporate course policy on student attendance in course syllabus 2. Monitor student participation in all scheduled graded course activities 3. Inform the Office of Student Affairs if a student is absent and the course and/or clinic directors have not been notified of this absence by the Office of Student Affairs 4. Inform the Associate Dean for Academic Affairs if a student has stopped attending scheduled course activities 5. Inform the Office of Academic Affairs when issues related to student attendance arise
College Registrar	1. Receive notices from the Associate Dean for Academic Affairs of students who stop attending a course 2. Determine if the student is no longer active in the predoctoral dental program 3. Redefine the student's academic status as necessary

Resources

University Faculty Rules Chapter 3335-9 Attendance and Graduation; section 3335-9-21 Absences

University Faculty Rules Chapter 3335-9 Attendance and Graduation; section 3335-9-22 Group absences

University Office of Human Resources Paid Leave Program Policy 6.27

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry Student Attendance
#02-01

Applies to: Dental hygiene and dental students

Contacts

Subject	Office	Telephone	E-mail/URL
Notification for student absences	Office of Student Affairs	614-292-7809	dentistrystudentaffairs@osu.edu
Notification by course directors of students who stop attending courses	Office of Academic Affairs	614-292-4250	delong.89@osu.edu hamamoto.4@osu.edu
Notification of clinic supervisors of student absences after being informed by the Office of Student Affairs	Office of Community Education	614-292-6111	levings.2@osu.edu
Appeal of an unexcused absence	Office of Academic Affairs	614-292-4250	delong.89@osu.edu hamamoto.4@osu.edu

History

Issued: 05/09/2016

Policy	**DMD/DMDAS Student Attendance**		
Sponsoring Office	Office of Academic Affairs		
Responsible Officer	Academic Dean	*Contact Information*	Dir. of Academic Affairs Lea Alexander leaalex@uic.edu
Approvals	Curriculum Committee	*Date*	7/21/2015

Objective/Rationale:
This policy establishes the expectations for student attendance while enrolled in the DMD curriculum. The DMD program is a hands on, interactive and collaborative educational experience that requires students be present and engaged. Care has been taken to ensure that all scheduled experiences are meaningful and courses are continuously reviewed and improved. Failure to attend course sessions and to fully participate in the educational experience limits individual student learning and small group activities and can diminish the overall educational experience. When students do not attend required sessions there are limited opportunities to offer proper make up sessions that include instructor feedback. Students who do not attend clinic sessions may compromise patient care experiences.

Policy Statement:
Student attendance is required at scheduled interactive didactic sessions, small group sessions, seminars, presentations, intramural clinic rotations, extramural clinic rotations, clinic sessions, assessments, class meetings and official College or University functions. Student attendance and proper management of unavoidable absences are part of the professionalism requirements of the College.

Requirements:
1. Students who cannot be present at the College (see unexpected absences below) must notify their supervising course/component leaders as soon as possible – prior to class/clinic.
2. Students who wish to spend time away from the College (see planned absences below) must contact their instructors to request approval.
3. Students must consult with the course director to determine a plan for completing missed assignments and assessments.
4. Credit given for make-up work, late assignments and missed assessments is at the discretion of the course and/or component director.
5. When an absence is due to illness and lasts three consecutive days or more, a note from a doctor must be submitted to the Office of Academic Affairs prior to returning to class.
6. When a student is unable to complete a scheduled assessment due to an illness or medical condition a note from a health care provider must be submitted to the Office of Academic Affairs prior to the student being allowed to take the assessment.
7. A pattern of absences, unreported absences or frequent absences will be reported to the Office of Student and Diversity Affairs for review.
8. Course syllabi may contain additional guidelines/requirements/procedures.

Procedures:

Unexpected Absences:

Examples: personal illness, illness of an immediate family member, transportation, etc.

1. If you are ill and potentially infectious to others, it is recommended that you remain at home. As a guideline, the CDC suggests that you not return to normal activity until you are afebrile for 24 hours.
2. Email your instructors (those responsible for instruction/supervision on the date(s) of the absence) prior to class/clinic and briefly explain the situation. A list of instructors is available in the syllabi and each session on the class schedule indicates an instructor. Contact your instructor upon your return to make up work.

Planned Absences:

Examples: medical appointments, national/state meetings, NBDE, PG interviews, externships, funerals, weddings, family events.

1. Contact your instructors (those responsible for instruction/supervision on the date(s) of the absence)-when the need to be absent arises, a minimum of two weeks when possible.
2. All missed work and assessments must be made up.
3. Credit given for made up work, late assignments and missed assessments are at the discretion of the course and/or component director.

Best Practices for Planned Absences:

- Use break weeks and personal days whenever possible.
- National Board Exams: allowed two days per exam
- Meetings/Conferences: should be approved by course directors and MP (where applicable) a minimum of 1 month in advance.^
- Externships – must utilize break weeks.^

Related Policies:

The UIC Senate Policy on religious holidays (approved May 25, 1988):

"The faculty of the University of Illinois at Chicago shall make every effort to avoid scheduling examinations or requiring that student projects be turned in or completed on religious holidays. Students who wish to observe their religious holidays shall notify the faculty member by the tenth day of the semester of the date when they will be absent unless the religious holiday is observed on or before the tenth day of the semester. In such cases, the students shall notify the faculty member at least five days in advance of the date when he/she will be absent. The faculty member shall make every reasonable effort to honor the request, not penalize the student for missing the class, and if an examination or project is due during the absence, give the student an exam or assignment equivalent to the one completed by those students in attendance. If the student feels aggrieved, he/she may request remedy through the campus grievance procedure."

Academic Year Holidays and Religious Days of Special Observance
http://oae.uic.edu/docs/ReligiousHolidaysFY20142016.pdf

Best Practices for Planned Absences updated per clinical dean, June 2016.

Clinical Attendance Policy (WVU School of Dentistry)

Revised May 2017

In order for the student to attain the goals of clinical competency in all of the prescribed clinical disciplines, a MANDATORY clinical attendance policy is in place. The student must be PRESENT at each clinical session. Attendance will be monitored using the Axium Clinical Tracking System which we have established. All clinical activities in which the student is engaged will be monitored including direct patient care, work on assignments, chair side assisting, Health Right, manikin practice, and special needs patient care.

Attendance data is utilized by the Academic Standards Committee as one of many factors to determine positive progression through the curriculum, lack of progress relative to sanctions up to and including dismissal, repeating a year, and determining a student's readiness for graduation. All students in the clinical portion of their curriculum must have five complete semesters (Summer Sophomore Year; Fall, Spring, Summer Junior Year; Fall Senior Year) of clinical attendance at 95% or above. If the attendance for a semester falls below 95%, the student must make up this time by volunteering for assignments during unscheduled time, volunteering for Health Right clinic, and/or scheduling and treating a student's own family of patients during a clinical session in which the priority scheduling is for the other class in the clinic. Attendance hours received beyond the 95% may be credited to the next semester only.

During the Spring semester of your senior year, **you will be required to have 25% Provider Attendance and 50% Total Attendance**. Any deficiencies in total attendance hours must be corrected by the conclusion of the Fall semester of the Senior Year or they will have to be made up during the Spring semester of the senior year. Students are required to fulfill their assigned in-house rotations. Consistent with your professional responsibility, you are also encouraged to continue to attend clinic during this final semester beyond your required attendance to assist fellow classmates and help in Urgent Care and Oral Surgery, as needed.

Less than 95% clinical time utilization for the first five semesters is considered unsatisfactory for progression through the clinical curriculum. Deficient hours for each semester will accrue over the course of the student's clinical curriculum.

Please consult your team leaders and any administrators within the School if you have any questions concerning this policy.

Seminars and Instructional Sessions Attendance

Students must be accountable for attending all clinically-related **mandatory seminars/instructional sessions**. For each session missed, the student will have clinic privileges revoked for a minimum of one week.

West Virginia University

Attendance Policy and Guidelines

Attendance policies at West Virginia University are set at the course level. There is no University- or College-level authority in charge of "excusing" absences. However, there are two University offices with roles referenced in the policy and guidelines below:
1. The Provost or her/his designee may designate an activity as an "Authorized University Activity." Such designation is normally limited to scholarly competitions, fine arts performances, and intercollegiate athletics competitions in which students are representing West Virginia University. Information regarding students participating in an Authorized University Activity will be communicated to faculty via an official letter or e-mail from a University official (such as the faculty member or unit that is sponsoring the event) and will be posted on a website with a list of Authorized University Activities with the dates.

2. Emergency military service and jury duty are treated in the same way as Authorized University Activities. Students will inform faculty about their participation in such activities via an official letter or document.
a. Refer to specific guidelines for absences due to military service at http://facultysenate.blogs.wvu.edu/r/download/150667, which was passed in Faculty Senate on February 11, 2013.
3. Students who encounter extreme circumstances that necessitate short-term absence, such as a death in the family or hospitalization, should contact the Office of Campus and Community Life at 304-293-5611. The Office of Campus and Community Life will notify instructors of imminent absence in situations in which the student is unable to do so. Please note that the Office of Campus and Community Life does ***not*** "excuse" absences.

4. Students with chronic illness may wish to consult with the Office of Accessibility Services at 304-293-6700.

GUIDELINES AND POLICIES FOR STUDENTS:

Importance of Class Attendance

- At West Virginia University, class attendance contributes significantly to academic success. Students who attend classes regularly tend to earn higher grades and have higher passing rates. Excessive absences may jeopardize students' grades or even their ability to continue in their courses. There is a strong correlation between regular class attendance and academic success.

Class Absences

- Students are responsible for making faculty members aware of anticipated absences due to Authorized University Activities as soon as possible to help facilitate the make-up process. Students **must** provide instructors a copy of the University documentation for the anticipated absences from class. Students are also encouraged to meet with their instructors at the beginning of the semester to discuss these anticipated absences. Students who fail to inform their instructors of their absence due to participation in a University Authorized Activity shall not be excused for that absence by the instructor.

- Students who are absent from class for any reason are responsible for all missed work and for contacting each of their instructors promptly, unless an instructor's policies require otherwise. Instructors cannot require documentation of student illness from any medical provider as medical conditions are confidential. Instructors are permitted to review medical documentation if the student voluntarily provides it. However, medical documentation does not constitute an "excused absence."

- Students who know that they will be absent for more than 15% of class time are strongly encouraged to take the course at a time when they will not be absent to this degree. (NB. It is the faculty member's prerogative to set a benchmark that is higher or lower as appropriate to the course.) During a regular semester, this equates to 2 absences for classes that meet once a week, 4 absences for classes that meet twice a week, and 6 absences for classes that meet three times a week. In some classes, collaborative work is completed in class and cannot be duplicated outside the classroom, or, particular competencies must be achieved to pass or achieve a particular grade in the course.

- For students who are absent more than 15% of classes, the opportunity to make up missed or incomplete work shall be determined by the instructor.

Appeals Process

- If the student and instructor cannot agree on make-up work and make-up exams within the parameters set forth by these policies and guidelines, the student may appeal the consequences due to the absences by contacting the Chair or Director of the program. Further appeals will be forwarded to the Dean's office in the College in which the course is being taken.

GUIDELINES AND POLICIES FOR FACULTY:

Attendance Policies

- All attendance policies that affect students' grades must be announced in writing within the first week of class, typically in the syllabus. Instructors are responsible for keeping accurate enrollment records, and for keeping accurate attendance records when attendance is used in grading. Instructors are strongly encouraged to require attendance in all 100-level and 200-level classes.

Class Absences

- Instructors who require attendance should accommodate at least 5% of absences for any reason. Authorized University Activities are counted among the allowed absences. This equates to at least 1 absence for classes that meet once a week, 2 absences for classes that meet twice a week, and 3 absences for classes that meet three times a week.

- If a student knows that he/she will be absent more than 15% of the time, the faculty member may advise the student that he/she take the course at another time or semester.

- Absences due to participation in Authorized University Activities with proper documentation will not directly affect a student's participation grade; however, they will count toward the total absences.

- Students absent for participation in Authorized University Activities are responsible for presenting the instructor with written notification from a University official prior to the proposed absence. For confirmation, the Authorized University Activities will be posted on a central webpage that included information about the activity, the dates, and the participating students.

- Students who are absent from class for any reason are responsible for all missed work and for contacting each of their instructors promptly, unless an instructor's policies require otherwise. Instructors cannot require documentation of student illness from any medical provider as part of an attendance policy, since medical conditions are confidential and frequently not verifiable. Instructors are permitted to review medical documentation if the student voluntarily provides it. However, medical documentation does not constitute an "excused absence."

- Instructors should provide, within reason, opportunity to make up work for students who miss classes for Authorized University Activities and other legitimate and unavoidable reasons. Legitimate, unavoidable reasons are those such as illness, injury, or family emergency. However, it is not unreasonable to adopt a broad attendance policy that allows 10% absences for any reason and does not require justification for a particular cause or purpose. Absence for religious observance is covered under the University policy regarding Days of Special Concern.

- Suggested syllabus language:

Attendance Policy: Active participation and regular attendance are expected. You are allowed [three] [or other number] "free" absences, for this class that meets [twice] a week. Each subsequent absence from all or part of a class will result in a reduction of your final grade by 5% (one half of a letter grade). If you have on your schedule an Authorized University Activity that conflicts with class sometime during the semester, you are expected to apply your "free" absences to meeting that commitment. If you encounter a genuine crisis you should talk to me as soon as possible.

- Instructors may also consider including language such as the following in their syllabi:

- For extreme circumstances that necessitate your short-term absence, such as a death in the family or hospitalization, contact the Office of Campus and Community Life at 304-293-5611. The Office of Campus and Community Life will notify your instructors of imminent absence in situations if you are unable to do so. Please note that the Office of Campus and Community Life does ***not*** "excuse" absences.

Policy on Make-up Examinations

- Students absent from regularly scheduled examinations because of Authorized University Activities will have the opportunity to take them at an alternate time. However, another equitable solution may be proposed by the instructor.

- Make-up examinations should be of comparable difficulty to the original examination.

- Students in courses with regularly scheduled evening examinations shall have the opportunity to make up these examinations if they miss them in order to attend a regularly scheduled class that meets at the same time. Such make-up examinations should be of comparable difficulty to the original examination.

- Attendance at a regularly scheduled evening examination will not excuse a student from a regularly scheduled class that meets at the same time as the examination.

- NOTICE: If the student and the faculty member cannot agree, normal appeal procedures are available to the student and can be followed.

Appeals Process

- If the student and instructor cannot agree on make up work and make up exams within the parameters set forth by these policies and guidelines, the student may appeal the consequences due to the absences by contacting the Chair or Director of the program. Further appeals will be forwarded to the Dean's office in the College in which the course is being taken.

CODE Meeting 2017 Region V
Submitted by Dr. James Kaim Chair
Dr. Melissa Ing Secretary

I am pleased to provide you with the report from the CODE meeting. The minutes reflect the discussion and recordings of our secretary Dr. Ing. I want to thank her for her hard work and her report.

Meeting Held at: NYU School of Dentistry
October 2, 2017
Product Manufacturers Represented: Columbia Dentoform, MOOG, Ultradent
Licensing Board Testing Agencies Represented: CDCA, WREB
Schools Represented: NYU, Tufts, Dalhousie, Stonybrook, Columbia, Touro, UPENN, Howard, Temple, Boston University, Toronto, Maryland, UCONN, Rutgers, Harvard

Dr. Jim Kaim, NYU, host and CODE Region V Coordinator/CAMBRA-CODE , started with a welcome, objectives and introductions.
General announcements: There were a few members that could not attend including Dr. Strassler due to Accreditation. U of New England had to cancel. McGill was asked but no response. Dr. Ing asked if the University of Western Ontario Faculty of Dentistry could be contacted to attend next year's CODE meeting. Lavell will also be contacted.

Currently all dues must be paid by check. Several schools still owed dues. All schools requested that they should be able to pay by credit card.

The vendors were introduced and offered 10 minutes strictly to introduce any new products that could be of interest to the educators present. . Dr. Kaim told the group that he did not feel that new vendors should be added since he thought that the meeting should remain focused on the listed agenda items. Vendors and attendees have ample time to interact at the evening dinner.

Columbia Dentoform representative Philip Briales talked about simulation and some changes with their teeth. This year marks Columbia Dentoforms 100 years in business. Columbia announced the production of a new series of carious teeth. These teeth with simulated dentin decay will allow tug back with an explorer. They tested the teeth in schools in Australia as Columbia supplies a majority of schools in Australia. Soft caries in these typodont teeth can be developed to schools' specifications. MOOG has returned this year to demonstrate it newest platform in simulation with their Simodont machine. Yang Xiao is the marketing manager based in Buffalo. Students can easily sign in work on numerous cases and get immediate self-assessment. There is more uniform evaluation of student work. Ultradent was represented by Ms Sue Coco the regional representative. She introduced their new products flowable MTA applied with a 29 gauge syringe. This is mixed with a gel to allow the user to adjust the viscosity. She also talked about the Gemini Diode soft tissue laser with super peak power and discussed a new composite material called Mosaic.

Testing agency represented included Dr. David Perkins and Dr. Peter Yamen from CDCA and Dr. Bruce Horn representing WREB.

Dr. David Perkins thanked the group for the invitation to be here. He announced that the only changes to the CDCA for 2018 requires each candidate to fabricate pre-preparation stents for the manikin Prosthetic section . The stent is used to confirm a failure. According to Dr. Perkins the typodont is still initially articulated to evaluate occlusal clearance. NYU asked for an update of the manikin portion failures where a photo is supposedly sent to the faculty if a candidate fails. NYU asked if that worked well. Dr. Perkins said: "The feedback was fantastic with the photos. These allow students to actually see their mistakes and provides faculty with extremely valuable feedback.
WREB: Dr. Horn came to the meeting with a detailed slide presentation including the many changes that were announced for the 2017-18 examination cycle. Currently three Northeast schools have WREB administer their examination: Tufts, Boston University and NYU.

Changes for the WREB examination:

1. Endodontics: eliminating the use of natural teeth and using a plastic tooth manufactured by Acadental.
2. Prosthodontic: Providing an optional Prosthodontic manikin section similar to the CDCA. Depending on individual state board requirements.
3. Operative section: The option depending on state board requirements to allow a candidate to pass this section by completing one Class II procedure that must be a Class II composite. If a second procedure is to be performed that choice of lesions is the same as in previous years. Depending on individual state board requirements.
4. The ability of a candidate who fails either Endo or Perio or Pros to retake it on the third day of the examination. However if necessary only one retake is permitted on day three.

   There was a great deal of discussion among the group especially around the one Operative procedure option: Dr. Horn mentioned that their statistical analysis demonstrated a 97.3% pass rate on first procedures. Both the WREB and CDCA currently are compensatory examination meaning a candidate may have a failing score on the first procedure and with a high enough score on the second procedure can pass the examination. Both testing agency however indicated that should a candidate fail the first procedure with a critical deficiency they would not be allowed to take the second procedure.
5. WREB will provide the candidate with same day results. This would allow candidates to retake Endo or Pros or Perio on day 3 of the examination should that be necessary. There would be no additional charge to the candidate

They would be no additional charge to the candidate for a retake during the same examination. Dr. Horn mentioned that WREB does customize examinations to the needs or requirements of individual states. For example Alaska requires that a candidate perform a Class II amalgam. Wyoming requires a second procedure which must be a Class III. Dr. Horn explained that the decision to allow WREB Operative Competency based on success on the first procedure which must be a Class II was based on the many years of statistics that demonstrated that over 97 % of those passing the first procedure passed the examination even when weighing in the grade of the second procedure . It was also WREBS intention to try to assist the mandate of the ADA, ADEA and others to reduce the need and the use of human subjects.

CODE National Agenda Questions :

In reporting the statistics for the different questions there were 15 schools present at the meeting. Eleven of those from the United States. So when reporting numbers we will report based on total schools unless it is important or significant to separate U.S. from non U.S.

1) **In your school do students practice on one another in preparation for their clinical experiences?** (Yes/No) All schools said yes

What type of procedures do the students practice on each other?

Extra/Intraoral examination: Yes, all schools
Periodontal probing: Yes, 6 schools. 9 No
Alginate impressions: Nearly all schools said yes photography: Yes, 4 schools
Radiographs: 2 schools yes with one school reporting that all their students get registered as patients.
Local anesthetics: Yes, 11 schools. 4 school no. 2 of these schools Columbia and NYU use an anesthesia simulator manufactured by Columbia Dentoform.
Prophy: We separated out polishing versus scaling and root planning. All said yes to polishing. 3 school said yes to SRP. .
Retraction Cord Placement: No schools
Rubber dam placement: 8 schools yes 7 no
Facebow exercise: 6 schools yes 9 schools no

Benchmarks for entering the pre doctoral clinics:

Is passing NBDE1 a requirement for entry into predoctoral clinics?

8 schools said YES
.
Some schools give students 90 days to pass exam before allowing in clinic.
Some schools restrict or reduce clinic activity if a student fails and has to retake

Is passing NBD2 a requirement for entry into the predoc clinic ?

The group felt that this question did not make sense and perhaps the question should have been reworded to have said: "If a student fails NBDE2 then should they be taken OUT of the clinic?"
If a student fails part 2 are they taken out of clinic? All schools said NO.
NYU students are told that they will not graduate on time if they don't pass the first time;

How many schools provide formal review courses?

5 schools provide formal reviews.

Will this policy change when part 1&2 are combined?

All school are undecided

Do all schools feel that passing Boards are pre requisites?
Yes

What other pre-requisites if any are necessary prior to being allowed to treat patients in the pre doc clinic?
All schools require students to pass pre-clinic courses that the student will need to perform in the clinic. This would include Perio, and Operative. Some schools allow students into clinic if they have not completed Oral Surgery, Endodontics and some Prosthetics. Temple said the students must pass all pre-clinical courses **Ratio of Faculty to Students in the Operative Clinics:**
There was a range of 1:4 to 1:8

Biological Aspects of Operative Dentistry:
Pulp Capping-What does your school use/teach for materials?
All schools said that they use Dycal (CaOH2).
All schools said that they use ZOE as temporary material.
Columbia said that they use MTA as a liner.
All schools use RMGI.
Theracal LC: Howard and UCONN sometimes as alternative to Dycal.

Is anyone using Biodentine? None of the schools are currently using.

Is there anyone not accepting the indirect pulp cap technique? All schools accepting indirect pulp cap.

<u>Materials and Techniques:</u>
What provisional materials are used in your school, for instance if it is a Class II restoration, the tooth is prepared and is not sensitive but the student has run out of time?
Most schools us either GI material or
12 schools teach and utilize GI or RGI materials.

How many schools have your department teaching single crowns?
Most American schools do NOT teach crowns.Maryland, UConn, and the Canadian schools do them occasionally in the clinic. Olumbia it is part of their teaching program.
All schools however report they have separate Operative and Prosthodontic departments.
Maryland, the Canadian schools, UCONN occasionally, Columbia does everything, Howard does some. Tufts said they don't teach it didactically but recently there has been movement to have faculty volunteer to teach single crowns in the clinic.
All schools say they have separate prosthodontics and operative departments.

Only the Canadian schools teach crowns in the operative preclinical course.

What temporary material is used for temporary crowns in your programs?
Most school use: BisaCryl , Jet AcrylicLuxatemp or Bisacryl used by 6 schools.

What techniques are taught to make temporary crowns?
The schools answered: block carved or with a shell. Most use Omni vacupress, or Putty technique. 11 schools use putty technique to make the temporary crown.
The schools said they rarely use temporary for CAD CAM.
3D printing: No schools are using 3 D printing at this time.

Direct Pin Placement:
In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite resin materials?
The goal of this question is to achieve a consensus report on the validity or not of direct pin placement in contemporary restorative practice.

Only The Canadian schools and UCONN teach pin placement in the preclinic What was described as rogue clinical faculty may place pins in those schools that do not teach it to their students in preclinic.

Restoration Repair
Does your school permit repair of defective amalgam margin with a composite resin or require a total restoration replacement?
3 schools replace amalgam completely:. Other schools teach complete replacement although some schools mentioned that there are some faculty that allow this to happen. .

Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?
All school except one allow composite repair. However, schools report that clinical factors such as occlusion, size of the restoration existing restoration, size of the replacement composite, etc factor into the decision.

Clinical Guidelines-Amalgam vs Resin:
Does your school have guidelines as to when amalgams vs composite resin restorations are placed?
Some schools said that they do not have written guidelines. Many of the schools are using composite resin almost exclusively. The schools agreed that size of the preparation ie if very large or if moisture control is a factor, as well as occlusion, then these would be considerations as to why amalgam may be chosen over composite resin.

What % of patients receive amalgam vs. composite resin on posterior teeth?

The range was 5/95 to 30/70.
Licensing Boards 90% composite resins. A very limited number of candidates in the region select Amalgam. As mentioned In Alaska they must perform a Class II.
<u>Assessment</u>
Clinical Productivity
Is the clinic productivity of your student a graded element in their clinical progress assessment?

Do you believe that it should be?
3 school yes

Administration
Attendance Policy
Describe the attendance policy for your schools' students
3 schools mandatory lecture attendance
All school mandatory attendance in simulation lab and clinics.
Do you feel the attendance policy is fair/appropriate?
Everyone feels it is fair to the students. A number of schools said that they did not believe that the lecture attendance policy was appropriate. Some schools reported that departments are allowed to have their own attendance policy.

Some schools use clickers for attendance. BU was using iphones for swipes for attendance.

Millennial Students

This topic was prompted by Dr. Howard Strassler and an article he sent out. Dr. Strassler could not be present due to U. Maryland's Accreditation Site visit is at this time. The Associate Dean for Faculty Development and Education, Dr. Maria Blanco from Tufts Medical School , provided some reading material for the group as well as lecture slides. Dr. Kaim gave one of Dean Blanco handouts "Twelve Tips for facilitating Millennials learning" by David Roberts. Dr. Kaim also used one of her slides as an example of how a millennial medical student feels they should handle patient care. We can't change them; apparently, we have to change us.
Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?
NYU said yes.
Dean Blanco from Tufts offers year-round courses in faculty development, some of which spans several weeks or several months' time. Some are Lunch and Learns. Some require a book read. Some are workshops.
How many schools have generation/millennial courses? UPENN, Temple, Columbia, Howard, Tufts, Stonybrook UPENN said the course within their schools is not formal but that seminars are presented. UPENN said that there is also a website is available for online help.
Are any surveys taken, other than course/faculty student evaluations to determine how effective?
No schools have formal surveys.

Are there any special teaching techniques that work better to teach the Millennials? Touro likes to use flipped classroom technique. "Learn through learning."
some school like videos. Some schools by their structure have students attend with medical students they have no control. Some schools like group learning along with problem based formats.
All school agreed that it seems today's student present an air of entitlement.
Dr. Melissa Ing representing Tufts presented her approach for dealing with the millennials. She talked about the need to "spice up" the lecture every 8-10 minutes to allow the students to refocus. Capturing any audience takes work. Dr. Ing said according to data done for television shows they go to

commercial at specifically timed intervals so it gives the mind time to refresh. She said it also helps with her classes when she asks students to actively participate within her courses such as in the acting or filming of videos. "People buy into what they help create."

What is the outcome assessment? How are you going to measure that this was successful? All schools said they did not have an effective or reliable tool to measure outcome assessments for teaching the Millennials.

Are students provided with behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

Only one school stated they have a formal program for the students.

Do you feel students are embarrassed they will get the wrong answer?

All schools answered YES.

The 2018 meeting will be held at NYU on Monday October 1 & Tuesday October 2.

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2017 Southeast Region VI
Consortium of Operative Dentistry Educators
Southeastern Region Meeting
National & Regional Agendas
October 25 - 27

&

2017 Southern CaMBRA Coalition
Caries Management by Risk Assessment
October 25 - 26

AU	Augusta University Dental College of Georgia
ECU	East Carolina University School of Dental Medicine
LECOM	Lake Erie College of Osteopathic Medicine School of Dental Medicine
MMC	Meharry Medical College School of Dentistry
MUSC	Medical University of South Carolina School of Dentistry
NSU	Nova Southeastern University College of Dental Medicine
UAB	University of Alabama School of Dentistry
UF	University of Florida College of Dentistry
UK	University of Kentucky College of Dentistry
UL	University of Louisville School of Dentistry
UNC	University of North Carolina at Chapel Hill School of Dentistry
VCU	Virginia Commonwealth University School of Dentistry

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Attachments

Consortium of Operative Dentistry Educators

Regional Meeting Reporting/National Meeting Information

The 2017 National Agenda was established after a review of the suggestions contained in the reports of the 2016 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 as to what has changed and 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 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 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.unmc.edu/code or within this document)

Send an electronic copy of the final regional report via an email attachment to the National Director (gary.stafford@mu.edu) within thirty (30) days of the meetings conclusion.

National CODE Meeting:

The meeting will be held Thursday, February 22nd, 2018 from 5:00 – 6:00 pm in the Parkside Room at the Drake Hotel, 140 East Walton Place in Chicago, IL. Any member who would like to present or who has suggestions for speakers should contact the National Director for more information.

2018 ADEA Section on Operative Dentistry and Biomaterials Meeting:

The meeting will be held during the ADEA Annual Session & Exhibition, March 17-20, 2018 in Orlando, FL.

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 university's directory listing on the CODE website at www.unmc.edu/code or by sending an email directly to the National Director at gary.stafford@mu.edu.

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

1. *School name and complete mailing address*
2. *Individual names: (F/T Faculty), phone number and email address of F/T Faculty who teaches operative dentistry.*
    a. This could be an individual who teaches 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 helps 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
Associate Professor and Chair
Department of General Dental Sciences
Marquette University School of Dentistry
1801 W. Wisconsin Ave. Rm 336 C
Milwaukee, WI 53233
414.288.5409

Consortium of Operative Dentistry Educators

Region VI (South)Meeting
October 25-27, 2017

Agenda

Wednesday, October 25

12:00 - 5:00pm	Arrive in Gainesville
5:30 pm	Transportation to Dinner (Meet in Hilton Lobby)
6:00 - 7:00pm	CaMBRA Lecture and Dinner at Paramount Grill
	Welcome from Dr. Roopsi Kaur, Director Southern CaMBRA Coalition
	Presentations: Dr. Marcelle Nascimento (UF)
	UFCD Caries Risk Assessment and Management Program
	Dr. Andrea Zandona (UNC)
	Silver Diamine Fluoride-What are dental schools teaching and what should we be teaching?
7:00 - 9:00pm	Dinner (Sponsored by **Ultradent**)

Thursday, October 26 Harrell Medical Building Room 128*

7:00 - 7:15am	Transportation to UF via UF Faculty
7:30 - 8:15am	Continental Breakfast (Sponsored by **CaMBRA**) (HMEB 460)
8:15 - 9:00am	Welcome from Drs. Deborah Dilbone and Alex Delgado (UF)
	Dr. Isabel Garcia, Dean, (UF)
	Dr. Mary Baechle, CODE Regional Director (VCU)
	Introduction of Region VI Represenatives
9:00 - 10:30am	**CODE Regional Agenda Discussion**
10:30 - 10:45am	Coffee Break
10:45 - 12:00pm	**CODE Regional Agenda Discussion**
12:00 - 1:00pm	Lunch (Sponsored by **Dentsply/Sirona**)
1:00 - 2:45pm	**CaMBRA Agenda and CODE National Agenda Discussions**
2:45 - 3:00pm	Coffee Break
3:00 - 5:00pm	**CODE National Agenda Discussion**
6:00pm	Transportation to Dinner (Meet in Hilton Hotel Lobby)
6:30 - 9:30pm	Dinner at Leonardo's 706 (Sponsored by **3M ESPE**)

Friday, October 27 Shands Room 2147*

7:00 - 7:15am	Transportation to UF via UF Faculty
7:30 - 8:30am	Continental Breakfast (Sponsored by **SHOFU**)
8:30 - 11:00am	**CODE National Agenda Discussion**
11:00 - 12:00pm	Boxed Lunch (Sponsored by **Brasseler USA**)
12:00 - 2:00pm	University of Florida College of Dentistry Tour
12:00 - 2:00pm	Transportation to Gainesville Airport

Special Thanks to:

Jill Joseph	**Ultradent Corporation**
Leslie Hollier-du Plooy	**Dentsply/Sirona**
Trish Dorazio	**3M ESPE**
LeAnn MacDonald	**SHOFU Dental Corporation**
Paul Spivey	**Brasseler USA**
Dr. Roopsi Kaur	**Director, Southern CaMBRA Coalition**
Dr. Jim Haddix	Assistant Dean, Continuing Education (UF)
Angela DeBono	Administrative Specialist, Restorative Dental Sciences (UF)

CODE Region VI (South)

University of Alabama
East Carolina University
University of Florida
Dental College of Georgia
University of Kentucky
Lake Erie College of Osteopathic Medicine
University of Louisville
Meharry Medical College
University of North Carolina
NOVA Southeastern
University of Puerto Rico
The Medical University of South Carolina
Virginia Commonwealth University

*HMEB 128- Between HPNP Building and McKnight Brain Institute.

*Shands Room 2147 - take main dental elevators to 2nd floor, turn left head to Shands, first room after balcony.

Southern CaMBRA Coalition
Agenda 2017

Thank you in advance for your participation in the 2017 Southern CaMBRA agenda. This agenda is based in part on responses to agenda questions from the previous year – it can be thought of as a continuation of a conversation regarding caries management education at our schools.

1. In the previous year CaMBRA agenda, all participating schools (16) reported incorporation of caries risk assessment and evidence-based management in their curriculum. What mechanism(s) is in place at your institution to calibrate current and new faculty regarding the caries management curriculum?
2. How successful would you rate the caries calibration efforts at your institution?
3. What are the barriers to calibration and "buy-in" amongst faculty members at your school, as it concerns evidence-based caries management?
4. What measures have proved helpful/successful in calibrating and garnering "buy-in" amongst faculty members at your school, as it concerns evidence-based caries management?

Notes-

1. **In the previous year CaMBRA agenda, all participating schools (16) reported incorporation of caries risk assessment and evidence-based management in their curriculum. What mechanism(s) is in place at your institution to calibrate current and new faculty regarding the caries management curriculum?**

NSU

We have annual or semi-annual lunch seminars on CAMBRA. These mostly take place during the mandatory faculty meetings therefore the attendance is usually good. New faculty are standardized by the Department Chair on CAMBRA concepts when they first start and are given the printouts of NSU CAMBRA Form. Most of the clinic faculty also participate in the preclinical courses and are welcome to attend each CAMBRA lecture given to the students.

UK

There is no mechanism for faculty calibration at this point; however, a couple of presentations are planned and scheduled for this purpose. This will be provided by the faculty who are teaching the Cariology course. A shared folder has just been created to help faculty members understand what is taught in the Cariology course. They can find published papers that are related to several topics such as "Caries detection", "Caries risk assessment and management", "Caries Prevention" and "Caries process", etc.

VCU

This topic is frequently discussed at annual General Practice Department retreats and other faculty development events. Additionally, our department has a calibration BlackBoard site with modules on different topics that we are required to review and pass quizzes. CRA and Hard Tissue Exam is one of these modules.

UAB

We have a "Clinical Guideline" document that was approved by the Faculty in charge of the Clinical Teams in the Undergraduate Comprehensive Care Clinic that is used to this goal.

UNC

Lecture presentation to department faculty (full time and adjunct).

UL

The current D1, D2 and D3 students have had a pre-clinical caries risk assessment didactic course where they learn data collection and test results for diagnosis and preventive treatment planning. We are currently developing a modified CAMBRA clinical competency assessment for both D3 and D4 students to follow said preclinical course. The forms will be housed in axiUm and tracked by the course director(s).

UF

Faculty - and especially new faculty - must attend the preclinical lectures on caries risk assessment and management. Several faculty calibration and literature review sessions have been done in the past years with the purpose of calibrating faculty and introducing new concepts and protocols related to caries management.

MUSC

There is only a power point I made that they (are supposed to) watch; it's the same one I give to the sophomores in Operative I. Really, I think new faculty (which are rare as hens teeth) pick it up from our seniors in clinic because our seniors are really on-board.

AU

We've been doing it for about 7 years and everyone is pretty well trained. New faculty are given a PowerPoint tutorial on it.

ECU

Via ITunes u course, presentations and discussions.

MMC

We discuss caries risk assessment as a part of our TEAM leaders calibration series on bi-weekly basis.

2. How successful would you rate the caries calibration efforts at your institution?

NSU There is not a big concern on caries calibration standardization. Most faculty are on the same page when it comes to identifying caries lesions and making decisions between preventive versus operative measures. However, when it comes to chemical prophylaxis and long-term maintenance phase, CAMBRA concepts are not followed word by word. Caries recall intervals, x-ray intervals and prescription of in-office or at-home used products may slightly vary between faculty members and from the CAMBRA protocol. We don't think that the issue is the lack of exposure to these concepts but rather, the buy-in.

UK No answer at this stage.

VCU Good- A calibration seminar was held in December 2014 at the Virginia Commonwealth University School of Dentistry, during which seven completed CRA forms for simulated patients were used to test 55 faculty members' risk assignment level before and after an instructional lecture was given. The results showed a statistically significant increase in the proportion of faculty members responding correctly for five of the seven cases on the pre- and posttests ($p<0.01$). Goolsby, S. P., Young, D. A., Chiang, H. K., Carrico, C. K., Jackson, L. V., & Rechmann, P. (2016). The Effects of Faculty Calibration on Caries Risk Assessment and Quality Assurance. Journal of dental education, 80(11), 1294-1300.

UAB Unsatisfactory still, but making tremendous progress lately.

UNC Full time faculty are more calibrated than part time faculty. No formal assessments have been incorporated.

UL At this point, we are average in calibration across the general dentistry faculty. We could benefit from additional training on caries diagnosis through the eyes of caries risk assessment. We are working on it though.

UF Faculty calibration sessions have been done separately with the Operative division faculty and also combined with the entire department (Team Leaders and Prosthodontic faculty). The answer to this question will depend on the calibration topic and on the group of faculty. For example, the session on "removal of carious tissues" was deemed successful for the entire department and seems to have impacted clinical practice by the introduction of a new clinical protocol. In another example, the session on "when to restore" and "assessment of proximal lesions" has generated more discussions, and may be considered more successful among the Operative faculty as compared with the Team Leaders.

MUSC Not very good, and that's my fault.

AU It's not usually a source of conflict… so pretty good.

ECU Ongoing effort, much resistance.

MMC Fair-good

3. What are the barriers to calibration and "buy-in" amongst faculty members at your school, as it concerns evidence-based caries management?

NSU The new and younger faculty members that start their academic life with these concepts can adapt better to the protocol. However, most of the faculty members that come from a long private practice career tell us that they had delegated preventive dentistry measures to their hygiene staff throughout their career. These individuals usually prefer to focus on restorative dentistry rather than preventive dentistry and base their one-on-one teaching style only on clinic procedures.

UK No answer at this stage because it has not yet been implemented. A couple of possible obstacles in faculty calibration will probably be related to identifying infected/affected dentin and caries removal, and a gap in caries management between CAMBRA and clinical board exams.

VCU I am not sure if there are barriers, but previously I think a potential barrier to calibration might have been not having a formal means of relaying the information. The annual retreats, faculty development, Blackboard calibration and communication amongst faculty members have improved this.

UAB Change. Recently trained vs older more veteran dentists that find it hard to trust the current body of knowledge.

UNC Board examinations are not aligned with evidence (for example class II lesions and selective caries excavation).

UL The buy-in is not the problem but finding time to provide profound faculty development exercises to calibrate faculty. My general dentistry department is currently understaffed with limited development time.

UF In general, the faculty educational background, professional experiences and willingness to change clinical practice based on research and evidence-based research seem to be the greatest barriers.

MUSC The biggest is that it is relatively new; and, retiring dentists, who are the bulk of new faculty, are not very familiar with it.

AU There has not been any trouble with it. However, not everyone follows up very vigorously.

ECU Manpower and time, open-minded faculty that would more readily accept new concepts.

MMC The biggest difficulty is the preconceived notions of caries identification and caries risk assessment

4. What measures have proved helpful/successful in calibrating and garnering "buy-in" amongst faculty members at your school, as it concerns evidence-based caries management?

NSU

Our Department's and Chair's philosophy is to strictly follow CAMBRA and ICDAS protocols in the clinic. Standardization lectures and e-mails have been useful.
In the clinic, all the caries risk codes and forms are on electronic database(Axium) and the students are required to fill them out for each one of their patients and at certain intervals. This way the faculty members are continuously exposed to CAMBRA concepts as they need to read and sign forms on a daily basis. We have a NSU High Caries Risk Kit in the clinic which includes at-home preventive products. The faculty members can easily prescribe this kit with a direct code in our electronic database. We also have prescription forms readily available which include printed product prescriptions. All they need to do is to enter patient and doctor information. The NSU CAMBRA Form and Patient Oral Care Instruction Forms are easily accessible.

UK

No answer at this point.

VCU

See answers #2 and #3 above.

UAB

In my personal experience, I took the time to go present the ideas to individual faculty on a one-on-one conversation to ask them for their input and then their support in the implementation efforts. This allowed a much wider acceptance, but the implementation is still a harder task. People agree, but always will default to what they have always done.

UNC

Lectures and one-on-one discussions. However, as stated before, no formal calibration and assessments have been conducted.

UL

We hope to implement ARS calibration sessions that have proven successful in our operative dentistry curriculum. We just need more time and resources.

UF

Literature reviews showing and discussing the latest evidence followed by the development of clinical protocols. The process of developing clinical protocols involves gathering the input from all faculty via email, and discussing the protocol topics over division and department meetings.

MUSC

The seniors and senior faculty "get it" because I harp on it every Tuesday in Advanced Treatment Planning course. It seems to filter down from there. So I think the biggest success factor is constant repetition.

AU

Probably the most helpful has been having faculty involved in the Caries Continuum series of labs in the D2 year. Between the tutorial and the lab handouts, it seems to get everyone on the same page. We've published them, with all the teaching bits if anyone wants to see/borrow:

- **Mitchell J,** Brackett M, Romero M. Caries Management with the International Caries Detection and Assessment System: Early Pit and Fissure Lesions. MedEdPORTAL Publications. 2016; 12:10380. http://dx.doi.org/10.15766/mep_2374-8265.10380
- **Mitchell J,** Brackett M, Brackett W. Caries management with the International Caries Detection and Assessment System II: established pit and fissure lesions. MedEdPORTAL Publications. 2017;13:10602. https://doi.org/10.15766/mep_2374-8265.10602

ECU

Frequent presentations, case based discussions, Itunes U courses.

MMC

Open discussion in preclinical and clinical settings.

2017 Regional CODE Questions

School Index

Notes-

VCU **1. What is the student to faculty ratio in clinic? How do they determine the number to safely treat? How difficult are the cases: extractions/crown & bridge versus exam/prophies/routine restorative?**

VCU The scheduled ratio is one faculty to seven students. Occasionally extra student(s) may be added on as an emergency. To my knowledge, appointments are scheduled based on available openings regardless of case difficulty. For example, one faculty may have 5 periodic exams with prophies vs. someone else who may have 6 crown and bridge cases.

UK We have 1-4 or 1-6 faculty-student ratio for 2nd year students. For 3rd and 4th year it ranges from 1-8 or 1-10 depending on the discipline.

UNC In DDS 2 and DDS 3 clinic the student to faculty ratio is 5:1. In DDS 3 and DDS 4 clinics this ratio is maintained at 6:1 with an upper limit of 8:1. The number to safely treat is determined by the clinical experience of the students. DDS 2 mostly perform prophylaxis and operative procedures.
- DDS 3 students perform Dx and Tx planning, extractions and fixed Pros.
- DDS 4 students work in a comprehensive care general dentistry clinic model.

MUSC It is usually 1:6 in restorative clinics. In CAD/CAM it is 1:4. The ratio is determined by the number of faculty available that day, not by the complexity of cases. On some days, chairs are blocked because there are not enough faculty.

UL Student to faculty ratio in clinic is 7:1
- The number to safely treat is arbitrary. CODA does not specify the ratio for dentistry. CODA specifies the ratio for dental hygiene…
  Standard 3-6 The faculty to student ratios must be sufficient to ensure the development of competence and ensure the health and safety of the public. In preclinical, clinical and radiographic clinical and laboratory sessions, there must not be less than one faculty for every five students. In laboratory sessions for dental materials courses, there must not be less than one faculty for every ten students to ensure the Dental Hygiene Standards development of clinical competence and maximum protection of the patient, faculty and students.
- Difficulty of cases in clinic. The General Dentistry clinic treats patients presenting with caries, simple crown and bridge, non-surgical perio, minor/simple extractions, prophylaxis, and root planning. Perio surgery and most oral surgery are performed in the respective specialty clinics. UL has a 60 chair clinic for initial screening, emergency patients, operative dentistry competencies, implants, and advanced prosthodontics.

UAB 20 students per Bay (team) 10 D4, 10 D3 for two Faculty Group managers.

AU Ratio is 4:1 in D2 clinic, 6:1 in D3 clinic, which are considered safe ratios. There is a division in the clinic into Operative, Fixed, and Removable Pros. Extractions and Endo is handled in specialty clinics. Prophies are done in perio. Exams done in the Oral Medicine section of the clinic, final diagnosis done one on one by selected faculty for continuity.

ECU In clinic, 1:6 and in preclinical labs, 1:8 or 1:13 depending on number of faculty available to cover the lab.

NSU 9 /1. Pre-doc directors determine if additional faculty need to be assigned to a team. No extractions in pre-doc clinic but all other procedures are performed.

UF Our policy is 6 to 1. We recently changed to have a better teaching quality time. Of course in that ratio is not considered emergencies, COE's, POE's or additional consultations.

MMC Ideally the ratio is and has been 1:5 (Faculty to Student). This ratio is dynamic and can fluctuate to 1:10 depending on faculty redistribution for classroom assignments, leave, etc.. Within the TEAMS we provide all services except Oral Surgery. Complex Endodontic procedures can be referred to the Endodontic area.

VCU

2. Are there written Isolation protocols established that can be/should be mandated regarding rubber dam and Isovac use - or - is this optional dep ending upon the instructor(s)/mentor(s)?

VCU

At VCU, we do have written protocol regarding when Isovac can be used. Students tend to favor Isovac over using the rubber dam.

UK

We mandate the use of rubber dam. We do not use Isovac. It is not intended to be optional, however some faculty are more strict than others.
Our Clinic Manual Reads:
Isolation:
After obtaining adequate anesthesia, rubber dam isolation should be achieved. Alternative methods of isolation will only be used with instructor approval. The student is to assume that ALL situations will require dental dam. If a student begins a procedure without dental dam isolation approved by the supervising faculty a grade of 0 will be given for that category on the evaluation sheet. Sometimes rubber dam isolation is difficult to obtain when the operator is working alone. You will find it much easier for you and your patient if you have assistance during this procedure. Students are encouraged to assist each other during placement of the rubber dam.

UNC

We consider rubber dam isolation as the gold standard and recommend that the students use the same especially for posterior composite restorations. However the enforcement of this recommendation depends on the attending faculty.

MUSC

It is written and reiterated frequently but students always try to ignore it.

UL

Isovac is not currently used in the clinics although it is being considered.

- Fixed Prosthodontics: 1. Rubber dam isolation is used when cementing a restoration unless an exception is made by the attending faculty. 2. If rubber dam isolation is not used, a 4" x 4" gauze pack should be utilized as a throat veil. 3. Fixed bridges must be ligated with dental floss prior to trying in the mouth.
- Rubber dam is mandatory for operative dentistry procedures

UAB

The use of rubber dam is mandatory for Operative procedures, but there are some clinic faculty that either request the student not to use it, or simply does not enforce its use. In each case it is a challenge we face.

AU

No, but the general rule is that a rubber dam should be used unless placement not possible, or restorative access preculudes. A faculty must sign for an isovac.

ECU

Yes, from operative standpoint, we recommend that it be used whenever possible but also based on covering faculty's discretion.

NSU

RUBBER DAM is Mandatory. In isolated cases, where rubber dam cannot be applied, Endo faculty are asked to help and then director of Pre-doc Restorative has to approve alternative isolation e.g. Isolite

UF

It depends on the situation. We would rather use a rubber dam in all cases, but if for some reason (student needs to justify it) can not use the rubber dam. Students can use Isovac, Isoligth, Optragate.

MMC

Rubber dam is taught in the D1 Pre-Operative Course and is mandated for Operative procedures in the clinic This mandate is subject clinical situations.

UK **1. How does your school teach Class II Composite Restorations when the gingival floor has only cementum/dentin (below the CEJ)?**

VCU Currently the open sandwich technique, placing a glass ionomer restorative material in the gingival box prior to the composite, is presented to the students. However, the students are told that this area of dentistry is changing and that additional/new information will be presented as it becomes available.

UK We teach a sandwich technique using resin modified glass ionomer. We use RMGI as base layer covered with composite for subsequent layers.

UNC Open sandwich restorations with Fuji IX to elevate the gingival floor, followed by composite restoration to restore the rest of the preparation.

MUSC Open sandwich with Fuji IX

AU Open sandwich- glass ionomer in the gingival, composite on enamel.

UAB Open sandwich technique with the use of Resin modified Glass Ionomer to elevate the proximal box to where it can be isolated properly for composite restoration. In general root surface is to be restored with RMGI .

ECU Use glass ionomer and Open sandwich, crown-lengthening depending on the case. Composite or amalgam addition.

NSU Currently we use ViscoStat Clear, to control fluid. Future plan to use self-etching bonding agent

UF We teach sandwich technique with RMGIc.

MMC We teach the open sandwich technique using glass ionomer on the gingival floor below the CEJ and restoring with isolation supragingivally.

Continued

UK

1. How does your school teach Class II Composite Restorations when the gingival floor has only cementum/dentin (below the CEJ)?

UL

- In most cases a special liner (e.g., glass ionomer or flowable resin composite) is not used. Chlorhexidine is placed following the etching procedure and before placement of the adhesive. The restoration is placed incrementally to enhance adaptation to the preparation.
- In some cases a glass ionomer is placed on the gingival floor to take advantage of its antibacterial properties and fluoride release. Flowable resin composite is not used.
- The literature does not uniformly support the use of glass ionomer or flowable resin composite versus no liner.

Effect of flowable composite liner and glass ionomer liner on class II gingival marginal adaptation of direct composite restorations with different bonding strategies. J Dent. 2014 May;42(5):619-25.
CONCLUSIONS: Placement of liners improved the values of 'continuous margin' in the gingival floor of the proximal cavities restored with composite resins using different bonding agent.

Dental cavity liners for Class I and Class II resin-based composite restorations. Cochrane Database Syst Rev. 2016 Oct 25
AUTHORS' CONCLUSIONS: There is inconsistent, low-quality evidence regarding the difference in postoperative hypersensitivity subsequent to placing a dental cavity liner under Class I and Class II posterior resin-based composite restorations in permanent posterior teeth in adults or children 15 years or older. Furthermore, no evidence was found to demonstrate a difference in the longevity of restorations placed with or without dental cavity liners. (Note: location of gingival margin was not specified).
Evaluation of Microleakage in Class II Cavities using Packable Composite Restorations with and without use of Liners. Int J Clin Pediatr Dent. 2012 Sep;5(3):178-84
It was concluded that in class II composite restorations gingival microleakage is more at the dentinal surface than on enamel. The use of a flowable composite and RMGIC, as liners, beneath the packable composite, in class II composite restorations, significantly reduces the microleakage when margins are in dentin, but the reverse is true, when the margins are in enamel.

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Continued

UK

1. How does your school teach Class II Composite Restorations when the gingival floor has only cementum/dentin (below the CEJ)?

UL

Effect of Chlorhexidine and Ethanol on Microleakage of Composite Resin Restoration to Dentine. Chin J Dent Res. 2017;20(3):161-168.
Class II cavities with dentinal margin were prepared on 96 premolar teeth. All specimens were acid-etched, rinsed and dried. Then the samples were randomly divided into four groups according to pre-treatment of the dentine: no treatment (control group); treatment with 100% ethanol for 60 s (group 2); treatment with 2% chlorhexidine for 60 s (group 3); 100% ethanol for 60 s and then 2% chlorhexidine for 60 s (group 4).
CONCLUSION: Ethanol-wet bonding and chlorhexidine application may have potential benefits in lowering the occurrence of microleakage in the long term.

Microleakage in Resin Composite Restoration following Antimicrobial Pre-treatments with 2% Chlorhexidine and Clearfil Protect Bond. J Int Oral Health. 2015 Jul;7(7):71-6.
RESULTS: Results indicate that group II (2% chlorhexidine gluconate group) had the minimum mean value (15.05) and group III(Clearfil protect Bond group) and IV (control group) had the maximum mean microleakage at the enamel margin (23.00). At the gingival margin the lowest mean microleakage values were obtained with group I (Clearfil SE bond group) and group II (2% chlorhexidine gluconate) (20.25) and highest with group III and group IV (20.85). The difference was not statistically significant both at the enamel margin and the dentin margin ($p>0.05$).

Efficacy of four lining materials in sandwich technique to reduce microleakage in class II composite resin restorations. Oper Dent. 2014 May-Jun;39(3):256-63.
Fifty sound human premolars were selected and randomly divided into five groups (n=10). Class II box only cavities were prepared in one of the proximal surfaces of each tooth with a gingival margin located approximately 0.5 mm below the cemento-enamel junction. Group A (control) was restored incrementally with composite resin (Tetric Ceram). Groups B, C, D, and E were restored with the sandwich technique using a compomer (Compoglass F), flowable composite resin (Tetric Flow), self-cure composite resin (Degufill SC), or resin modified glass ionomer (Fuji II LC), respectively.

RESULTS: The least amount of microleakage was detected in the incremental group (1.28 ± 0.98). The sandwich technique using resin modified glass ionomer (7.99 ± 9.57) or compomer (4.36 ± 1.78) resulted in significantly more leakage than did the sandwich technique using flowable (1.50 ± 1.97) or self-cure composite (2.26 ± 1.52).
CONCLUSION: According to the results of this study, none of the four sandwich technique composite resin restorations used in this study could reduce gingival microleakage to a greater degree than the incremental technique.

UK **2. How many schools are teaching the medical model for the treatment of caries?**

VCU VCU teaches the Population Health Model whereby caries lesions are treated by elimination or reduction of risk factors. Medicaments are used in addition to oral hygiene education and nutritional education. The patient is treated as a whole (social determinants).

UK We are transitioning to the medical model.

UNC UNC

UL One definition of the medical model is that "Dental caries can be assessed using a medical model for caries management that recognizes the need to treat the bacterial component of caries rather than simply repairing the damage caused by decay. Unlike the surgical model, the medical model places shared responsibility for new carious lesions on the dentist and the patient, as new carious lesions indicate that the infection was not treated to a therapeutic endpoint."
Given this definition, we are using the medical model, starting with the Preventive Dentistry course in the D1 year and the classification of each clinical patient's carious activity.

UAB At UAB we do emphasize the medical model vs the traditional surgical only model. The biggest challenge we have is the persistence on a “requirements based system” and the way Operative is managed for licensure exams.

MUSC I hope all but MUSC is.

AU WE certainly are. Extensively.

ECU We are teaching it.

NSU 100% NSU-CDM is committed to teaching the medical model of caries management.

UF If the medical model is considered here as a personalized caries management based on risk assessment, then we are using this model.

MMC The model is being taught in D2/D3 pre-operative classes. Use is subject to treatment planning on the clinic floor by TEAM leaders.

UK **3. Could each school discuss their competencies for preclinical and clinical grading? How is the grading rubric composed?**

VCU Our preclinical exams are called practical exams or laboratory exams. The term "competency" is reserved for clinical exams. This past spring our clinical operative competency rubrics were revised/updated to reflect the preclinical operative exam rubrics as much as applicable. These exams are based on a 0-5 scale, with each rubric allowing a possible score of Ideal, Satisfactory or Unacceptable. One critical error (scoring an Unacceptable in any category) will fail the exam both preclinically and clinically.

UK Our preclinical Operative Rubrics have specified criteria listed according to sections. The faculty then evaluate each section and assign a grade.
Our clinical grading rubric is composed of the following sections: Clinical Preparedness, Technical Performance, Clinical Judgement, and Professionalism/Professional Conduct. There is a number grade assigned to each section 0-100.

UNC See page 71 - 76

MUSC See page 77

UL Preclinical:
There are 4 competency examinations:
Class II (MO) preparation (amalgam) and restoration (amalgam)
Class II (MO) preparation (resin composite) and restoration (resin composite)
Class II (MO and DO boxes) preparation (resin composite) and restoration (resin composite)
Class V and Class III preparation
Clinical:
There is a D3 clinical exam in the fall and spring for all D3 students to assess their level of competency. The exam consists of one Class II and one Class III resin composite on dentoform.
There are two competency exams on patients in the D4 year… one Class II and one Class III resin composite.
There is a D4 (mock board) Exam in the D4 year to establish eligibility to participate in a regional licensing examination on dentoform.
See page 78 - 99

AU We use a rubric grading sheet that the students receive at the beginning of the section and use for self-evaluation throughout the lab session. See page 100 - 101

ECU Every Class taught in preclinical is tested. For clinic, we have non-surgical management, Class 2 amalgam / composite, class 3 composite, class 5 composite.

NSU Competencies for pre-clinical and clinical grading are the same, except for the preclinical do there is an additional Class IV. The rubric in the clinic has additional patient foundation component.

UF See page 102

MMC We have changed our preclinical practical examination to more closely resemble the board examination. All students start at the same time by instructors who will not be grading. At the preparation step the grading faculty enter the room to assess not knowing the case at hand. This will be done again at the completion step. Failures will be confirmed by a second testing faculty member. Clinical competencies follow the daily grade sheet except that it is pass-fail subject to assessment of critical and non-critical errors.

UNC **1. Does your school employ any hands-on experiments/exams for dental school applicants? If not, are you considering making this change?**

VCU Our school does not employ any hands-on experiments/exams for dental school applicants, although they are rotated through the DentSim laboratory during their interview (although not for any grade/evaluation). To my knowledge, there are no plans to begin this type of testing with applicants. However, we have a hands-on component for the International Dentist Program (IDP) applicants. They take a DentSim test as well as a practical in the simulation laboratory that consists of operative preparations and restorations, as well as a fixed prosthodontic preparation and provisional.

UK We do not require students to take any exams or hands-on experiments when they are here for an interview. While we have discussed, we are not sure of the validity of a one day hands on exercise; have the time to do it; or be able to discern if the outcome of a hands on exam means the individual cannot learn techniques when taught in dental school. The PAT is not a good indicator of handskills, but there hasn't been another valid option of identification that I have seen in the literature.

UNC Currently we do not have a hands-on test for applicants but are considering it.

UL No manual exam for applicants. Not being considered

MUSC No we do not. Only the operative faculty see a need for it so no, it will not happen.

UAB N/A

AU No, but it's tempting. This year we kept track of Payne Block waxing scores (informal) but didn't seem to show much correlation.

ECU No, Yes, Possibly in the future.

NSU No hands on for applicants except for IDG's which will have a bench test as part of their interview process.

UF UF does not currently require any psychomotor exercises for our applicants. This decision is based on the lack of evidence to support including it. See page 103 - 120.

MMC No.

UNC

2. What efforts are in place at your school to ensure faculty calibration in preclinical and clinical courses?

VCU

Speaking for the operative preclinical course, faculty meet before every laboratory session and go over what the assignment and expectations are for the day. Prior to grading a laboratory practical exam, 8-10 cases are discussed and calibrated by faculty prior to beginning the official grading for fairness and consistency.
Clinically, our department has a calibration BlackBoard site with modules on different topics that we are required to review and pass quizzes. This began last year, and has grown to include 13 modules this year. Topics include: Biomaterials, CAD/CAM, Cariology/Hard Tissue Exam, Endodontics, Ethics, Evidenced-Based Dentistry, Occlusion, Operative, Oral Pathology, Periodontology, Pharmacology, Radiology, and Treatment Planning.

UK

We have a clinical manual available via AxiUm. We also strive to have clinical faculty teach in pre-clinical courses, so what is taught is then practiced in the clinic setting. In pre-clinical courses, calibration occurs via discussion.

UL

Preclinical DA
- The course director has assembled photographs illustrating various levels of performance for the wax-ups done as competency exams in the course. This is available to faculty and students.
- Prior to the competency exam, sample wax-ups are graded by faculty and discussed.

Preclinical Operative
- The course director has assembled photographs illustrating various levels of performance for the preparations and restorations done as competency exams in the course. This is available to faculty and students.
- Evaluation criteria is discussed with the faculty prior to the competency exam.

Clinical Operative
- Periodically, the course director holds calibration sessions with the faculty. The sessions are comprised of photographs of preparations and restorations and audience participation devices are used to question the faculty regarding various aspects of the photographs. Discussion follows.
- Only a select few faculty are used to grade competency examinations. These faculty are calibrated along with the faculty in the calibration sessions.
- Pairs of faculty grade the competency exams and they may compare their grades following the exam to determine their calibration level.
- The course director acts as a third grader during some competency exams to gain first-hand knowledge about how well the paired faculty are calibrated. Discrepancies, if any, are discussed.

Continued

UNC **2. Continued: What efforts are in place at your school to ensure faculty calibration in preclinical and clinical courses?**

MUSC The four of us in Operative teach together and grade together. When outsiders are needed, there is often little calibration.

UAB This is a very difficult question to answer… we are revising our clinical guidelines and adding new ones as needed. We also do Grand Rounds and Calibrations sessions. There is a lot of effort poured into this particular endeavor, but I am not sure the results are what we are hoping for yet. It is a work in progress. Change is hard…

AU We have full- to half- day meetings for each course to view samples, grade samples and compare.

ECU I tunes U course, Random presentations by faculty, other online platforms, Faculty rotations including part time faculty to facilitate calibration.

NSU Blackboard, Standardization meetings, Lectures and one on one faculty training.

UF The course directors make videos on how to grade pre-clinically. We work together in creating the rubric for preclinical. We also create iRubric (electronic rubric). Sometimes we grade a few dentoforms together to calibrate ourselves before a grading session.

UNC We hold sessions for adjunct faculty on a regular basis but little to no efforts for fulltime faculty.

MMC We have TEAM Leader's meeting every two weeks and focus on topics that encourage calibration. Prior to mock examinations all faculty are brought together for a simulated calibration of successes and failures by slide presentation.

NSU

1. **Have you implemented use of ICDAS codes 1-6 or merged codes- initial, moderate, extensive, including lesion activity (+/-) on axiUm for a broader caries diagnosis?**
2. **Have you linked treatment options to caries diagnosis in axiUm?**

VCU

1. Taught to D2s but not widely implemented in clinics.
2. No. Have capability but not being implemented.

UK

1. We are using ADA Classification with the lesion activity assessment. This is in process.
2. Yes, in process.

UNC

1. UNC has implemented it in pre-clinical exercises. Students can enter the ICDAS codes as part of their EPR notes (we do not use Axium).
2. We do not use axiUm at UNC.

UL

1. We currently do not use ICDAS coding as ULSD. We have plans to introduce this system in lecture format in our preclinical operative dentistry and preventive dentistry courses as an initial step.
2. We have not linked treatment options to caries diagnosis in axiUm at this time.

MUSC

1. No, I wish we would. Maybe this year under new dean.
2. No, not yet.

UAB

1. We use SALUD, not Axium. We have not done ICDAS on SALUD.
2. We use SALUD, not axiUm. We have not done ICSAD on SALUD.

AU

1. Yes. It is not recorded in axiUm (yet!) but is discussed in diagnosis/tx planning and operative.
2. Yes, For pit and fissure, smooth surface, and root caries.

ECU

1. We teach ICDAS but not in axium, others are incorporated into axium.
2. No

UF

1. No

NSU

1. Didactic information in D-1 year. Currently trying to implement in PG OP Clinic
2. Decision-Making for treatment and Restorative Materials; Informed consent
NSU Policy – effective October 2013
The Department of Cariology and Restorative dentistry follows medical model of caries management which includes caries risk assessment and formulation of the preventive treatment plan. With emphasis on the preservation of tooth tissue, we take all steps to encourage demineralization of non-caveated lesions before resorting to an irreversible surgical procedure. Where restorative procedures are indicated, we follow principles of minimally invasive dentistry. Although we teach principles of amalgam preparation and restoration and use amalgam in our pre-clinic and clinic curriculum, there is no requirement that students restore teeth with amalgam on patient. Amalgam is not the default restorative material but may be considered as an option for high caries risk patients, when preparation ends on cementum and/or when rubber dam isolation cannot be achieved. With the use of composite resin, we can take more conservative approach to preparation extension; we do not make preparations larger to accommodate the physical and mechanical principles required with the use of amalgam… the most conservative approach is prevention.

MMC

1. It is taught in the D2 and D3 pre-operative classes.
2. No.

MUSC **1. Do you use silver diamine fluoride in your schools clinics and how is it used?**

VCU Yes. It is used in the Pediatric Dentistry Clinic, and also in the General Practice Groups. In the GPGs it can be used as a dentin desensitizing agent and for remineralization around margins of crowns and restorations.

UK Yes. We have a specific protocol in place. We use it according to the following indications: extreme caries risk (dry mouth, etc), behavior or medical management challenges (ex. Frail or pediatric patients), multiple lesions that are likely to progress further by the next appointment, difficult to treat areas/locations, patients without access to care, root caries in which surgical treatment is likely to compromise restorability, and patients who refuse surgical treatments. We have a clinic form for informed patient consent.

UNC Yes, in Pedo and Comp Care clinics for desensitizing and arresting caries.
Patient signs a consent form first which describes the color change that occurs with the use of SDF(consent contains pictures) .
Clinical procedure: Rinse the cavity, apply SDF, leave it on for 3 min, apply fluoride varnish on top.

UL Currently we don't use silver diamine fluoride in our clinics. We have plans to introduce this agent in lecture format in our preclinical operative dentistry and preventive dentistry courses as an initial step.

MUSC Yes. It is used to arrest caries in patients with so many lesions the student cannot possibly treat them before they get worse. We also use it as a very effective desensitizer.

UAB In Pedo clinics yes. It has not been implemented in CompCare Clinic as of now.

AU Limited, just starting.

ECU Yes, we do as per manufacturer instructions. In rampant decay, older patients, younger patients, patients who cant afford, Deep lesions.

NSU Yes

MMC It is taught in D2 Preclinical Operative Classes and Pediatric Dentistry. It is available for use in the Pediatric Dentistry area.

Continued

MUSC **1. Do you use silver diamine fluoride in your schools clinics and how is it used?**

UF Yes, and the following protocol is used in the DMD clinics for application of Advantage Arrest (adapted from Horst et al., J Calif Dent Ass, 2015)

1. Plastic-lined cover for counter, plastic-lined bib for patient.
2. Standard personal protective equipment (PPE) for provider and patient.
3. One drop of SDF into the deep end of a plastic dappen dish.
4. Remove bulk saliva with saliva ejector.
5. Isolate tongue and cheek from affected teeth with 2-inch by 2-inch gauze or cotton rolls, Isolite, Optragate, etc.
6. Clean tooth/carious lesion with pumice/rinse and dry.
7. Protect adjacent soft tissues with petroleum jelly.
8. Dry affected tooth surfaces with triple syringe or if not feasible dry with cotton.
9. Microbrush, immerse into SDF, remove excess on side of dappen dish.
10. Apply directly onto the affected tooth surface(s).
11. Allow SDF to absorb for up 30 second, then remove excess with dry micro-brush, cotton pellet or HVS (surgical tip).
12. Repeat step 10 one more time
13. Apply light from a light curing unit for 5 to 10 seconds. The precipitated silver phosphate compound will turn the affected dentin black
14. For esthetic reasons, a RMGI can be inserted to the cavity.
15. Place gloves, cotton and microbrushes into plastic waste bags.

MUSC **2. Do you use antimicrobials to help manage high caries risk patients in your operative clinic? If so, what is used and how is it used?**

VCU Yes. For both High Risk and Extreme High Risk: Chlorhexidine (10 ml x 1 min x 1 times per day x 1 week, once a month), 5000 ppm fluoride toothpaste (Clinpro), and MI paste.

UK Silver diamine fluoride for active caries lesions.

UNC No.

UL We use Hibiclens (chlorhexidine gluconate) prior to restoration placement on all restorations. High caries risk patients get either 5% NAF varnish or 1% NAF paste as a remineralization agent and antimicrobial agent. We selectively use Cervitec Plus, a protective varnish containing chlorhexidine and thymol, on high caries risk patients.

MUSC Yes, we use chlorhexidine, ½ ounce once per day for seven days, repeated monthly.

UAB Clorhexidine rinses are prescribed for short term initial management of severely affected patients/dentitions.

AU No.

ECU Yes

NSU Yes, chlorohexidine is used as part of the high caries risk kit. First week of every month for up to 8 months.

UF Two antimicrobials are available as options for management of high and extreme risk patients: chlorhexidine (CHX: 0.12% gluconate rinse) and SDF (if you consider this product as antimicrobial). However, the CHX rinse is rarely recommended by faculty and students.

MMC No except for Chlorhexidine rinses.

1. What are the protocols and clinical thresholds for placement of restorations on primary carious lesions? Please be specific about type of lesions (enamel and dentin), activity (active or inactive), cavitation (cavitated or non-cavitated), radiographic interpretation of proximal lesions (lesions in enamel: E1 and E2, and lesions into dentin: D1, D2, D3), and caries risk (does the patient's caries risk affect the restorative decision?).

a. Is the technique of tooth separation using orthodontic rubber rings being used at your school for detection of cavitation (or assessment of cavitation status) in proximal lesions? If yes, please describe the tooth separation protocol including the indications and methods used?

UF

UNC

Active lesions – cavitated (ICDAS 3, 4, 5, 6)– restore, on very specific cases SDF may be recommended (root caries, inaccessible surface).
Active Lesions - Non-cavitated lesions – smooth surfaces – fluoride varnish, non-cavitated on occlusal surfaces (no dentin shadow – ICDAS 1 &2), sealants, with dentin shadow (ICDAS 4) or radiographic radiolucency into dentin: restoration
Inactive lesions – cavitated into dentin – restoration (small arrested root caries lesions are not always restored); cavitated into enamel (ICDAS 3), no radiolucency – occlusal surface sealant or no treatment; smooth surface, no treatment. – Caries risk considered when making decisions
Inactive lesions – non-cavitated – no treatment (unless indicated by other needs, like esthetics)
For proximal lesions where activity cannot be determined, Tooth separation is recommended – ortho separator used, placed with floss, left in place 48-72h. Remove the separator, clinical exam of the lesion and follow the protocol above based on lesion activity and extend.

UL

Any lesion that is radiographically at the DEJ or deeper is restored at ULSD. These lesions are evaluated by use of image enhancement methods available within MiPACS. Any E2 lesion is restored at ULSD if the patient is a moderate or high caries risk patient unless the patient is willing and demonstrates modifications to their lifestyle that decreases the caries risk. All cavitated lesions are restored at ULSD. We do not differentiate between active and inactive (arrested) carious lesions at ULSD. This cannot be determined clinically unless the lesion is opened and explored or evaluated radiographically over time. The technique of separating proximal surfaces to evaluate for cavitation of a lesion is not done at ULSD.

MUSC

No, it is not used.

AU

Gosh, this is a whole lecture! Our overall philosophy is that cavitated lesions get treated, including interproximal lesions, and others are treated non-invasively.

UK

This classification is in process. We are teaching the use of orthodontic rubber rings for detection of cavitation in preclinical Cariology Course. and this is available in the clinic.

ECU

We attempt to use the ICDAS and CAMBRA model but it is a challenge in clinic with part time. Operative does teach minimally invasive protocols, resin infiltration of incipient lesions as well as partial excavation of deep caries.

Continued

UF **1. Continued: Protocols and Clinical Thresholds**

VCU

1. In Cariology and Operative we teach:
-Restore a cavitation if it meets one or more of these criteria:
1) Need to Restore Esthetics
2) Need to Restore Function
3) Need to Protect pulp from progressing caries/decrease sensitivity
4) Need to restore Cleansibility
-"A cavitated lesion by nature is more likely to be active and progress because self-cleaning is difficult." http://jada.ada.org/article/S0002-8177(14)00029-4/pdf. Accessed 01-05-16. The American Dental Association Caries Classification System for Clinical Practice. February 2015.
-"Although studies show that sealants can be applied over small, cavitated lesions, with no subsequent progression of caries, sealants should be used primarily for the prevention of caries rather than for the treatment of existing caries lesions.34,35 A bitewing radiograph should be obtained and evaluated before sealant placement to ensure that no dentinal or proximal caries is evident. Only caries-free pits and fissures or incipient lesions in enamel not extending to the dentinoenamel junction (DEJ) currently are recommended for treatment with pit-and-fissure sealants.36" (Heymann, et. al, Sturdevant text 6th edition, p. 256)
34. Handelman, SL, Leverett, DH, Espeland, MA, et al.: Clinical radiographic evaluation of sealed carious and sound tooth surfaces. J Am Dent Assoc. 113(5), 1986, 751–754.
35. Mertz-Fairhurst, EJ, Smith, CD, Williams, JE, et al.: Cariostatic and ultraconservative sealed restorations: Six-year results. Quintessence Int. 23(12), 1992, 827–838.
36. Beauchamp, J, Caufield, PW, Crall, JJ, et al.: Evidence-based clinical recommendations for the use of pit-and-fissure sealants: A report of the American Dental Association Council on Scientific Affairs. J Am Dent Assoc. 139(3), 2008, 257–268. (Heymann p. 278)
-ICCMS recommends restoring enamel cavitations on approximal surfaces.
a. No

UF

Enamel, active or inactive lesions are not restored. Dentinal, active cavitated lesions are restored. Dentinal, inactive cavitated lesions are restored only if determined that the cavity promotes biofilm formation (therefore increases the caries risk) or for esthetic reasons. D1 lesions that are non-cavitated should not be restored – however, the patient is informed of the risks and benefits and should agree with the monitoring and management plan to stop lesion progression. The presence of cavitation and lesion activity - rather than the caries risk - are the main determinants for placement of restorations. However, and as expected, patients at high/extreme caries risk are more likely to receive restorative treatment.
a. Yes by a recently developed protocol. See page 121-122

NSU

Department philosophy: radiolucency in the inner ½ of the enamel ± DEJ: for borderline lesions, will look at all risk factors including lesion activity / likelihood of lesion progression - active lesion can push the scale, medical history- medications, head neck radiation, sjogren's syndrome- leading to dry mouth, ability and willingness for compliance to recommended preventive treatment modalities, diet high in fermentable carbohydrates / frequency of consumption, DMFT- dental history, ability to monitor lesion over time in an educational setting (small percentage of patients enter Re-Care pool) vs private practice setting , if other lesions in patients' mouth- with similar radiographic staging were surgically treated and were much larger than radiographs would indicate.

MMC

These concepts are taught but implementation is slow due to the difficulty in changing the mindsets.

UF

2. Is the technique of resin infiltration (Icon) being used at your school? If yes, please describe the protocol including the indications and methods used?
3. What is the protocol used at your school for monitoring the progression of carious lesions that were not restored? For example, E1 and E2, and even D1 lesions that were treatment planned for preventive measures that aid the re-mineralization instead of surgical treatment.

VCU

2. No.
3. We document them in progress notes

UK

2. No.
3. No protocol is currently established, however we there is a need and plan to establish protocol.

UNC

2. Yes, only the graduate program.
3. Re-examine and take radiograph if necessary at an appropriate interval.

UL

2. Not Currently Utilized.
3. Monitoring of unrestored E1 and E2 interproximal lesions if done radiographically. The frequency of the radiographic evaluation is determined by the caries risk of the patient and can be modified if the patient's caries risk changes.

MUSC

2. No, it is not used.
3. There basically isn't any. They are marked on the chart but often not examined again until time for final exam before dismissing patients to recall/maintenance.

UAB

2. It is used but in the research clinic, not yet in the CompCare undergrad clinic. We want to have our results first before we implement it.
3. In all those cases a non-surgical management is detailed in the Electronic Record (including, OHI, dietary counseling, remineralizing pastes, rehydrating gels, increased frequency of maintenance visits, etc and followed up by the student in charge of the case. When appropriate, new radiographs are taken and comparisons are made.

AU

2. No.
3. Re-evaluation at recall exams. No specific protocol.

Continued

UF

2. Is the technique of resin infiltration (Icon) being used at your school? If yes, please describe the protocol including the indications and methods used?

3. What is the protocol used at your school for monitoring the progression of carious lesions that were not restored? For example, E1 and E2, and even D1 lesions that were treatment planned for preventive measures that aid the re-mineralization instead of surgical treatment.

ECU

2. Yes per manufacturer instructions on E1 and E2 lesions per classical recommendations. For patients who are not compliant.

3. We have watch codes in axium that prompt students/ faculty to revisit and record at predefined recall dates. Progression is tracked with radiography along with clinical photos to track progression.

NSU

2. Taught, in pre-clinical didactic only.

3. Monitor code entered in a AxiUm and kept in process, therefor the lesion can be evaluated during annual exam and before exiting the patient.

UF

2. Yes. Only on smooth surfaces (facila, Lingual, Buccal). The protocol that we used is the protocol recommended by the manufacture. We clean the tooth, apply the etch, apply the alcohol and then the resin infiltration. We take photographs before/after to show the patient.

3. We follow the same newly developed protocol for monitoring carious lesions. See attached 29a

MMC

2. No. We teach the use of MI paste.

3. We are striving to assess or reassess at the recall appointment.

1. The Minamata Convention on Mercury, with the goal to prevent mercury and mercury compounds from negatively impacting humans and the environment, will enter into force on August 16, 2017 now that 50 countries have ratified it, including the US. Will this impact how dental schools use amalgam? Will it impact your teaching of amalgam restorations?

UL

VCU I was not aware of this conference until seeing this CODE question. I would like to learn more about it and also know what the ADA, IADR, etc. have to say on this subject.

UK We have not implemented immediate changes in curriculum relating to amalgam regarding the Minamata Convention at this time.

UNC It will not impact the way we teach at UNC.

UL The Minamata Convention on Mercury is a global treaty to protect human health and the environment from the adverse effects of mercury. The Convention's provisions for dental amalgam—a mercury-added product containing 50% mercury—make it highly relevant to the dental profession. Dental amalgam is a key restorative material in the fight against dental caries, the cause of tooth decay, which afflicts 90 percent of the world's population, making it a global public health issue. Dental amalgam is the only mercury-added product subject to a phase-down by the Convention. Dental amalgam continues to be an important treatment modality for dental caries that has compromised tooth structure since it has been clinically proven, is cost-effective, and affordable.
It has been a general trend for dental schools to reduce the number of amalgam restorations and the Convention will drive that trend.
ULSD will continue to teach and offer dental amalgam while emphasizing the importance of preventive dentistry which will minimize the need for dental restorations and the proper handling and disposal of mercury waste.

MUSC I believe it will but not soon in South Carolina. For now it will not affect what I teach as I already teach about that in my environmental effects lecture. (We don't even have amalgam separators in our school)

UAB Yes. We have already de-emphasized the teaching of amalgams, NOT because we do not think it is a good option to restore teeth, but because it is increasingly difficult to have patients acceptance.

AU We already place very few amalgams, but no plans to modify.

ECU No, we are still teaching and will continue to teach. The population our school caters to, will not allow us to discontinue teaching of amalgam.

NSU No, the amalgam and amalgam prep is still used as the gold standard for evaluating hand skills

UF As long as ADA and FDA are supporting the use of amalgams. The University of Florida will teach amalgam and support its use.

MMC We are in the process of obtaining amalgam separators for clinic use. As long as board examinations offer the amalgam option on the licensure examination we will teach it.

UL

2. Does your school use a desensitizing agent under restorations? If yes, which agent do you use? Is it applied under all (amalgam and composite) restorations? Is there evidence of efficacy?
3. How are your schools preparing for the INDBE quickly approaching in 2020?

VCU

2. We seal our amalgams using Optibond Solo Plus, unless it extensive in which case we will bond it in using Scotchbond Multipurpose Plus. Optibond Solo Plus is the bonding system we currently use for our composites. We do have a GLUMA product available for desensitization, but it not taught as a routine application underneath amalgams.
3. 1. Stressing what a general dentist needs to know. This board will be based on application to the general dentist.
2. Creating more case based learning.

UK

2. Yes. We use Fuji Liner and Gluma.
3. We have not started at this time.

UNC

2. We use Gluma and G5. We recommend placing it under all amalgam restorations desensitization. Under all composite restorations with dentin exposure, except the ones that employ use of self-etch adhesives, as a desensitizing agent and primer.
3. N/A

MUSC

2. We use GLUMA under all amalgam restorations. It is not used under composites, we use chlorhexidine under composites followed by OptiBond XTR.
3. So far, nothing has happened here. Once accreditation is over later this month, I expect this will become the next big issue.

UAB

2. We do not teach a mandatory use of a desensitizing agent under every restoration.
3. N/A

AU

2. No.
3. Well, it would help to know what it's going to look like. No changes yet.

ECU

2. Yes, if needed, Gluma.
3. Through CIE's. we are being particular about OSCE to help connect the dots between basic science and clinical aspects.

NSU

2. No

UF

2. We have gluma under amalgams and we use chlorhexidine under resin-based composites. To avoid sensitivity in the restoration we stress the use of bases or use a self -etch approach (Clearfil SE Bond2)

Continued

UL

2. Does your school use a desensitizing agent under restorations? If yes, which agent do you use? Is it applied under all (amalgam and composite) restorations? Is there evidence of efficacy?

3. How are your schools preparing for the INDBE quickly approaching in 2020?

UL

2. ULSD does not utilize a desensitizing agent. Chlorhexidine is applied under all operative dentistry preparations (references cited under UK section above).

Clinical performance of cervical restorations with desensitizing agents: 18-month clinical trial J Adhes Dent. 2012 Apr;14(2):183-9.
CONCLUSION: The use of potassium oxalate-based desensitizing agent did not decrease postoperative sensitivity when it was used under composite resin restorations.

Effect of desensitizing agents on the bond strength of dental adhesive systems. Applied Adhesion Science. December 2014, 2:24
A total of 48 molars were divided into six groups, according to conventional application (CV) of the adhesive systems Scotchbond Multipurpose (SB) and Clearfil SE Bond (CF) and their association with bioglass (BG/Biosilicate®) or arginine (AR/ Sensitive Pro-Relief/TM).
It is concluded that arginine did not interfere with the bond strength with dentin, while the use of Biosilicate® tended to strengthen the bond between dentin and the adhesive systems used.

Desensitizing bioactive agents improves bond strength of indirect resin-cemented restorations: preliminary results. J. Appl. Oral Sci. vol.15 no.2, Mar./Apr. 2007
The teeth were assigned to 4 groups (n=5): Group I: acid etching + Prime & Bond NT (Dentsply); Group II: application of a bioactive glass (Biosilicato®)+ acid etching + Prime & Bond NT; Group III: One-up Bond F (J Morita); Group IV: Biosilicato® + One-up Bond F.
CONCLUSION: The use of desensitizing agent did not affect negatively the bonding of the indirect composite restorations to dentin, independently of the tested adhesive systems.

Clinical Performance of Cervical Restorations with Desensitizing Agents: 18-month Clinical Trial. journal of adhesive dentistry 1(2) · June 2011
There were no statistical differences between the groups restored with or without the use of a desensitizing agent for postoperative sensitivity.

3. The written examinations in Preclinical Operative Dentistry will include some questions in the new format in order to familiarize students with the exam.

MMC

2. We teach the use of Gluma because research has shown it to be effective. It is used in the clinic when we have it available.

3. We are currently undergoing curriculum review to see how we are going to change the curriculum to accommodate INDBE. We are changing to integrate the curriculum by modifying biomedical, clinical, and behavioral aspects into case studies.

AU **1. How is everyone handling SDF?**

VCU See answer for MUSC - "Yes. It is used in the Pediatric Dentistry Clinic, and also in the General Practice Groups. In the GPGs it can be used as a dentin desensitizing agent and for remineralization around margins of crowns and restorations."

UK We have a specific protocol in place. We use it according to the following indications: extreme caries risk (dry mouth, etc), behavior or medical management challenges (ex. Frail or pediatric patients), multiple lesions that are likely to progress further by the next appointment, difficult to treat areas/locations, patients without access to care, root caries in which surgical treatment is likely to compromise restorability, and patients who refuse surgical treatments. We have a clinic form for informed patient consent.

UNC Sensitivity and caries arrest – unidose, charged per dose. Patient signs a consent form first which describes the color change that occurs with the use of SDF (consent contains pictures).
Clinical procedure: Rinse the cavity, apply SDF, leave it on for 3 min, apply fluoride varnish on top.

UL Currently we don't use silver diamine fluoride in our clinics. We have plans for introducing the agent in lecture format in our preclinical operative dentistry and preventive dentistry courses as an initial step.

MUSC See page 123

UAB See answer for MUSC above- "In Pedo clinics yes. It has not been implemented in CompCare Clinic as of now."

ECU In rampant decay, older patients, younger patients, patients who cant afford, Deep lesions.

NSU At this point only under supervision of the director of Restorative.

UF
- Plastic-lined cover for counter, plastic-lined bib for patient.
- Standard personal protective equipment (PPE) for provider and patient.
- One drop of SDF into the deep end of a plastic dappen dish.

MMC Silver Diamine Fluoride is taught in Pre-clinical Operative Dentistry and in Pediatric Dentistry. It is available for use with Faculty with experience using it.

MMC

1. **How is the ICDAS being implemented at your school? Is there a form being used?**
2. **What caries detection systems are being used?**
3. **Are you using digital impression systems and to what extent?**

VCU

1. We have ICDAS instruction in the Cariology course, and D2 students can properly assign ICDAS codes by the end of the fall semester.
2. Visual (loupes magnification), bitewing radiographs, explorer and/or WHO probe.
3. Yes, for mostly crowns and implant guides at this point in time. By the time the currently enrolled students graduate, all will have done at least one CAD/CAM restoration.

UK

1. No. We are using ADA Classification.
2. Adequate lighting and careful visual inspection. Teeth are clean and dry.
3. We are beginning to use digital impressions this semester.

UNC

1. Yes, in preclinical.
2. Trans-illumination and visual.
3. We use it mostly in the DDS4 clinics. At least half the impressions are done in this manner.

UL

1. We currently do not use ICDAS coding as ULSD. We have plans to introduce the system in lecture format in our preclinical operative dentistry and preventive dentistry courses as an initial step.
2. At this point, caries detection is done by clinical and radiographic visualization through caries risk assessment (CAMBRA). We do not use any laser or fluorescent caries detection systems.
3. We are currently using E4D and E4D compare digital scanning technology in our preclinical fixed courses. We just recently implemented a digital E4D clinic where students can see their patients to both scan and mill restorations.

MUSC

1. It's not and no form. Yet. I expect this to be added this year.
2. N/A
3. We use it extensively. After first completing one case with traditional impression techniques, our students use digital impressions almost exclusively.

AU

1. We are primarily teaching it for diagnosis, with treatment planning done around the CRA in the CAMBRA framework.
2. Visual Tactile and radiographs
3. Not very much clinically.

MMC

1. We use a Caries Risk Assessment Form in Oral Diagnosis.
2. None but they are taught in D2 and D3 pre-clinical courses in Operative Dentistry.
3. We are not using Itero of other digital impression systems. We are using CAD-CAM system for impression and milling.

MMC

1. **How is the ICDAS being implemented at your school? Is there a form being used?**
2. **What caries detection systems are being used?**
3. **Are you using digital impression systems and to what extent?**

UAB

2. I prefer that students learn the clinical expertise for detection rather than relying on color solutions, Diagnodent or others. Those are presented in lecture for their information. Disclosing solutions are available in clinic and are used at the discretion of the attending. We do not have Diagnodent or Cari-vu or such available in our clinics.
3. Yes. True Definition by 3M. it really has not been widely used because not all faculty feel comfortable enough to use it in clinic.

ECU

1. Yes, we cover in lecture but not used much in clinic at this point.
2. Visual , radiographic, trans illumination.
3. Yes, limited to what our CADCAM system supports

NSU

1. Not in the clinic but taught didactically in pre-clinical courses.
2. Visual tactile X-Rays
3. Yes, routinely for single crowns.

UF

1. As part of the new Cariology and Preventive Dentistry course, ICDAS is taught in the format of a lecture followed by preclinical lab using extracted teeth for scoring carious lesions. ICDAS has not been introduced into the clinical program yet and no form is available. The goal is to transition ICDAS into the clinical program.
2. Caries detection methods: visual, tactile (gentle use of explorer without damaging tooth structure), radiographic, and transillumination (same device as ligh-curing device). Caries detection systems: ICDAS in preclinic and no specific system in clinic (see answer to 1st UF question).
3. No, we are not using digital impressions, but we are using E4D for our Aesthetic clinic for our digital cases.

ECU

1. **Faculty calibration - how are you calibrating preclinical and clinical faculty at your school?**
2. **What percentage of the operative curriculum is focusing on amalgam**

UK

1. We have a clinical manual available via AxiUm. We also strive to have clinical faculty teach in pre-clinical courses, so what is taught is then practiced in the clinic setting. In pre-clinical courses, calibration occurs via discussion.
2. Curriculum focusing on amalgam is approximately 40% of the Restorative I/ Operative Curriculum.

UNC

1. Faculty calibration in preclinical courses are mostly the responsibility of the course director. Clinical faculty calibration/ orientation sessions are held for adjunct faculty. Not many efforts in place for full time faculty members.
2. About 40%

MUSC

1. We really don't I'm sorry to admit.
2. About 1/3 at present. The Operative I course covers amalgam and Operative II covers composite. But in my Operative I course I also cover operative anatomy, instrumentation, isolation, and cariology.

UAB

1. See answer for UNC above. - "This is a very difficult question to answer… we are revising our clinical guidelines and adding new ones as needed. We also do Grand Rounds and Calibrations sessions. There is a lot of effort poured into this particular endeavor, but I am not sure the results are what we are hoping for yet. It is a work in progress. Change is hard… "
2. Very small percentage now. It is taught in preclinic D1, and we have a Competency (prep/fill) at the end of Preclinic D2 before they get to see patients in clinic and a minimal amount of clinical expectations though.

AU

1. At faculty retreats for each teaching section, and course. We grade preclinical work together. The rubrics are the most effective tool for calibration.
2. It's still almost a third, even though the clinical numbers say it's less than 10%.

ECU

1. By itunes U course, Presentations but its hard to keep up with the volume of part time faculty teaching in clinic.
2. About 25-30 percent.

NSU

1. Blackboard, Standardization meetings, Lectures, one on one faculty training. In addition, we also have grading team for Pre-clinical and clinical that are fully standardized that can grade for both Pre-clinic and clinic.
2. 1/5

MMC

1. We are conducting calibrations as a part of our biweekly TEAM Leaders Meetings and before mock exams with visual calibrations.
2. 100% D1. 50% D2. 25% D3 (mostly in review).

2017 National CODE Questions

Notes-

I. Clinical Curriculum

a. In your school, do students practice on one another in preparation for their clinical experiences?

i. What types of procedures? – Examples include:

1. Extra/intraoral examination
2. Periodontal probing
3. Alginate impressions
4. Photography
5. Radiographs
6. Local anesthetic
7. Prophylaxis
8. Retraction Cord Placement
9. Others – Please be specific

Types	AU	ECU	MMC	MUSC	NSU	UAB	UF	UK	UL	UNC	VCU
1. Extra/intraoral exam	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Periodontal probing	Y	Y	N*	Y	Y	Y	Y	Y	Y	Y	Y
3. Alginate impressions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4. Photography	Y	Y	N	N	Y	Y	Y	Y	Y	N	Y
5. Radiographs	N	Y	Y	N	N	Y	N	N	Y	N	Y
6. Local anesthetic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*	Y
7. Prophylaxis	Y	N	Y*	Y	Y	Y	Y	Y	Y	Y	Y
8. Retraction Cord	Y*		N	N	N		N	N	N	N	N

AU

8. Retraction Cord Placement- Yes, Very Limited.
9. Others- Caries Risk Assessment

UK

a. Yes, for specific procedures.

UNC

a. Yes. Although the only invasive procedure they practice on each other if LA lab.
6. Local anesthetic- fondly called "stab lab"
9. Others- Salivary testing, plaque detection, blood pressure monitoring

UF

9. Others- Collecting saliva, Facebow

MMC

2. No-The students will do self-probing only on their front teeth.
8. Yes- optional
9. NO2 application

I. Clinical Curriculum

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic?
ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic?
iii. Will this policy change when INDBE is in place?
iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?
v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

Benchmarks	AU	ECU	MMC	MUSC	NSU	UAB	UF	UK	UL	UNC	VCU
i. NBDE1 Entry	N	N	Y	N*	Y	Y	N	N	N	*	N
ii. NBDE2 Entry	N	N	N	N*	N	N*	N	N	N	N	N

MUSC

i. But passing it by the third attempt is required to continue. Students who fail on the third attempt are removed from clinic until they pass. This tends to happen once every-other year of so.
ii. It is a requirement for graduation and conferral of the D.M.D. degree.

UNC

i. Not anymore. They were required to pass NBDE1 to move into DDS 3 clinics. This was requirement was recently eliminated.

UAB

ii. No, but it is a requirement for graduation.

I. Clinical Curriculum

b. Benchmarks for entering the pre-doctoral clinics

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iii. Will this policy change when INDBE is in place?
iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?
v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

Benchmarks	AU	ECU	MMC	MUSC	NSU	UAB	UF	UK	UL	UNC	VCU
iii. Policy Change	*	N*	*	N*	Y	*	N	N	*		*
iv. Passing All	Y	Y	Y	Y	Y	N	N*	Y	Y	Y*	*

AU

iii. Don't know

ECU

iii. No, not likely

MUSC

iii. I don't know but believe passing it will still be required for graduation in South Carolina.

UAB

iii. Students will take INDBE as D4 students. It will NOT be a requirement for clinic, but will be a requirement for graduation.

UL

iii. Maybe, there is talk in the academic dean's office to update policies associated with national boards.

UNC

iv. Yes, to perform procedures in clinic the students have to pass the pre-clinical component of that procedure/subspecialty.

VCU

iii. No decision yet; will likely at least set a timeline by which they must take the exam. Our current policy is on when you must attempt the exam, not when you must pass.

iv. Not officially, but APC does not let a student remediating pre-clinical Prosthodontics begin clinical prosthodontics patient care. Operative being D1 remediation would always be complete well before D3 year, but I don't think APC allows a student repeating operative to do patient-based operative in D2 clinical skills.

UF

iv. No, the last removable course is taught the same semester in which our students begin in the clinic.

MMC

iii. Most likely. We are currently undergoing discussions in curriculum revision.

I. Clinical Curriculum

b. Benchmarks for entering the pre-doctoral clinics

i. Is passing NBDE1 a requirement for entry into the pre-doctoral clinic?
ii. Is passing NBDE2 a requirement for entry into the pre-doctoral clinic?
iii. Will this policy change when INDBE is in place?
iv. Is passing all pre-clinical operative, fixed, and removable courses a pre-requisite for entry into the pre-doctoral clinic?
v. What other pre-requisites, if any, are necessary prior to being allowed to treat patients in the pre-doctoral clinic?

Benchmarks	AU	ECU	MMC	MUSC	NSU	UAB	UF	UK	UL	UNC	VCU
v. Other	None	*	*	*	*			*	*	*	*

MUSC

v. Pass the Pre-clinical competency exam

ECU

v. All skills assessments passed. Passing all preclinical assessments

NSU

v. CPR Recertification

UK

v. The 2nd year students must pass the local anesthesia course before they can give anesthesia.

UL

v. Alginate and Anesthesia Competencies

UNC

v. They need to pass the gateway course DENT 120 – Novice Clinician Portal, which conveys many different information pertinent to clinical setting.

VCU

v. Pass or remediate relevant D1 and D2 preclinical courses. Implied, if not explicit.

MMC

v. None

I. Clinical Curriculum

c. What is the student/faculty ratio in your school's pre-doctoral clinic?

i. Does case complexity play a role in determining this ratio?

	Student : Faculty Ratio	Case Complexity Determine Ratio?
AU	8:1 D4, 6:1 D3, 4:1 D2	N
ECU	6:1	
MMC	Ranges from 1:5 ideally to 1:10 due to faculty absence from the clinic for other assignments.	Only when requested for the schedule to be lightened.
MUSC	6:1 On good days	It should, but doesn't
NSU	6:1	No
UAB	Typically 8:1	No
UF	The ratio is 6:1 in regular predoctoral clinic and 2:1 in our esthetic/CAD CAM clinic.	No
UK	2nd year goal 6:1, can be 8:1 or 10:1 for third and fourth years students	No
UL	6:1	No, complex cases are referred to a specialty clinic prn.
UNC	In DDS 2 and DDS 3 clinic 5:1. In DDS 3 and DDS 4 clinics maintained at 6:1, upper limit of 8:1.	The number to safely treat is determined by the clinical experience of the students. DDS 2 mostly perform prophylaxis and operative procedures.
VCU	The scheduled ratio is 7:1. Occasionally extra student(s) may be added on as an emergency.	To my knowledge, appointments are scheduled based on available openings regardless of case difficulty. For example, one faculty may have 5 periodic exams with prophies vs. someone else who may have 6 crown and bridge cases.

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

1. $CaOH_2$
2. ZOE
3. RMGI
4. MTA

Material	AU	ECU	MMC	MUSC	NSU	UAB	UF	UK	UL	UNC	VCU
1. $CaOH_2$	Y	Y	Y*	Y*	Y	Y	Y	Y	Y	Y*	Y*
2. ZOE	N	Y	Y*	N	Y	Y*	N	N	Y	Y*	Y*
3. RMGI	*	Y	Y*	N	Y	Y	Y*	N*	Y	Y*	Y*
4. MTA	Y	Y	Y*	N	Y	*	Y*	N*	N	Y	Y*

AU

3. RMGI Only over a CaOH2 pulp cap.

MUSC

1. CaOH2 PulpDent paste

UAB

2. ZOE- Yes: rarely.
4. MTA NO in undergrad, YES in GRAD ENDO and GRAD PEDO

UK

3. RMGI No: Place over Dycal.
4. MTA No: (Endo is teaching)

UNC

1. CaOH2 Yes: Dycal, Reserved for use only when a pulp exposure is apparent or suspected.
2. ZOE IRM. (Rarely used in our clinics for pulp protection).
3. RMGI Vitrebond as liner/base material

VCU

1. CaOH2 Yes: This is taught, but we also teach TheraCal LC which we have switched to in the pre-doc clinic.
2. ZOE Yes: as a temporary restoration
3. RMGI Yes: Vitrebond Plus (as a liner/base)
4. MTA Yes: taught by Endodontics Dept.

UF

3. RMGI Yes: Over the CaOH2
4. MTA Yes: Endodontics

MMC

1. CaOH2 Yes: Direct Placement
2. ZOE Yes: as a temporary greater than 1mm away from the pulp.
3. RMGI Yes: as a temporary greater than 1mm away from the pulp.
4. MTA Yes: taught in D2/D3 pre-clinical operative and available for use in Endo dontic clinic-Direct Placement

Continued

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

i. Material(s) used – Please be specific

5. TheraCal LC (Bisco Dental)
6. Biodentine (Septodont)
7. Others

ii. Technique(s) taught – Please be specific

Material	AU	ECU	MMC	MUSC	NSU	UAB	UF	UK	UL	UNC	VCU
5. TheraCal	N	N	Y*	N	N	N*	N	N	N	N	Y*
6. Biodentine	N	N	Y*	N	N	N*	N	N	N	N	N

AU

7. Others Ultrablend
ii. Technique(s) taught – Teach conservative caries excavation and Indirect PC preferred.

MUSC

ii. Technique(s) taught – Clean preparation with Bisco Cavity Cleanser (2% chlorhexidine), place small amount of CaOH2, cover with RMGI (VitraBond), restore tooth. Advise patient tooth may need endodontic therapy. If rubber dam was not present, case goes straight to endo.

NSU

ii. Technique(s) taught - See page 124 - 125

UAB

5. TheraCal LC No (Yes in research)
6. Biodentine No (Yes in research)
ii. Technique(s) taught - STEPWISE and NO RE-ENTRY are taught in lectures and performed in clinic at the discretion of the Faculty member covering the case that day.

UK

ii. Technique(s) taught - We teach them to use CaOH2 (Dycal) if pulp tissue has been exposed. We teach them to cover the Dycal with a GC Fuji Lining LC Paste. No Dycal placement if no pulp exposure.

UL

ii. Technique(s) taught - We currently use CAOH for the majority of asymptomatic pulp capping both direct and indirect. We cover the highly soluble and brittle CAOH with RMGI LC lining material. We use ZOE in those symptomatic cases where the pulpitis may need to resolve

UNC

ii. Technique(s) taught - See page 126 - 127

VCU

5. TheraCal Yes (for direct and indirect pulp capping)

MMC

5. Yes. Taught but not used in the clinic. Direct Placement
6. Yes. Used in the clinic as Direct Placement and taught in D2/D3 pre-clinical Operative

Continued

II. Biological Aspects of Operative Dentistry

a. Pulp capping and pulp tissue management

ii. Technique(s) taught – Please be specific

UF

Regarding the materials: In our DMD clinics, TheraCal LC was being used as the indirect and direct pulp capping material. However, we were facing some issues, such as the easy removal of that material during the adhesion steps. Moreover, as it contains resin monomers and also require the light curing step could add more damage to the pulp tissue, and the literature is still lacking evidence regarding this material. Therefore, it was decided by the Operative Division to stop the use of TheraCal and go back to the use of calcium hydroxide (liner) protected by the RMGI (base).

ii. Technique(s) taught – Please be specific

Indirect Pulp Capping:

1) Leave affected (leathery or firm) dentin only on pulpal or axial walls in the area immediately adjacent to the pulp.
2) Apply Consepsis (2%chlorhexidine) solution with a brush tip with a gentle scrubbing motion for 60 seconds and gently air dry (do not rinse).
3) Place Dycal (CaOH2) over the demineralized dentin
4) Place Vitrebond (RMGI) over and beyond the margins of the Dycal, but keep Vitrebond away from the cavosurface margins.
5) Restore with a bonded restoration. As determined by attending faculty, if time does not permit to do a definitive restoration, use Resin Modified Glass Ionomer (RMGI) as a protective restoration.

Direct Pulp Capping: to continue with this procedure, the following criteria should be met: during carious tissue removal, there is a small (< 1mm) mechanical exposure; any bleeding from the exposure can be easily stopped and there is no sign of suppuration or necrotic pulp tissue. After the correct diagnostic, the following steps should be performed:

1) Establish hemostasis by applying light pressure using a sterile cotton pellet with a 1.25% sodium hypochlorite solution. Gently rinse and dry. Bleeding should be easily controlled. If not, endodontic treatment should be considered.
2) Place Dycal (mix A & B) over the demineralized dentin.
3) Place Vitrebond (mixA&B) over and beyond the margins of the Dycal, but keep Vitrebond away from the cavosurface margins.
4) Restore with a bonded restoration. As determined by attending faculty, if time does not permit to do a definitive restoration, use Resin Modified Glass Ionomer (RMGI) as a protective restoration.

In both cases (indirect and direct pulp capping), Rubber dam isolation must be complete and no contamination with blood or saliva.

III. Materials and Techniques

a. Provisionals

i. Material(s) used – Please be specific

AU RMGI is preferred material for directs, acrylic for indirect

MUSC Jet Acrylic

NSU The protocol for most provisionals (for both natural teeth and implants) is to use polymethyl methacrylate; specifically Colpac from Henry Schein. We also teach the students to use Composite Resin specifically Revotek from GC America. The students on a limited basis can use a bis-Acryl composite material; specifically Luxatemp Ultra from DMG America. The bis-Acryl Composite material is very expensive so the Team Leaders must sign for the material. It is generally used for veneer provisionals using a putty matrix. We allow the student also to make CAD/CAM provisionals from Lava Ultimate on a limited basis. The patient gets charged $50 and must agree to this (i.e. provisionals during orthodontic treatment for example).

UAB Integrity and Jet Acrylic/Ortho acrylic

UK Integrity (Bis-acryl), Jet (PMMA), Polycarbonate Crowns

UL Polycarbonate crowns - Ion Crowns (3M)
Integrity (Dentsply)
Jet Acrylic (Lang)

UNC Bis Acryl composite provisional material: Pre-clinical Pro Temp Plus. Clinic: Integrity.

VCU Integrity (resin) and Alike (acrylic)

UF A provisional restoration, defined as a prosthesis to enhance esthetics, stabilization and/or function for a limited period of time after which it is to be replaced by a definitive prosthesis.
Type of Provisional restorations:
Prefabricated crown forms – used in emergency situations
Polycarbonate crown – anterior teeth
Aluminum crown – posterior teeth
Custom molded crowns – used in most cases
Vacuum form matrix
Silicone putty matrix
Materials for the fabrication of provisional restorations:
Acrylic Resins
Polyethyl Methacrylate – Snap Acrylic
Bis-Acryl Composite
Chemically activated – Smart Temp, Luxatemp or Integrity

MMC Jet Acrylic

III. Materials and Techniques

ii. Technique(s) taught

1. Discuss various techniques

a. Traditional

i. Describe

AU

i. Describe- Jet Acrylic / Bis-acryl with vacuum or direct matrix

MUSC

i. Describe- We use a suck-down matrix or pre-preparation silicone impression. Occasionally a pre-fab crown is relined. We used to use Bis-acryl materials but moved away from that this year in student clinics as it is too brittle and problematic in student hands.

NSU

i. Describe- Direct: This is used for most provisionals using an Omnivac clear carrier using stent material from Henry Schein.
Indirect/Direct: This is required from some team leaders at our offsite clinics to have a shell made on a minimally prepared cast that is relined in the mouth.
Prefabricated Polycarbonate Crowns: Ion Crowns/GC America Crowns for anteriors on an emergency basis.
Block provisionals: Used for emergencies or when student is not prepared.
PVS Putty Matrix: Used for veneer provisionals.

UAB

i. Describe- Vacuum-formed matrix per dx wax-up on mounted casts

UK

1. Discuss various techniques- Impression with Blu Mousse for temporary fabrication. Impression with alginate, pouring of a cast, and VFM fabrication. PVS putty for impression and temporary fabrication. Shell reline.
a. Traditional- Yes

UL

i. Describe- Ion Crowns: trimmed to fit preparation; lined with acrylic; cemented with Freegenol Temporary Cement (GC)
Integrity or Jet: alginate or silicone impression of the arch including tooth/teeth to be prepared; dispense Integrity material directly into the preliminary impression in the area of the preparation; reseat the preliminary impression into the patient's mouth; remove the impression containing the Integrity temporary restoration during the firm elastic stage; when set, remove temporary from the impression, trim, and polish; cement with Freegenol

UNC

a. Traditional- Pre-clinical: We teach both direct and indirect methods. Indices: Pre-op impression, Silicone index from a wax up or thermoplastic index. We also teach indirect method on cast of the prepared tooth outside the mouth using PMMA. Same indices as previous.

VCU

i. Describe- Regisil fast-set putty impression prior to preparing the intact tooth or impression of a wax-up or a pre-existing stone model.

Continued

III. Materials and Techniques

ii. Technique(s) taught

1. Discuss various techniques

a. Traditional

i. Describe

UF

ii. Direct technique – intra-orally
Vacuum form matrix
Silicone putty matrix
Indirect technique – Laboratory on a stone cast
Stone cast of the prepared tooth/teeth
Acrylic Resin material
Vaccum form matrix
Combination technique – for bridge restorations
Custom shell made in the laboratory on a stone model
The restoration is relined intra-orally with acrylic resin

MMC

a. Traditional- Make a suck-down carrier

III. Materials and Techniques

ii. Technique(s) taught

b. CAD/CAM

c. 3D Printing

	d. CAD/CAM	c. 3D Printing
AU	Rarely, long term provisionals	No
ECU	Yes	Yes, occasionally/rarely
MMC	No	No
MUSC	No	No
NSU	Yes on a case by case basis, most particularly for long term provisionals and during orthodontic treatment. The material of choice has been either **Lava Ultimate or Telio-CAD**.	Not at this time even though we have a form labs printer.
UAB	No	No (Yes for Grad Pros)
UF	Is not taught in the DMD program. Although students are exposed to this technology, the provisional restorations are not fabricated in these machines.	Is not taught in the DMD program. Equipment is not available.
UK	Planning to have CADCAM temps available in 4th year.	No
UL	Yes, E4D	No
UNC	Yes, theory only	Yes, theory only. Application coming soon.
VCU	Yes: For the CADCAM provisional, we are milling some provisional crowns using composite material and sometimes, ithium disilicate, on natural teeth and implants.	We are looking for a way to print provisional crowns and FPDs. However, currently we do digital wax up and print diagnostic wax up to be used as template for provisional crowns/FPDs for natural teeth and implants.

III. Materials and Techniques

b. Direct Pin Placement

i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

AU

We teach use of pins to retain core material if insufficient retention is available from the coronal tooth. We often place pins in cusp coverage restorations because we do not know if a crown will be placed.
The goal of this question is to achieve a consensus report on the validity (or not) of direct pin placement in contemporary restorative practice.

ECU

We teach and implement whenever needed.

MUSC

We teach the use of pins in Operative I ("the amalgam course", Fall of D-2). There are two lectures on complex restorations and a tooth block exercise in lab.
We teach that pins also have a place in large composite restorations as well though we typically use smaller pins.
Pins are still used in our clinics for both amalgam and composite.

NSU

Brief lecture no laboratory component, not used in pre-doctoral clinic

UAB

De-emphasized, but still utilized in specific situations as per the Faculty covering clinic's judgement

UK

i. Yes, we teach pre-clinically but rarely used for amalgam in clinics.

"1. The goal of this question is to achieve a consensus report on the validty (or not) of direct pin placement in contemporary restorative practice."
1. This is not valid for current dental practice

UNC

We teach pin placement along with complex amalgam restorations.

VCU

Taught in pre-clinical operative, although seems not to be done too often in the pre-doc clinics.

UF

The division of operative dentistry teaches the steps on how to place an auxiliary pin for amalgam retention. In clinics we do not practice it, because we rather place retention features (amalgam pin, slots, coves, etc...)
The University of Florida do not support placing auxiliary pins on adhesive restorations.

MMC

i. It is taught in the D2 pre-operative dentistry curriculum for amalgam. The use in the clinic is up to the clinical instructors.

Continued

III. Materials and Techniques

b. Direct Pin Placement

i. In your school, what is the current status of curriculum focus on the teaching of direct pin placement in vital teeth requiring extensive restoration, to augment resistance and retention for amalgam or adhesively bonded composite materials?

UL

Summitt's and Sturdevant's textbooks continue to present the pin placement technique for complex amalgam restorations. Neither mentions pin-retained resin composite. Our school provides instruction in pin retained amalgam; pin retained resin composite (posterior only); and amalgapins/slots in extensive, complex restorations. Adhesively bonded amalgam is not taught. There has been a gradual decrease in the use of pins but it is still presented as a valid technique in selected cases for amalgam but less so for resin composite.

Fracture resistance of extensive amalgam restorations retained by pins, amalgapins and amalgam bonding agents. Oper Dent. 2008 Nov-Dec;33(6):666-74
This in-vitro study compared the resistance of extensive amalgam restorations retained by either four Regular TMS Link Plus pins, four amalgapins, Amalgambond Plus, Amalgambond Plus with HPA, Scotchbond Multi-Purpose Plus, PQ Amalgam, Panavia F 2.0, All-Bond 2 or Resinomer.

Conclusion: A one-way ANOVA and Tukey post hoc analysis indicated all amalgam bonding agents were statistically equal to either four Regular TMS Link Plus pins or four amalgapins.

Retention of complex amalgam restorations using self-threading pins, amalgapins, and Amalgambond. Am J Dent. 1995 Jun;8(3):117-21.

PURPOSE: To compare the shear fracture resistance of complex amalgam restorations retained by four regular TMS pins, four amalgapins, Amalgambond, or four amalgapins in conjunction with Amalgambond.

MATERIALS AND METHODS: Sixty maxillary molars free of caries were mounted in acrylic resin and the occlusal surfaces were ground flat to within 2 mm of the CEJ. The specimens were randomly divided into four groups of 15 teeth. Each group provided one of the four different methods of resistance. Dispersalloy was condensed into the prepared specimens. The specimens were adjusted to provide 4 mm height of amalgam. After 1000 thermocycles, the specimens were loaded at a 45 degree angle to the occlusal surface at a crosshead speed of 1 mm/second.

RESULTS: Statistical analysis revealed that Amalgambond, four amalgapins, and four amalgapins in conjunction with Amalgambond provided more resistance to shear force than four regular TMS pins.

III. Materials and Techniques

c. Restoration Repair

i. Does your school permit repair of a defective amalgam margin with a composite resin or require a total restoration replacement?

AU We teach and recommend repair, but some faculty have reservations.

ECU Depends on the case, repair is possible.

MUSC Repair is permitted if the defect is small and there is no caries.

NSU NO

UK Yes, permit repair.

VCU Repair with composite if appropriate.

UNC We encourage the repair of defective amalgam margins thus encouraging a very conservative treatment approach.

UAB NO repair with composite. In a case like that usually a replacement is indicated.

UL As far as I know, we do not teach repair of an amalgam with resin composite. The literature indicates that this can be done successfully but the repair is very technique sensitive. Survey results indicate success with repairs but the repair techniques were not presented. If a large amalgam core has a defect and the amalgam has just been placed, we will repair with amalgam. (See full answer document on page 128 - 131)

UF We promote repair rather than replace a restoration. We repair amalgams with amalgam or composites.

MMC **i.** We allow repair of the restoration if the restoration was placed by the student.

III. Materials and Techniques

c. Restoration Repair

ii. Does your school permit repair of a defective composite margin with a composite resin or require a total restoration replacement?

AU We teach and recommend repair, but some faculty have reservations, even more so than amalgams.

ECU Depending on case, repair is obviously encouraged.

MUSC Repair is permitted if the defect is small and there is no caries.

NSU REPAIRS ONLY IF RESTORARTION DONE AT NOVA

UK Yes, permit repair.

VCU Repair with composite if appropriate.

UNC Yes, the Operative Department encourages the repair of defected composite margins by simply fixing the defect and preserving parts of the previous restoration that is intact and with no defects. In addition, it depends on the case itself and the judgment of the supervising faculty.

UAB The students are advised to repair a restoration when they placed it themselves and the rationale is that they know the conditions at the starting point so they can assess the validity of repairing versus replacing. Repairing somebody else's restoration where there is no real knowledge of the conditions such restoration was placed could mean validating a restoration that can potentially have more faults than those readily evident. There is always variability in the type of isolation used, technique for bonding and such.

UL We will allow the defective margin to be repaired depending on placement date and location of placement.

UF We promote repair rather than replace a restoration. We repair amalgams with amalgam or composites.

MMC We will allow a repair if the restoration was placed by the student.

III. Materials and Techniques

d. Clinical Guidelines – Amalgam/Resin

i. Does your school have guidelines as to when amalgam vs composite resin restorations are placed?

AU We teach that amalgam is preferable in high caries risk patients; that composite is preferable if the carious lesion is relatively small as the preparations can be more conservative.

ECU Based on minimally invasive mindset, warranted by size of the lesion and patient compliance.

MUSC Yes but they are largely ignored (by pataients). Posterior restorations, especially class II's on molars, should be amalgam. But most patients balk at "silver" fillings even after being advised that amalgam lasts longer and is better suited to high caries risk patients. So, at least with regards to high caries risk, we are allowing patients to dictate treatment. We require the amalgam/composite discussion to occur but do not yet require a signed consent. I'm working on that.

ii. Why so we allow this? Because we cannot afford to have patients leave the program.

NSU YES (caries risk/isolation)

UK We do not have specific clinical guidelines via our clinic manual. We refer to curriculum presented in the Operative course.

UL UofL does not have formal guidelines for the use of amalgam versus resin composite. In general, we are not placing large resin composite cores in posterior teeth. We have included large composite resin cores in the D3 Core Class done on dentoforms.

UNC Primarily material selection is based on the location and extent of the lesion/defect. Secondary factors such as patient preference, cost etc is also take into consideration. However, the Operative Department holds multiple meetings with clinical faculty to calibrate the clinical faculty, and discuss/enforce evidence-based dentistry.

VCU Yes. We look at factors such as isolation, occlusion and esthetics, for example.

UAB The Caries Risk Assessment is used to recommend Amalgam vs Resin Composite.

UF The general rule is we should not place resin-based composites restorations, when it is difficult to obtain absolute isolations, in areas with heavy stress or patients with high caries risk. No too many faculty members follow that protocol.

MMC Posterior composites can be placed if the restored surface is less than 1/3 the width of the tooth or if the patient demands it and will sign a consent. It is case dependent.

IV. Assessment

a. Clinical Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment?

ii. Do you believe it should be?

iii. How do you assess their productivity?

AU

i. Yes, Junior Clinical Restorative Dentistry.
ii. Productivity is 50% of the grade (Comptency Exams= 30%, Faculty Subjective = 20%). We think encouraging productivity is an important part of the Jr year experience.
iii. Junior year: daily grades and productivity consisting of a minimum of 40 directs and 4 indirects. RVU points are part of the final grade but they must finish 40 & 4 (above).

ECU

i. Yes
ii. Yes
iii. By tracking their skills assessments and patient population that they are catering to and specifically through axium.

MUSC

i. No it isn't; although the ability to complete the planned procedure in one three hour appointment is considered in grading.
ii. No, but there are some who do. I agree that it would tend to prepare some students for the reality of clinical practice. But at MUSC the distribution of suitable patients is much too uneven to make competition among students even close to being fair.
iii. Currently students need 200 RVU "hours" in Operative to graduate. Most students earn that or close to it. Some earn considerably more and occasionally one or two will double that score. (This is related to section V. a. Attendance policy.)

NSU

i. NO
ii. NO, BUT SHOULD BE AND IS USED FOR CLINIC PROGRESS ADVISING
iii. DAILY GRADES, MEETING BENCHMARKS AND INDEPENDENT COMPETENCY EXAMINATIONS, SEVERAL TIMES PER YEAR STUDENT PROGRESS COMMITTEE REVIEW

UAB

i. YES. For the D4 Comprehensive Care Course. There are set productivity goals that impact the final clinical course grade.
ii. YES, to some extent.
iii. Based on complete procedures in the CCC: Diagnostic, preventive, operative and pros. Reports are generated for procedures completed by each student and his/her group throughout the year. The Faculty Group Managers have access to the data for their group as well

Continued

IV. Assessment

a. Clinical Productivity

i. Is the clinic productivity of your student a graded element in their clinical progress assessment?

ii. Do you believe it should be?

iii. How do you assess their productivity?

UK

i. No, it is not. During the 4th year Fall mentoring meetings, the student's production is compared (anonymously) to the other members of the team to give them an idea of where they stand and if they need to improve their efficiency. Team Leaders will work with the student to increase efficiency.
ii. No
iii. We run an Axium report that totals their total procedures by discipline and their total financial productivity from the beginning of their clinical experience.

UL

i. The only courses that have a component of student productivity is D3 and D4 Clinical Treatment Planning. Both courses use the number of completed cases for this portion of the student's grade.
ii. We believe it should be if there is a direct correlation between the productivity and opportunities for educational experiences.
iii. For the two Clinical Treatment Planning courses, the productivity is assessed by the number of Completed Case codes in the student's name in axiUm.

UNC

i. No
ii. No
iii. Attendance for direct patient care and clinic activities is closely monitored.

VCU

i. A grade is not assigned to progress assessment, although the productivity does affect the grade at the end of the course
Assessed in different ways: competent or not, productivity, overall performance
ii. No
iii. It is assessed or measured directly by looking at their revenue/following their production, and assessed indirectly by Group Leaders in their quarterly Subjective Evaluations.

MMC

i. No
ii. No
iii. Productivity is tracked and monitored by grade sheets and cross-referenced to axiUm production. The overall grade can be increased based on productivity and initial overall grade as it appears in our Operative Dentistry Curriculum.

V. Administration

a. Attendance Policy

i. Describe the attendance policy for your school's students.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

AU

1. Attendance to didactic classes is required. Attendance for available clinical sessions is set at 85% for juniors and 85-90% for seniors. They can get attendance credit by assisting another student if they don't have a patient.

ECU

1. They are allowed 10 days of vacation but are supposed to be here rest of the time.

MUSC

1. The instruction in all courses will begin as scheduled. No student may receive credit for a course that has not completed registration within five (5) days of the last stated day for registration for each semester.

Attendance is required at all scheduled classes, seminars, and laboratories unless permission to be absent has been granted by the course director or the Vice Dean for Academic and Student Affairs.

In any course, the minimum attendance for which credit will be given, or which will admit the student to the final examination, is 75% of the time scheduled for instruction in the course. The margin of 25% absence is provided to accommodate only unavoidable absences due to illness, delayed registration or other approved causes, and it is not contemplated that this concession shall apply to other than exceptional cases.

Students entering a lecture, seminar or laboratory later than 15 minutes after the scheduled hour for instruction to begin will be recorded as absent for the entire period or for one hour if the class is more than one hour long. Students with excessive absences may not receive credit for a course.

Students missing classes should report the reason to the office of academic and student affairs (792-2344) no later than 24 hours after the absence. Official excuses will be given for student illness or death in a student's family only. Validity of other excuses will be assessed by course directors whose classes have been missed.

NSU

i. Required attendance to all sim lab and clinical activities; Didactic courses attendance requirement is at the discretion of the course director. Students may have "Excused Absences", according to the protocol. See page 132 - 135.

UF

See page 136

UL

i. Students are required to attend all preclinical and clinical course work. The responsibility to determine if an absence is excused rests with the course director who is expected to follow established policy.

Continued

V. Administration

a. Attendance Policy

i. Describe the attendance policy for your school's students.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

UAB

1. "The Office of Academic Affairs expects students to faithfully attend all classes, clinics, and special events as planned through the School of Dentistry. If special circumstances prevent attendance, the student should promptly notify the appropriate parties and provide any relevant documentation. The Office of Academic Affairs supports all course-specific attendance policies as determined by the individual course directors for predoctoral dental students"

UK

1. Enrollment in a professional curriculum is often compared to full-time employment, and is very different from undergraduate education. Student dentists often attribute their success in the curriculum to the mindset that dental school is a full-time job. They also understand that work-life balance is essential to their overall success and well-being. Ensure your success by attending all classes and clinics. Attendance in classes and clinics is mandatory, unless excused by course directors, Associate Dean for Clinical Affairs and the Associate Dean for Academic Affairs. Additionally, even if there appears to be an open time on your schedule, last minute changes can and will occur. All clinical experiences are associated with courses and are part of the overall curriculum. When patient cancellations occur, students will be expected to participate in an alternative clinical experience during that scheduled clinic time. It is the student's responsibility to understand that they are available from 8-5pm Monday through Friday unless the College is closed. The College has a detailed -*Absences Policy* (Appendix C: Miscellaneous Academic Policies- Policy One) which describes the procedures for requesting an excused absence.
See the University's *Student Rights and Responsibilities* publication, Part II, Section 5.2.4.2 if you have questions regarding excused absences.

VCU

1. It varies by Instructor and Course, and is listed in each Instructor's syllabus.

MMC

i. We have a new on-line attendance tracker created by one of our faculty that was been implemented in mid-October where all faculty are to keep track of attendance in their clinics and classrooms on a weekly basis and submit it to academic affairs.

1. STUDENT ATTENDANCE, LEAVE OF ABSENCE AND WITHDRAWAL Attendance Students must attend all scheduled classes and clinics. Clinical, hands-on experience is a basic required competency. Proper documentation is required for all absences. Appropriate documentation for excused absences must be provided to the Office of Academic Affairs within two (2) days of the student's return to school. A student with absences in excess of ten percent (10%) may fail the course/clinic and may be dismissed from the program. Excused absences will be issued by the Office of Academic Affairs. The Office of Academic Affairs will notify the appropriate faculty faculty/department chair of the absence decision. Absences of two consecutive weeks or longer in a didactic or clinical course without appropriate notification and written documentation will result in immediate dismissal from the School.

Continued

V. Administration

a. Attendance Policy

i. Describe the attendance policy for your school's students.

1. Please quote the actual attendance policy as outlined in your Academic Affairs manual.

UNC

1. Attendance in Classes at UNC-SOD

- Didactic Courses and Preclinical Courses a. Students are expected to attend all classes and preclinical courses/labs.
- Students must follow attendance requirements found in course syllabi, which may be more stringent than in this policy and may have direct impact on grade performance if those policies are not followed.

Clinic Attendance at UNC-SOD
Definition: To ensure that each dental Student Dentist receives an enriching education, minimum attendance requirements are enforced. Clinic attendance will be monitored by the Office of Clinical Affairs. Note that although minimum requirements are set forth, it is desirable for all Student Dentists to maximize their clinical experience. Student Dentists participating in the group practices will also be required to fulfill the requirements of the practice system. The attendance requirements apply to each semester beginning the summer of the second year. Student Dentists are required to be present for the entire session. Student Dentists are expected to treat their own patient, work chairside with a classmate to care for a patient or volunteer to see an urgent care or screening patient. Attendance Grade: In order to progress in the development of the knowledge, skills and ability required to become a competent beginning general dentist, students must work chairside in providing oral health care to a variety of patients. Clinic attendance will be graded as follows:

Clinic Attendance		
Deliverable	**Points Received**	**Total Possible Points**
Total Attendance	80%+ = 25 points 70.0-79.9% = 15 points 60.0-69.9% = 5 points 59.9% or below = 0 points	25
Patient Attendance	60%+ = 25 points 50.0-59.9% = 15 points 40.0-49.9% = 5 points 39.9% or below = 0 points	25

It is the student's responsibility to maintain their attendance. The PCCs will review attendance reporting on a regular basis. If a student appears to be trending toward not meeting the attendance requirements when the PCC performs an attendance audit, a meeting will be required with the PCC so that remediation activities can take place to increase the percentage prior to the end of the semester.

Attendance policy – UNC- SOD

V. Administration

a. Attendance Policy

ii. Is the policy enforced?

iii. Do you feel that this policy is fair?

iv. Do you feel that the policy is appropriate?

	ii. Enforced?	iii. Fair?	iv. Appropriate?
AU	If affects their grade, so yes, it is enforced.	Y	Y
ECU	Y	Y	Y
MMC	It has not been due to monitoring issues.	Y	Y
MUSC	Y	Y	Y
NSU	DEPENDS UPON THE COURSE DIRECTOR, ENFORCED BY SOME AND NOT BY OTHERS; IS ENFORCED AT THE ACADEMIC AFFAIRS LEVEL	YES, BECAUSE MULTIPLE REASONS AND SITUATIONS ARE ACCEPTED AS EXCUSED ABSENCES, AND REQUIRE STUDENT TO ABIDE BY THE PROTOCOL. The granting of the excused absence helps students, as it is non-punitive.	Y
UAB	The policy is enforced at the course level.	Y	Y
UF	Y	Y	Y
UK	Y	Y	Y
UL	Y	Y	Y
UNC	Y	Yes, the expectations are fair	"The clinic attendance policy is complicated" – Clinical Affairs Director
VCU	Up to each course director to enforce his/her own policy.	Speaking only for my own Attendance policy, which I do enforce, I believe it is fair and reasonable.	Y

V. Administration

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

AU

i. Yes, very limited. It would helpful to understand their mindset even if we still want them to adapt to us in most situations.
ii. No
iii. In personal experience, active learning like flipped classroom, TBL, seems to be both popular and effective with students.
iv. Yes, a half-day seminar on preparing students for feedback during D1 orientation. We've published the module here: Mitchell J, Gillies R, Mackert, R. Setting expectations about feedback in dental education. MedEdPORTAL Publications. 2017;13:10580. https://doi.org/10.15766/mep_2374-8265.10580

ECU

i. Yes
ii. No
iii. Yes, Flipped classroom and use of technology (Itunes U courses, Ibooks for labs and Flipped classrooms with in class online quizzes)
iv. Yes, through dental ethics and professionalism course.

MUSC

i. Yes, quite a few. These are typically offered by the university library, often as noon-time classes.
ii. No
iii. They seem to want things canned/pre-packaged and delivered at the point of service.
iv. Yes; these are offered by the university library but are only required for students having difficulty. Freshmen do receive some general "introduction to Dental School" lectures.

UAB

i. UAB offers a number of courses regarding millennials. For instance, the Center for Teaching and Learning is offering a course this month as part of their "Medical Educators Series" titled "Teaching Millennials".
ii. Not that I am aware of.
iii. Don't know
iv. Not to my knowledge

NSU

i. Yes
ii. No
iii. No
iv. Yes

Continued

V. Administration

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

UL

i. Yes, as part of our fall break faculty retreat.
ii. No
iii. Active Learning and Engagement with self-reflection.
iv. Yes, as part of their calibration for operative dentistry self-assessment, students are taught about interactions during the grading process.

UNC

i. Not at the school. Dean De Rossi encourages attendance at ADEA meeting where different teaching modalities that are appealing to millennials are discussed.
ii. No
iii. Engaging them with the use of smart phones and laptops. EVpoll, Kaboom etc.
iv. Yes, students receive patient-student-faculty communication and sensitivity workshop during DDS 2 as part of the DENT 210 Behaviour, Communication and Culture course. In DDS 4 they have a competency assessment with 'calibrated' patients on provider-patient communication.

VCU

i. Frank Medio covered this at the faculty retreat last year; we specifically requested the topic.
ii. No, but we have plans to start peer teaching evals ... timeline TBD.
iii. They really like Echo 360 recordings for review after class or before a test. They like to be able to take notes in the PPT slides during class. They like lecture/lab incorporated together so each mini lecture is followed immediately by a demo and hands on practice.
iv. Students are provided a complete sequential behavioral science curriculum beginning with "Introduction to Behavioral Science in Dentistry", followed by "Foundation of Interpersonal Skills During Patient Interactions I and II" and "Advanced Interpersonal Skills During Patient Interactions I and II". The focus of the lectures is on building emotional intelligence and interpersonal skills. Through lectures and formative and summative exercises, students increase their communication skills not only with patients, but among the oral health team as well. As they enter clinic, discussion around interpersonal communication and relationship building issues including those with faculty and other staff are discussed during Advanced Interpersonal Skills During Patient Interactions I and II (D3 and D4 year) at the Small group Case Processing activity.

UK

i. No
ii. N/A
iii. Yes
iv. Yes

Continued

V. Administration

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

MMC

i. They are arranged through Dee Gardner our Director for Student and Academic Services (CEDS). We have had several Faculty In-service programs over the past several years. In 2014 The Learner Model of Teaching an Innovative Way of Teaching the Generation "Me" Student was offered and in 2015 a program on strategies to identify and respond to current mental health issues was provided. In 2015 a retreat was held for Faculty, Students and Staff to identify and respect generational differences. Those participating in the Dean's Scholar Programs through ADEA have had topical course studies of this area.

ii. D4 students are given exit interviews. There are also Town Hall Meetings with the President of the College for Students and Faculty and Staff.

iii. Utilizing more active student involvement and interaction. It has been advised to make the courses quick moving, interactive, and to avoid information overload

vi. Yes in the Public Health Department setting. The students in the D3 Behavior Class are given the opportunity to write up a case of an interaction the student had with a faculty member or one that was observed that showed conflict and to write an appropriate response to the situation for conflict resolution.

UF

i. We use various platforms such as college events, focus groups, cultural competency trainings and cross-population meetings, for faculty, staff, alumni and students to engage and build collegial relationships. Last year, we also started a "Building Bridges and Bonds" program for faculty, students and staff that uses the Strengths Quest program in order to work from the position of strength rather than focusing on weaknesses. The Strengths Quest program begins with the Clifton StrengthsFinder, an online assessment that allows students and educators to discover, understand, and maximize their strengths. This program also gives participants a common strengths-based language and lens as a starting point to difficult conversations. Other workshops provided to all college members include topics such as effective communication and trust building strategies, anger management, anxiety management and mindfulness meditation. Additionally, our Assistant Dean of Students provided faculty with a presentation on working with today's students during the annual faculty retreat. In addition the Division of Operative Dentistry undertook a literature review about millennials and how to teach them. Also this year we have started to try and match our student tutors with tutees having the same learning style by using the VARK questionnaire on learning styles. All of our present 1st year students took the VARK learning styles questionnaire before matriculating and any student wishing to act as a tutor must also take it. When and if a student requires tutoring in didactic coursework or in psychomotor skills, they are paired with a tutor who has a similar learning style.

Continued

V. Administration

b. Millennial Students

i. Has your school offered any faculty development programs related to teaching/dealing with the new generation of students?

ii. Are any surveys taken, other than course/faculty student evaluations to determine the effectiveness of these interactions?

iii. Are there any special teaching techniques or styles that seem to work better with the new generation of students?

iv. Are students provided with any behavioral lectures to sensitize them to the nature of student/faculty interaction in the dental setting?

UF

ii. Our faculty, staff and students are asked to complete the Dental Learning Environment Survey in order to assess the quality of staff, student and faculty interactions and comfort levels

iii. Blended learning and Team-based learning methods best accommodate the new generation of learners, as well as, our learners that cross generations. Blended courses (sometimes referred to as flipped classrooms) have student view the video recorded lectures as homework and students complete assignments and/or review cases with faculty during the scheduled class time. Team-based learning (as developed by Michaelsen) Team-Based Learning is an evidence based collaborative learning teaching strategy designed around units of instruction, known as "modules," that are taught in a three-step cycle: preparation, in-class readiness assurance testing, and application-focused exercise. Students must complete preparatory materials before a class or the start of the module. Materials may be text, visual or other, and set at a level that is appropriate to the students and the course. Students complete an individual readiness assurance test. After submitting their individual answers, and they take the same test, the team RAT (TRAT), with their team. The readiness assurance process holds students accountable for coming to class prepared and working together as a team. The remainder of the session or module is taken up with exercises that help students learn how to apply and extend the knowledge that they have pre-learned and tested. Teams are given an appropriate problem or challenge, and must arrive at a consensus to choose a "best" solution out of options provided. Teams then display their answer choice, and the educator facilitates a classroom discussion between teams to explore the topic and the possible answers to the problem. This method utilizes peer learning with structured problem-solving in-class activities which engage students with the content and how to apply their learning in authentic practice situations.

iv. Throughout orientation, students are provided with workshops that address not only how to succeed academically but also how to interact successfully with faculty, staff and their peers. In one workshop, the new students are given potentially awkward or tense scenarios between faculty or staff and students. The students are asked to work in groups and decide on an action that would garner the best outcome. The actions are then examined for potential pitfalls. Upperclassmen attend this workshop and offer their perspective based on experience.

Regional Meeting Report Form

Region:

Host University, Address, and Dates of the 2017 Regional Meeting:

Host University	Address	Dates of Meeting

Chairperson and Contact Information for the 2017 Regional Meeting:

Chairperson	University/Address	Phone/email

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

Contact Person, Host University, and Dates of the 2018 Regional Meeting:

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

Regional Meeting Attendee's Form

Name	University	Phone	Email

Suggested Questions for 2018 National Agenda

Regional Nominee for Presenting at the 2018 CODE Annual Meeting (Please Include Topic)

Name	Topic	Contact Info

Please return all completed enclosures to:

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

Associate Professor and Chair
Department of General Dental Sciences
Marquette University School of Dentistry
1801 W. Wisconsin Ave. Rm 336C
Milwaukee, WI 53233

414.288.5409
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Deadline for return: 30 days post-meeting

Please send the requested documents via email with attachments

FOR YOUR NOTES