2011 ADEA
House of Delegates Manual
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Schedule of the 2011 ADEA House of Delegates

Opening Session of the ADEA House of Delegates
Saturday, March 12, 2011, 4:00 to 5:00 p.m., Manchester Grand Hyatt, Elizabeth Ballroom Section A-E.

Voting for ADEA President-elect
Sunday, March 13, ballots may be cast between the hours of 8:00 a.m. and 5:00 p.m., at the ADEA House of Delegates booth in the registration area at the Manchester Grand Hyatt, Elizabeth Foyer.

Monday, March 14, ballots may be cast between the hours of 8:00 a.m. and 4:30 p.m., at the ADEA House of Delegates booth in the registration area at the Manchester Grand Hyatt, Elizabeth Foyer.

Tuesday, March 15, ballots may be cast between the hours of 8:00 a.m. and 4:30 p.m., at the ADEA House of Delegates booth in the registration area at the Manchester Grand Hyatt, Elizabeth Foyer.

ADEA Reference Committee Hearings
ADEA Reference Committee Hearing on Association Policy
Monday, March 14, 2:00 to 3:00 p.m., Manchester Grand Hyatt, Douglas Pavilion Section A.

ADEA Reference Committee Hearing on Administrative Affairs
Tuesday, March 15, 1:00 to 2:00 p.m., Manchester Grand Hyatt, Douglas Pavilion Section A.

Closing Session of the ADEA House of Delegates
Wednesday, March 16, 2011, noon to 1:00 p.m., Manchester Grand Hyatt, Elizabeth Ballroom Section A-E.

For the order of business of each session of the House, please see the section on “Order of Business of the ADEA House of Delegates” on page 24. For the names of the members of the Reference Committees and the resolutions assigned to them, please see page 22.
Members of the 2011 ADEA House of Delegates

ADEA Board of Directors
Dr. Sandra C. Andrieu, President, Louisiana State University
Dr. Leo E. Rouse, President-elect, Howard University
Dr. Ronald J. Hunt, Immediate Past President, Midwestern University - Arizona
Dr. Susan J. Crim, Vice President for Allied Dental Program Directors, University of Tennessee Health Science Center
Ms. Barbara Nordquist, Vice President for Corporate Council, Pelton & Crane, KaVo, Marus Dental Corporation
Dr. John N. Williams, Vice President for Deans, Indiana University
Dr. Michael A. Siegel, Vice President for Faculties, Nova Southeastern University
Dr. Todd E. Thierer, Vice President for Hospitals and Advanced Education Programs, University of Rochester
Dr. Lily T. Garcia, Vice President for Sections, University of Texas Health Science Center at San Antonio
Ms. Evelyn Lucas-Perry, Vice President for Students, Residents, and Fellows, University of Michigan
Dr. Richard W. Valachovic, Executive Director, American Dental Education Association

ADEA Council of Allied Dental Program Directors
Administrative Board
Prof. Ethel G. Campbell, Chair, University of North Carolina at Chapel Hill
Dr. Susan I. Duley, Chair-elect, West Coast University
Prof. Christine Mary Blue, Secretary, University of Minnesota
Prof. Vickie Joanne Kimbrough-Walls, Member-at-large, Truckee Meadows Community College
Dr. Susan J. Crim, Vice President, University of Tennessee Health Science Center

Additional Delegates, Dental Hygiene
Prof. Phebe Blitz, Mesa Community College
Prof. Michele Carr, The Ohio State University
Dr. Janice P. DeWald, Baylor College of Dentistry
Prof. Debbie Gerecke, Missouri Southern State University
Prof. Debi Gerger, West Coast University
Prof. Krista Hahn, Manhattan Area Technical College
Prof. Gwen L. Hlava, University of Nebraska Medical Center
Dr. Laura Joseph, Farmingdale State College
Prof. Carrie Mason, Louisiana State University
Prof. Kathleen Neveu, University of Detroit Mercy
Prof. Trisha Nunn, Texas Woman's University
Prof. Sharon G. Peterson, College of Southern Nevada
Prof. Phyllis A. Spragge, Foothill College
Prof. Cheryl M. Westphal, New York University
Prof. Kris Wilkins, Loma Linda University
Prof. Donna Wittmayer, Clark College

Additional Delegates, Dental Assisting
Prof. Cara Miyasaki, Foothill College
Prof. Pamela Wood, Texas State Technical College
Prof. Madge B. Webster, University of North Carolina at Chapel Hill
Additional Delegates, Advanced Programs
Prof. Michelle Hurlbutt, Loma Linda University

ADEA Council of Deans
Administrative Board
Dr. Huw F. Thomas, Chair, University of Alabama at Birmingham
Dr. Denise K. Kassebaum, Chair-elect, University of Colorado Denver
Dr. R. Lamont MacNeil, Member-at-Large, University of Connecticut
Dr. Cecile A. Feldman, Secretary, University of Medicine and Dentistry of New Jersey
Dr. John N. Williams, Vice President, Indiana University

Additional Delegates, Deans
Dr. Mert N. Aksu, University of Detroit Mercy
Dr. Carole A. Anderson, The Ohio State University
Dr. Wayne W. Barkmeier, Creighton University
Dr. Charles N. Bertolami, New York University
Dr. Ann M. Boyle, Southern Illinois University
Dr. Thomas W. Braun, University of Pittsburgh
Dr. Richard N. Buchanan, University of Southern Nevada
Dr. Jack Clinton, Oregon Health & Science University
Dr. James S. Cole, Baylor College of Dentistry
Dr. Jack Dillenberg, Arizona School of Dentistry and Oral Health
Dr. Teresa A. Dolan, University of Florida
Dr. R. Bruce Donoff, Harvard School of Dental Medicine
Dr. Connie L. Drisko, Georgia Health Sciences University
Dr. John D. B. Featherstone, University of California, San Francisco
Dr. Patrick J. Ferrillo, Jr., University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Steven W. Friedrichsen, Western University of Health Sciences
Dr. Russell O. Gilpatrick, Midwestern University - Arizona
Dr. Michael Glick, University at Buffalo
Dr. Jerold S. Goldberg, Case Western Reserve University
Dr. Charles Goodacre, Loma Linda University
Dr. Bruce S. Graham, University of Illinois at Chicago
Dr. Henry A. Gremillion, Louisiana State University
Dr. Timothy L. Hottel, University of Tennessee Health Science Center
Dr. James R. Hupp, East Carolina University
Dr. Jeffrey W. Hutter, Boston University
Dr. Amid I. Ismail, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. David C. Johnsen, University of Iowa
Dr. Kenneth L. Kalkwarf, University of Texas Health Science Center at San Antonio
Dr. Denis F. Kinane, University of Pennsylvania
Dr. Ira B. Lamster, Columbia University
Dr. Patrick M. Lloyd, University of Minnesota
Dr. William K. Lobb, Marquette University
Dr. Lex MacNeil, Midwestern University - Illinois
Dr. Lonnie H. Norris, Tufts University
Dr. No-Hee Park, University of California, Los Angeles
Dr. Peter J. Polverini, University of Michigan
Dr. Marsha A. Pyle, University of Missouri-Kansas City
Dr. John W. Reinhardt, University of Nebraska Medical Center
Dr. Avishai Sadan, University of Southern California
Dr. John J. Sanders, Medical University of South Carolina
Dr. David C. Sarrett, Virginia Commonwealth University
Dr. John J. Sauk, University of Louisville
Dr. Martha J. Somerman, University of Washington
Dr. Janet H. Southerland, Meharry Medical College
Dr. John Stamm, University of North Carolina at Chapel Hill
Dr. Christian S. Stohler, University of Maryland
Dr. Sharon P. Turner, University of Kentucky
Dr. Robert A. Uchin, Nova Southeastern University
Dr. John A. Valenza, University of Texas Health Science Center at Houston
Dr. Louise T. Veselicky, West Virginia University
Dr. Humberto J. Villa Rivera, University of Puerto Rico
Dr. Karen P. West, University of Nevada, Las Vegas
Dr. Ray C. Williams, Stony Brook University
Dr. Stephen K. Young, University of Oklahoma

Additional Delegates, Non-Hospital Based Advanced Dental Education Programs
Dr. Rolf G. Behrents, Saint Louis University
Dr. Cyril Meyerowitz, University of Rochester
Dr. Philip Stashenko, The Forsyth Institute
Dr. Mark Warner, Mayo Graduate School of Medicine

Additional Delegates, Federal Dental Service Programs
Dr. Patricia E. Arola, Department of Veterans Affairs
RADM William Bailey, United States Public Health Service
Maj. Gen. Gerard A. Caron, United States Air Force Dental Service
Col. Robert Manga, United States Army Dental Corps
Col. Thomas R. Schneid, United States Air Force Dental Service
Cpt. Robert Michael Taft, United States Navy Dental Corps
RADM Elaine C. Wagner, United States Navy Dental Corps
Maj. Gen. M. Ted Wong, United States Army Dental Corps

Additional Delegates, Association of Canadian Faculties of Dentistry
Dr. Harinder S. Sandhu, University of Western Ontario

ADEA Council of Faculties
Administrative Board
Dr. Kenneth R. Etzel, Chair, University of Pittsburgh
Dr. Robert G. Rashid, Chair-elect, The Ohio State University
Dr. Valerie A. Murrah, Secretary, University of North Carolina at Chapel Hill
Dr. Nereyda P. Clark, Member-at-Large, University of Florida
Dr. Michael A. Siegel, Vice President, Nova Southeastern University

Additional Delegates
Dr. Elizabeth A. Andrews, Western University of Health Sciences
Dr. Laura Caroline Barritt, Creighton University
Dr. Carol A. Bibb, University of California, Los Angeles
Dr. Susan M. Chialastri, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Madelyn Coar, University of Alabama at Birmingham
Dr. John D. Da Silva, Harvard School of Dental Medicine
Dr. Joseph A. D'Ambrosio, University of Connecticut
Dr. Evelyn Donate-Bartfield, Marquette University
Dr. Vicky Evangelidis-Sakellson, Columbia University
Dr. Kim E. Fenes, University of Medicine and Dentistry of New Jersey
Dr. Ronald E. Forde, Loma Linda University
Dr. Robert Quinn Frazer, University of Kentucky
Dr. Marc J. Geissberger, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Jane Gillespie, Southern Illinois University
Dr. Riki Gottlieb, Virginia Commonwealth University
Dr. John F. Guarente, Boston University
Dr. Kevin Michael Gureckis, University of Texas Health Science Center at San Antonio
Dr. Armando J. Guzman, University of Puerto Rico
Dr. Uri Hangorsky, University of Pennsylvania
Dr. Wayne W. Herman, Georgia Health Sciences University
Dr. Edwin H. Hines, Meharry Medical College
Dr. Andrea D. Jackson, Howard University
Dr. Nancy L. Jacobsen, University of Oklahoma
Dr. T. Roma Jasinevicius, Case Western Reserve University
Dr. Bernard Aaron Karshmer, University of Colorado Denver
Dr. Gordon G. Keyes, West Virginia University
Dr. Allan J. Kucine, Stony Brook University
Dr. Peter M. Loomer, University of California, San Francisco
Dr. James R. Lott, University of Mississippi
Prof. Melinda L. Meadows, Indiana University
Dr. Lisa M. Mruz, University at Buffalo
Dr. Ivy D. Peltz, New York University
Dr. Elizabeth S. Pilcher, Medical University of South Carolina
Dr. Judith A. Porter, University of Maryland
Dr. Sandra K. Rich, University of Southern California
Dr. Frank A. Roberts, University of Washington
Dr. David D. Rolf, II, Midwestern University - Arizona
Dr. Larry Salzmann, University of Illinois at Chicago
Dr. Victor Sandoval, University of Southern Nevada
Dr. Mark Scarbecz, University of Tennessee Health Science Center
Dr. Mark S. Schweizer, Nova Southeastern University
Dr. Chet A. Smith, Louisiana State University
Dr. Woosung Sohn, University of Michigan
Dr. Robert D. Spears, Baylor College of Dentistry
Dr. Michael Spector, University of Iowa
Dr. Henry St. Germain, University of Nebraska Medical Center
Dr. Dawne Stefanik, The Ohio State University
Dr. Jeffery C. B. Stewart, Oregon Health & Science University
Prof. Jill Stoltenberg, University of Minnesota
Dr. Paul Lewis Trombly, Tufts University
Dr. Randall L. Vaught, University of Louisville
Prof. Donna P. Warren-Morris, University of Texas Health Science Center at Houston
Dr. Robert Todd Watkins, Jr., East Carolina University
Dr. Michelle Wheater, University of Detroit Mercy
Dr. J. Craig Whitt, University of Missouri-Kansas City
Dr. Janet L. Woldt, Arizona School of Dentistry and Oral Health
Dr. Wendy Sue Woodall, University of Nevada, Las Vegas
ADEA Council of Sections

Administrative Board
Dr. Michael A. Landers, Chair, Case Western Reserve University
Dr. Judith Skelton, Chair-elect, University of Kentucky
Dr. Sharon Siegel, Secretary, Nova Southeastern University
Dr. Joan E. Kowolik, Member-at-Large, Indiana University
Dr. Lily T. Garcia, Vice President, University of Texas Health Science Center at San Antonio

Academic Affairs
Dr. Pamela R. Overman, Councilor, University of Missouri-Kansas City
Prof. Cheryl H. DeVore, Chair, The Ohio State University

Anatomical Sciences
Dr. H. Wayne Lambert, Councilor, West Virginia University
Dr. Neil S. Norton, Chair, Creighton University

Behavioral Sciences
Dr. Elaine L. Davis, Councilor, University at Buffalo
Dr. Catherine A. Demko, Chair, Case Western Reserve University

Biochemistry, Nutrition, and Microbiology
Dr. Alan E. Levine, Councilor, University of Texas Health Science Center at Houston
Prof. Linda D. Boyd, Chair, Massachusetts College of Pharmacy and Health Sciences

Business and Financial Administration
Mr. John W. Barch, Councilor, University of Texas Health Science Center at San Antonio
Scott K. Arneson, Chair, University of Iowa

Cariology
Dr. Mark S. Wolff, Councilor, New York University
Dr. Margherita R. Fontana, Chair, University of Michigan

Clinic Administration
Dr. Wilbert H. Milligan III, Councilor, University of Pittsburgh
Dr. Denice C.L. Stewart, Chair, Oregon Health & Science University

Clinical Simulation
Dr. Kenneth L. Allen, Councilor, New York University
Dr. Alice Urbankova, Chair, Stony Brook University

Community and Preventive Dentistry
Dr. Vladimir W. Spolsky, Councilor, University of California, Los Angeles
Prof. Jane E. M. Steffensen, Chair, University of Texas Health Science Center at San Antonio

Comprehensive Care and General Dentistry
Dr. Fred J. Fendler, Councilor, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Mary Norma Partida, Chair, University of Texas Health Science Center at San Antonio
Continuing Education
Prof. Sue C. Felton, Councilor, University of North Carolina at Chapel Hill
Prof. Lynda Jeanne Young, Chair, University of Minnesota

Dental Anatomy and Occlusion
Dr. Charles Kennedy Hill, Councilor, University of Nevada, Las Vegas
Dr. Elizabeth Taylor Nance, Chair, Virginia Commonwealth University

Dental Assisting Education
Prof. Donna Estes, Councilor, Texas State Technical College
Prof. Jeannie Martinez Monaghan, Chair, University of New Mexico

Dental Hygiene Education
Prof. Joyce Cain Hudson, Councilor, Ivy Tech Community College
Prof. Harold A. Henson, Chair, University of Texas Health Science Center at Houston

Dental Informatics
Dr. Muhammad F. Walji, Councilor, University of Texas Health Science Center at Houston
Dr. Robert Todd Watkins, Jr., Chair, East Carolina University

Dental School Admissions Officers
Dr. Venita J. Sposetti, Councilor, University of Florida
Prof. Dianne D. Foster, Chair, University of Louisville

Development, Alumni Affairs and Public Relations
Prof. William O. Butler, Councilor, University of Texas Health Science Center at San Antonio
Prof. Sara Piety, Chair, University of Texas Health Science Center at San Antonio

Educational Research/Development and Curriculum
Prof. Gail Schneider Childs, Councilor, University of Florida
Dr. Ranier Marfil Adarve, Chair, University of Minnesota

Endodontics
Dr. Bruce Cary Justman, Councilor, University of Iowa
Dr. Robert Allan Handysides, Chair, Loma Linda University

Gay-Straight Alliance
Prof. Mark Gonthier, Councilor, Tufts University
Dr. John L. Zimmerman, Chair, Columbia University

Gerontology and Geriatrics Education
Dr. Georgia Dounis, Councilor, University of Nevada, Las Vegas
Dr. Katherine F. Schrubbe, Chair, Marquette University

Graduate and Postgraduate Education
Dr. Gerald N. Glickman, Councilor, Baylor College of Dentistry
Dr. Kathy Marshall, Chair, Howard University
Minority Affairs  
Dr. Keith A. Mays, Councilor, University of Maryland  
Dr. Mildred A. McClain, Chair, University of Nevada, Las Vegas

Operative Dentistry and Biomaterials  
Dr. Derek R. Williams, Councilor, University of Missouri-Kansas City  
Dr. Christine Kaplan Beninger, Chair, Baylor College of Dentistry

Oral Biology  
Dr. Anthony M. Iacopino, Councilor, University of Manitoba  
Dr. Rena N. D'Souza, Chair, Baylor College of Dentistry

Oral Diagnosis/Oral Medicine  
Dr. Samuel P. Nesbit, Councilor, University of North Carolina at Chapel Hill  
Dr. Shin-Mey Yin (Rose) Geist, Chair, University of Detroit Mercy

Oral and Maxillofacial Pathology  
Dr. Alice E. Curran, Councilor, University of North Carolina at Chapel Hill  
Dr. Terry Dean, Chair, Western Kentucky University

Oral and Maxillofacial Radiology  
Dr. James R. Geist, Councilor, University of Detroit Mercy  
Dr. Vijay Parashar, Chair, University of Detroit Mercy

Oral and Maxillofacial Surgery/Anesthesia/Hospital Dentistry  
Dr. Jeffrey D. Bennett, Councilor, Indiana University  
Dr. Larry L. Cunningham, Chair, University of Kentucky

Orthodontics  
Dr. David A. Covell Jr., Councilor, Oregon Health & Science University  
Dr. Mitchell Jay Lipp, Chair, New York University

Pediatric Dentistry  
Dr. Alton G. McWhorter, Councilor, Baylor College of Dentistry  
Dr. Larry B. Salzmann, Chair, University of Illinois at Chicago

Periodontics  
Dr. Grishondra Branch-Mays, Councilor, University of Maryland  
Dr. Elio Reyes Rosales, Chair, Southern Illinois University

Physiology, Pharmacology, and Therapeutics  
Dr. Ted D. Pate, Councilor, University of Texas Health Science Center at Houston  
Dr. Medha Gautam, Chair, Southern Illinois University

Postdoctoral General Dentistry  
Lt. Col. Sheryl Lyn Kane, Councilor, United States Air Force Dental Service  
Dr. Brian K. Singletary, Chair, University of Minnesota

Practice Management  
Dr. David Owen Willis, Councilor, University of Louisville  
Dr. Brian M. Lange, Chair, University of Nebraska Medical Center
Prosthodontics
Dr. Larry C. Breeding, Councilor, University of Mississippi
Dr. Stephan Jay Haney, Chair, University of Texas Health Science Center at San Antonio

Student Affairs and Financial Aid
Dr. Hugh Philip Pierpont, Councilor, University of Texas Health Science Center at Houston
Ms. Melissa L. Friedman, Chair, Tufts University

ADEA Council of Hospitals and Advanced Education Programs
Administrative Board
Dr. Gerald N. Glickman, Chair, Baylor College of Dentistry
Dr. Pamela Hughes, Chair-elect, University of Minnesota
Dr. David Paquette, Secretary, Stony Brook University
Dr. Tracy M. Dellinger, Member-at-Large, University of Mississippi
Dr. Todd E. Thierer, Vice President, University of Rochester

Additional Delegates
Dr. David P. Cappelli, University of Texas Health Science Center at San Antonio
Dr. Edwin H. K. Yen, University of British Columbia
Dr. Robert J. Flinton, University of Medicine and Dentistry of New Jersey
Dr. George T. Gallagher, Boston University
Dr. Peter M. Gershenson, Jacobi Medical Center Hospital
Dr. Nicolaas Geurs, University of Alabama at Birmingham
Dr. James Johnson, University of Washington
Dr. Lynette Kagihara, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. George M. Kushner, University of Louisville
Dr. Jaleh Pourhamidi, University of Southern Nevada
Dr. Christine L. Quinn, University of California, Los Angeles
Dr. N. Sue Seale, Baylor College of Dentistry
Dr. Raymond Simmons, University of Texas Health Science Center at Houston
Dr. Sotirios Tetradis, University of California, Los Angeles

ADEA Council of Students, Residents, and Fellows
Administrative Board
Mr. David A. Simhaee, Chair, Columbia University
Mr. Ryan T. Hajek, Vice Chair, University of Nebraska Medical Center
Ms. Jacqueline Heejung Yoon, Secretary, University of Kentucky
Ms. Danielle Causey, Member-at-Large, Louisiana State University
Ms. Evelyn Lucas-Perry, Vice President, University of Michigan

Predoctoral Dental Students – Northeast
Mr. Garrick Alex, Columbia University
Mr. Andrew C. Burke, University at Buffalo

Predoctoral Dental Students – Southeast
Mr. Staš Grandi, Nova Southeastern University
Predoctoral Dental Students – South Central
Ms. Tamara L. Jones, Baylor College of Dentistry
Ms. Ande Loveless, University of Oklahoma

Predoctoral Dental Students – Midwest
Ms. Elizabeth McCourt, Marquette University
Mr. Mark Parete, University of Detroit Mercy

Predoctoral Dental Students – Pacific
Mr. Stanko Bjelajac, University of California, San Francisco
Mr. Roderick Youngdo Kim, University of Washington

Predoctoral Dental Students – Ohio Valley
Ms. Anna Jayjock, University of Louisville
Ms. Kavita Patel, The Ohio State University

Postdoctoral Dental Students – Hospital Programs
To be determined

Postdoctoral Dental Students – Non-Hospital Programs
Maj. Sean P. Connolly, Arizona School of Dentistry and Oral Health

Allied Dental Students – Dental Hygiene
To be determined

Allied Dental Students – Dental Assisting
To be determined

Allied Dental Students – Dental Laboratory Technology
To be determined

ADEA Corporate Council
Administrative Board
Mr. Daniel W. Perkins, Chair, President/CEO, AEGIS Communications
Mr. Brian Kline, Chair-elect, Regional School Manager, A-dec
Ms. Barbara Nordquist, ADEA Vice President for the Corporate Council, Pelton & Crane, KaVo, Marus Dental Corporation
Introduction
The American Dental Education Association is an organization run by its members and has a democratically based governmental structure that at first appears complex. It really isn’t. Nevertheless, members—especially new ones—would have difficulty trying to understand the Association by studying its Bylaws. This is a summary of the Association’s structure and its policy-making procedures.

How ADEA is Organized
You first must know how ADEA is organized in order to understand the Association’s policymaking procedures. Illustration 1 at the end of this section shows that ADEA is organized into four basic components: (1) the House of Delegates, (2) the Board of Directors, (3) councils and their administrative boards, and (4) sections.

ADEA House of Delegates
The ADEA House of Delegates is the Association’s legislative (policymaking) body. It convenes twice at each ADEA Annual Session & Exhibition. The House of Delegates consists of the Board of Directors (see below) and all or some members of the Association’s seven councils. All members of the ADEA Councils of Deans and Faculties are delegates. The numbers of delegates from the ADEA Councils of Allied Dental Program Directors, Hospitals and Advanced Education Programs, and the Students, Residents, and Fellows are based on percentages of those councils’ members. The number of section delegates depends on the number of sections. The councilor and chair of each section serve as delegates. The chair, chair-elect, and vice president serve as delegates for the ADEA Corporate Council.

ADEA Board of Directors
The Board of Directors is ADEA’s administrative body and is responsible for running the Association’s affairs between ADEA Annual Sessions. It has 11 members—President, President-elect, Immediate Past President, the Vice President for each of the seven Councils, and the Executive Director. The Board of Directors can establish interim Association policies that are consistent with existing policies if it apprises the House of its actions at the next ADEA Annual Session & Exhibition.

ADEA Councils
Six of the Association’s seven councils represent different constituencies at Member Institutions. The seventh consists of the councilor and chair of each ADEA section (see below). Councils represent their constituencies in the Association and at its Member Institutions. They identify, initiate, and oversee projects and reports of value to their members and other Association members. Councils may also participate in the Association’s policy-making process. When requested, they identify potential consultants to the Board of Directors and other groups. All councils meet at the ADEA Annual Sessions, and some hold additional meetings between Annual Sessions.

The ADEA Council of Allied Dental Program Directors consists of the directors of dental hygiene, assisting, and laboratory technology education programs conducted by Member Institutions. In addition, the council includes directors of special allied dental education programs at the post-entry level that lead to a baccalaureate or advanced degree.

The ADEA Council of Deans consists of the dean of each U.S. dental school; the chief dental administrative officer of each affiliate (nondental school) member institution conducting non-hospital-based postdoctoral dental education programs; the chief dental officer of the U.S.
Air Force, Army, Navy, Public Health Service, and Veterans Administration; and the President of
the Association of Canadian Faculties of Dentistry.

The ADEA Council of Faculties consists of one faculty representative from each U.S.
dental school.

The ADEA Council of Hospitals and Advanced Education Programs consists of the chief of
hospital dental service and directors of each accredited residency program in active or
provisional member institutions (including hospitals under the same governance as a dental
school) and in hospitals that are affiliate members, in addition to any members of the council
Administrative Board who are no longer in the above categories and one representative of all
non-recognized specialty programs at each institution described above.

The ADEA Council of Sections consists of the councilor and chair of each of the
Association’s sections.

The ADEA Council of Students, Residents, and Fellows consists of one student
representative for each of the following types of programs conducted by all Member Institutions:
(1) programs leading to the D.D.S. or D.M.D. degree, (2) postdoctoral dental education
programs, (3) dental hygiene education programs, (4) dental assisting education programs, and
(5) dental laboratory technology education programs.

The ADEA Corporate Council consists of the official representative of each Corporate
Member.

Council Administrative Boards

Each council has a five-member administrative board, consisting of a Vice President (who
is an Association officer who serves on the ADEA Board of Directors), a Chair, a Chair-elect, a
Secretary, and a Member-at-Large. Each administrative board meets at least once between
Annual Sessions and is responsible for planning its council’s ADEA Annual Session & Exhibition
program and for managing the council’s affairs. Administrative boards relate to their councils
much as the Board of Directors relates to the House of Delegates.

Sections

Each ADEA Individual, Student, Honorary, or Retired Member may join any of the
Association’s sections. Each section is concerned with a particular academic or administrative
area. Individual members may attend the meetings of any sections but can participate in the
business affairs of only those to which they belong. Each section has a councilor, chair, chair-
elect, and secretary. The section officers function much as the council administrative boards do,
in that they plan their section’s ADEA Annual Session & Exhibition meetings and manage the
section’s affairs between Annual Sessions.

Standing and Special Committees

From time to time, the ADEA Board of Directors appoints standing and special committees
to assist it in its operations.
How Resolutions are Introduced and What Happens to Them

Resolutions are the vehicles by which the Association’s policies and administrative procedures are established, amended, or deleted.

Resolutions may be introduced either between ADEA Annual Sessions or at an Annual Session during the Opening Session of the House of Delegates. Each year, the ADEA Board of Directors presents several resolutions to the House, and any individual member may also present resolutions.

How to Introduce a Resolution at an ADEA Annual Session & Exhibition

Only delegates may introduce resolutions at an ADEA Annual Session & Exhibition and only at the Opening Session of the House (See Illustration 2). The ADEA councils meet before the Opening Session of the House. During those meetings, they have an opportunity to develop resolutions that can then be presented by one of their delegates at the Opening Session.

If a council develops a resolution after the Opening Session, the resolution cannot be considered by the House until the following year. However, the resolution can be sent immediately after the Annual Session to the ADEA Executive Director who then presents it to the ADEA Board of Directors for consideration before the next Annual Session.

How to Introduce a Resolution between ADEA Annual Sessions

Any individual member may submit a resolution between ADEA Annual Sessions (See Illustration 3). Resolutions should be sent to the ADEA Executive Director who forwards them to the other members of the ADEA Board of Directors.

The Board of Directors often refers resolutions to appropriate councils, sections, or standing and special committees for their recommendations. The Board of Directors, however, takes action on all resolutions prior to the Annual Session and sends them on to the ADEA House of Delegates. The Board of Directors may recommend approval, postponement, or rejection of a resolution, or may simply forward a resolution without comment.

All individual members must present resolutions to the Executive Director in writing before November 1 preceding the ADEA Annual Session & Exhibition in order for the Board of Directors to review the resolution prior to the Annual Session. Nondelegates who fail to meet that deadline may still ask a delegate to introduce a resolution for them at the Opening Session of the House.

Format of Resolution

Resolutions must follow a specific format. They should not be numbered because staff assigns numbers.

“Whereas” clauses should not be used. Instead, when necessary, a succinct background statement should precede the resolution.

Resolutions proposing expenditure of Association funds must be accompanied by a cost impact statement estimating the total amount of funds required and the period of expenditure. Such resolutions presented without cost impact statements will be declared deficient. Staff will assist resolution drafters in estimating expenditures.

Any resolution whose approval would change the ADEA Policy Statements and Position Papers must specify exactly how those documents would be affected. Likewise, any resolution whose approval would change the ADEA Bylaws must specify exactly how those documents would be affected. Staff will assist members in drafting these resolutions.

The following fictitious statement and resolution exemplifies the format of an ADEA resolution.
Sample ADEA Resolution  
Board of Directors Quorum

The present *Bylaws* of the American Dental Education Association provide that a majority of the members of the Board of Directors constitutes a quorum for the transaction of business. It is believed that the quorum requirements should be increased because it is presently possible for only six individuals to make important decisions affecting the Association. The following resolution is therefore presented for consideration.

*Resolved*, that the quorum requirement for the Board of Directors be increased from a majority of the members to two thirds of the members; and be it further

*Resolved*, that *Bylaws* Chapter IV (Board of Directors), Section E (Quorum), which reads:

*Section E. Quorum*, A majority of the members constitutes a quorum for the transaction of business at regular or special sessions.

Be amended to read:

*Section E. Quorum*. Two thirds of the members constitute a quorum for the transaction of business at regular or special sessions.
2. What Happens to Resolutions Introduced at Annual Session

3. What Can Happen to a Resolution Introduced Between Annual Sessions
How ADEA Reference Committees Function

Purpose

Before each ADEA Annual Session & Exhibition, the ADEA Board of Directors appoints two Reference Committees, the ADEA Reference Committee on Association Administrative Affairs and the ADEA Reference Committee on Association Policy. Most resolutions to be considered by the ADEA House of Delegates are referred to one of these committees. Resolutions dealing with administrative, procedural, and business affairs of the Association are referred to the Reference Committee on Association Administrative Affairs. Resolutions dealing with the policies and public positions of ADEA are referred to the Reference Committee on Association Policy.

The Reference Committees hold hearings at the Annual Session, at which all individual members have an opportunity to discuss and debate the resolutions before they are considered by delegates at the Closing Session of the House. After their hearings, the Reference Committees write reports recommending specific actions on each resolution, and the reports are presented at the Closing Session.

Hearings

Hearings are open to all individual members and other ADEA Annual Session & Exhibition participants. Reference Committee chairs have the authority to determine whether a nonmember may speak.

At their hearings, each Reference Committee provides an opportunity for discussion on each resolution referred to it. A Reference Committee must recommend action to the House on each resolution, even if there is no discussion at the hearing. However, if there is no discussion, a Reference Committee need not necessarily recommend approval of a resolution; it can recommend another action. Reference Committees have considerable authority; they may propose the adoption of a resolution, or they may recommend amendment, postponement, or rejection. Each Reference Committee prepares a report at the end of its hearing, which will be given at the Closing of the House. Each committee must, in its report, explain its recommendations briefly, noting the reasons for agreement or disagreement with the original recommendations.

A Reference Committee chair cannot permit motions or votes at hearings because Reference Committees are intended only to receive information and opinions. Further, a chair may not debate points, either at the hearing or the Closing Session of the House.

More

There is more on Reference Committees specific to the 2011 ADEA Annual Session & Exhibition in the next section.

Conclusion

We hope this information has given you a basic understanding of how ADEA works and has encouraged you to participate actively in the Association’s affairs. Please contact ADEA staff members Ms. Sue Sandmeyer, Associate Executive Director for Knowledge Management, or Ms. Susan Krug, Associate Executive Director for Member Services, at 202-289-7201 or at sandmeyers@adea.org or krugs@adea.org for any further information you need.
ADEA Reference Committees

Additional information on Reference Committees appears in “Introduction to the ADEA Governing Process,” which immediately precedes this section. That material explains the purpose of Reference Committees and the ground rules governing their hearings at the ADEA Annual Session & Exhibition.

The ADEA Board of Directors has selected the following members to serve on this year’s Reference Committees:

**ADEA Reference Committee on Association Administrative Affairs**
Ms. Ande Loveless, University of Oklahoma, ADEA Council of Students, Residents, and Fellows, Chair
Prof. Michele Carr, The Ohio State University, ADEA Council of Allied Dental Program Directors
Dr. Tracy M. Dellinger, University of Mississippi, ADEA Council of Hospitals and Advanced Education Programs
Dr. Cecile A. Feldman, University of Medicine and Dentistry of New Jersey, ADEA Council of Deans
Mr. Brian Kline, A-dec, ADEA Corporate Council
Dr. Ted D. Pate, University of Texas Health Science Center at Houston, ADEA Council of Sections
Dr. Mark S. Schweizer, Nova Southeastern University, ADEA Council of Faculties

**ADEA Reference Committee on Association Policy**
Mr. Staš Grandi, Nova Southeastern University, ADEA Council of Students, Residents, and Fellows, Chair
Prof. Christine M. Blue, University of Minnesota, ADEA Council of Allied Dental Program Directors
Prof. Gail S. Childs, University of Florida, ADEA Council of Sections
Dr. R. Lamont MacNeil, University of Connecticut, ADEA Council of Deans
Dr. Lisa M. Mruz, University at Buffalo, ADEA Council of Faculties
Dr. David W. Paquette, Stony Brook University, ADEA Council of Hospitals and Advanced Education Programs
Dr. Elizabeth Roberts, Johnson & Johnson Healthcare Products, Division of McNEIL-PPC, Inc., ADEA Corporate Council

**ADEA Reference Committee Hearings Times and Locations**
ADEA Reference Committee Hearing on Association Policy
Monday, March 14, 2:00 to 3:00 p.m., Manchester Grand Hyatt, Douglas Pavilion Section A.

ADEA Reference Committee Hearing on Administrative Affairs
Tuesday, March 15, 1:00 to 2:00 p.m., Manchester Grand Hyatt, Douglas Pavilion Section A.
Resolutions to be Considered by the ADEA House of Delegates

While there are 5 Resolutions (1H-2011 through 5H-2011) that will be acted upon by the House at its Opening Session on Saturday, March 12, 2011, from 4:00 to 5:00 p.m., Manchester Grand Hyatt, Elizabeth Ballroom Section A-E, there are 10 resolutions (6H-2011 through 15H-2011) that the Board of Directors has referred to hearings of Reference Committees. In addition, any resolutions introduced at the Opening Session of the House will also be referred to the appropriate Reference Committee.

After the Reference Committees have met on March 14 and 15, these 10 resolutions (and any that are presented from the floor) will be considered by the House at its Closing Session on Wednesday, March 16, noon to 1:00 p.m., Manchester Grand Hyatt, Elizabeth Ballroom Section A-E. At the Closing Session the Reference Committees’ chairs will read the resolutions that their committees have heard, and their reports will be submitted to the House (but not read aloud).

Resolutions to be Heard by the ADEA Reference Committee on Association Policy

The Reference Committee on Association Policy will hold a hearing on resolutions 6H-2011 through 11H-2011 at its hearing, which will be Monday, March 14, from 2:00 to 3:00 p.m. at the Manchester Grand Hyatt, Douglas Pavilion Section A. Additional resolutions introduced at the Opening Session of the House may be referred to this committee.

Resolutions to be Heard by the ADEA Reference Committee on Association Administrative Affairs

The Reference Committee on Administrative Affairs will hear resolutions 12H-2011 through 15H-2011 on Tuesday, March 15, from 1:00 to 2:00 p.m. at the Manchester Grand Hyatt, Douglas Pavilion Section A. Additional resolutions introduced at the Opening Session of the House may also be referred to this committee.
Order of Business of the ADEA House of Delegates

Opening Session

Saturday, March 12, 4:00 to 5:00 p.m., Manchester Grand Hyatt, Elizabeth Ballroom
Section A-E.

Call to Order—ADEA President Dr. Sandra C. Andrieu
Report of Quorum
Approval of the Minutes of the Previous Session
Reports
President-elect’s Address—Dr. Leo E. Rouse
Executive Director’s Report—Dr. Richard W. Valachovic
Report of the Nominating Committee—Dr. Ronald J. Hunt
Referrals of Reports and Resolutions
—Recess, until March 16, 2011, noon

Closing Session

Wednesday, March 16, noon to 1:00 p.m., Manchester Grand Hyatt, Elizabeth Ballroom
Section A-E.

Call to Order—ADEA President Dr. Sandra C. Andrieu
Report of Quorum
Consideration of Reference Committee Reports and Action on Resolutions
Unfinished Business
New Business
President’s Address—Dr. Sandra C. Andrieu
Announcement of New Officers and Recognition of Retiring Officers
Adjournment
Procedures for the Conduct of Business in the
ADEA House of Delegates

Designates
A delegate unable to attend a House session or who serves in the House in two or more positions (e.g., as a member of the Council of Faculties and Council of Sections) may appoint a designate to represent him or her. A delegate from the Councils of Allied Dental Program Directors, Hospitals and Advanced Education Programs, or Students, Residents, and Fellows must appoint a designate who is a member of the same council. A delegate from the Council of Sections must appoint the Secretary or Chair-elect of his/her section. A delegate from the Councils of Deans or Faculties must appoint a designate from his/her institution. A delegate representing two or more councils must decide which council to represent and then appoint a designate for the other position according to the foregoing guidelines. A delegate must notify ADEA of the name of the designate. This can be done by emailing ADEA prior to the ADEA Annual Session & Exhibition or when picking up voting cards at the ADEA House of Delegates booth in the registration area at the ADEA Annual Session & Exhibition.

Admission Cards
At registration, each delegate (or designate) will receive three cards: (1) one for admission to the Opening Session of the House, (2) one for admission to the Closing Session, and (3) one for balloting for President-elect. Each delegate and designate must surrender the signed, appropriate card when entering the floor for the Opening and Closing Sessions. Any delegates or designates who misplace their admission or voting cards should immediately report the loss to staff in the Association’s registration area.

Seating of Delegates
Delegates are seated by council affiliation, and each delegate is required to sit with his or her council. The council seating areas will be marked by signs.

Visitors
All registered ADEA Annual Session & Exhibition participants are not only invited but also encouraged to attend the ADEA House of Delegates sessions as well as meetings of the Reference Committees. There will be visitors’ seating sections at both the Opening and Closing Sessions.

Presiding Officer
The Association’s President—Dr. Sandra C. Andrieu—is the presiding officer of the House. In the absence of the President, the President-elect is the presiding officer. The President may cast a vote in cases when her vote could alter the outcome, appoints judges and tellers to assist in determining the result of any action taken by ballot, and performs any other duties required by the rules of order.

Recording Officer
The ADEA Executive Director is the recording officer of the ADEA House of Delegates and the custodian of its records. The Executive Director may appoint a public stenographer to record the verbatim proceedings of the Opening and Closing Sessions of the House.
Rules of Order

The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the deliberations of the House in all cases where they are applicable and not in conflict with the Association’s Bylaws.

Parliamentarian

A parliamentarian will be present during the sessions of the House of Delegates.

Explanation of Motions

To avoid confusion, each type of motion is assigned a definite rank as shown in the table on pages 28 through 30.

The rank is based on the urgency of each motion. When a motion is before the House, any motion is in order if it has a higher precedence or rank than the immediately pending motion, but no motion having a lower precedence is in order. Motions are considered and decided in a reverse order to that of their proposal. For example, a motion to amend the main motion is dispensed with before the main motion, and a motion to amend an amendment is voted on before the original motion to amend.

After a motion to approve is made and seconded, the resolution is before the House for debate, amendment, and final action. A motion to approve is a main motion, and a vote by the House disposes of the resolution.

A motion to postpone definitely may be used to defer consideration of a resolution until some definite future time, during this ADEA Annual Session & Exhibition. Resolutions may be referred to the ADEA Board of Directors, councils, or sections for their recommendations.

There is no motion to postpone indefinitely available to delegates. The motion to postpone indefinitely was often confused with the motion to lay on the table, because they both set aside the pending main motion without bringing it to a direct vote. Unlike a motion to lay on the table, however, the motion to postpone indefinitely was debatable, and also opened the main question to debate. Because theoretically it was a new motion, it provided a loophole for those who had exhausted their right of debate, enabling them to get around the limitation and continue debating the main motion. This practice has been criticized because it prolongs debate, and because it violates the principle of majority rule, providing a means of thwarting the will of the assembly, as expressed in the motion limiting debate. It also confuses those who are not familiar with the motion, and who assume that it would merely “postpone” the pending question, as the name might seem to indicate, instead of killing it.

The motion to postpone temporarily can accomplish the main purpose of the motion to postpone indefinitely—that is, it suppresses the main motion without bringing it to a vote—but without the unintended result of prolonging discussion without the assembly’s permission. To prevent misuse of the motion, a two-thirds vote is required when the motion to postpone temporarily is used to prevent discussion of a motion (to kill a motion).

Legislative bodies have traditionally killed motions by tabling them, and this is the most common method of “postponing indefinitely” in American organizations of all kinds. It is recommended that when a motion is made to postpone indefinitely, the chair handle it as a motion to lay on the table.

If an amended or substitute resolution is approved, the issue is resolved. However, if an amended or substitute resolution is not approved, the House returns to discussion of, and a vote on, the original version.
Amendments to the ADEA Bylaws

A proposed amendment to the Bylaws must be presented in writing at the Opening Session, and is then voted on at the Closing Session. A Bylaws amendment is enacted if it receives an affirmative vote of at least two thirds of the delegates present and voting.

Voting Procedures during ADEA House of Delegates Sessions

The presiding officer usually determines the method of voting during sessions of the House. He or she may choose a voice vote, a show of hands, a standing vote, or a secret ballot, depending on the closeness of the vote and the presiding officer’s sense of the House.
### Principal Rules Governing Motions in the ADEA House of Delegates

<table>
<thead>
<tr>
<th>Order of Precedence1</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>What other motion can be applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>3. Question of Privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Postpone temporarily (table)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main Motion</td>
<td>None</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable Motions</td>
<td>None</td>
</tr>
<tr>
<td>6. Limit debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>2/3</td>
<td>Debtable Motions</td>
<td>Amend</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main Motion</td>
<td>Amend, close debate, limit debate</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main Motion</td>
<td>Amend, close debate, limit debate</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Rewordable Motions</td>
<td>Close debate, limit debate, amend</td>
</tr>
</tbody>
</table>

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1. Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

2. Debatable if no other motion is pending

3. Requires two-thirds vote when it would suppress a motion without debate
### Principal Rules Governing Motions in the ADEA House of Delegates

<table>
<thead>
<tr>
<th>Order of Precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>What other motion can be applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. a. The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Restorative, Subsidiary</td>
</tr>
<tr>
<td>10. b. Restorative main motions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main motion</td>
<td>Subsidiary, Restorative</td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Previous action</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Previous action</td>
<td>Subsidiary</td>
</tr>
<tr>
<td><strong>No order of Precedence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes⁵</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Resume consideration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
</tr>
</tbody>
</table>

⁴ Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

⁵ Debatable if no other motion is pending.
<table>
<thead>
<tr>
<th>No order of Precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>What other motion can be applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Decision of Chair</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td><strong>Requests</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Any error</td>
</tr>
<tr>
<td>Parliamentary inquiry</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Main motion</td>
<td>None</td>
</tr>
</tbody>
</table>

Voting for the ADEA President-elect

The members of the ADEA House of Delegates will cast ballots for ADEA President-elect during the ADEA Annual Session & Exhibition. Delegates may cast their ballots for President-elect between the hours of 8:00 a.m. and 5:00 p.m. on Sunday, March 13; between 8:00 a.m. and 4:30 p.m. on Monday, March 14; and between 8:00 a.m. and 4:30 p.m. on Tuesday, March 15. Voting will take place at the ADEA House of Delegates booth in the registration area at the Manchester Grand Hyatt, Elizabeth Foyer. These are the only times when a delegate or designate may cast a ballot for President-elect. Only a delegate (or official designate) may vote, and he/she must surrender his/her voter registration card to receive a ballot.

The 2011 Nomination Process for ADEA President-elect

The Board of Directors placed several calls for nominations in the Bulletin of Dental Education Online and Journal of Dental Education.

All members were invited to nominate as many individuals as they wished, including themselves.

The Council Administrative Boards were also invited to nominate candidates; however, the Boards were not informed of the identity of the other candidates. In order to maintain confidentiality, only the Nominating Committee and the ADEA Executive Director knew the identity of all nominees.

The deadline for submitting nominations was November 1, 2010.

The Nominating Committee voted to select the candidates to stand for election.

Upon the recommendation of the Nominating Committee, the Board of Directors presents three candidates for 2011-12 ADEA President-elect. (The office leads in successive years to the offices of President and Immediate Past President.) The three candidates are:

Dr. Gerald N. Glickman, Professor and Chair, Department of Endodontics, Baylor College of Dentistry
Dr. Diane C. Hoelscher, Associate Professor, University of Detroit Mercy
Dr. Sheila H. Koh, Principal Investigator and Special Patient Clinic Director, University of Texas Health Science Center at Houston

A brief biographical sketch of each follows.
Nominees for ADEA President-elect

Gerald N. Glickman, D.D.S., M.S., M.B.A., J.D.

I am deeply privileged to be a candidate for President-elect of the American Dental Education Association. For 25 years, I have been actively involved in ADEA and in dental education. As one of the founding members of ADEA’s Commission on Change and Innovation in Dental Education, I share the basic belief that we can lead change in dental, allied dental, and advanced dental education.

This is why I seek your vote for President-elect of ADEA - because I believe I can make a lasting, positive impact throughout the Association. I will engage each constituency of our membership to continue to enhance all aspects of dental education, to identify areas where change is most necessary, and to promote policies and procedures to implement such change. As an example of my leadership skills, this past year I served as President of the American Association of Endodontists. There, I pushed for increased access to care and was heartened when AAE members volunteered to provide free endodontic treatment to underserved patients at our annual meeting. It is always a great honor to serve and to see the tangible results of that service.

My passion for dental education is not a fleeting interest. It has spanned the scope of my career and has been reflected in my activities in ADEA. Within a year of accepting my first educational position at Baylor College of Dentistry, I was elected to the ADEA Council of Faculties, where I proudly represented Baylor for 8 years. In the years since, I have chaired the Sections on Endodontics and Graduate and Postgraduate Education, and served as Councilor for both Sections for a combined 12 years. In 1998, I was elected Member-At-Large for the Council of Sections Administrative Board, eventually becoming Vice President of the Council from 2002-2005. Another recent accomplishment has been leading the COS task force that developed the Competencies for the New General Dentist and is now completing a Foundation Knowledge document to support the competencies. I also currently chair the Administrative Board of the Council of Hospitals and Advanced Education Programs; in that role, I am working with dozens of educators to develop the 4th Advanced Dental Education Summit for the Fall of 2011. These opportunities have been deeply rewarding and have provided critical learning experiences for me; more importantly, I am confident that my contributions have become part of a larger mission benefitting our entire community.

In fact, the process of lifelong learning is incredibly important for all of us - it is essential to our profession. We need to give our members, our students, our faculties, our constituencies the tools for self-direction and self-reflection. By doing so, we instill in them a spirit of inquiry - a spirit that begins at entry-level and continues throughout dental education and to personal life beyond. ADEA must play a significant role in that process and it is why I intend to focus my attention on fostering lifelong learning as an elected representative of the Association.

I am an eternal optimist bursting with enthusiasm for our future. I am also a pragmatist. I recognize that our dental education community faces many challenges ahead and I intend to approach them with clear eyes, an abiding sense of purpose, and a recognition that we are all in this together. To quote an old Hopi Indian saying, “one
finger cannot lift a pebble,” our success depends on our ability to work together. If elected, each member of ADEA can count on me to diligently and relentlessly represent their interests with integrity, passion, and constant energy. Together, we can accomplish great things and as such, I seek your support and your vote.
Diane C. Hoelscher, D.D.S., M.S.

I am honored to be considered for the position of President-Elect of the American Dental Education Association. ADEA has been an integral part of my career and I’m excited by this opportunity to “pay it forward” and serve this Association, which has done so much in support of so many.

In making a choice for President-Elect, it’s important to consider leadership qualities and understand the candidate’s capacity to communicate and represent both within and outside ADEA. As President-Elect I will serve as a communicator, connector and promoter to be sure the voice of dental education is heard and understood.

My experiences have uniquely prepared me to serve as President-Elect. I practiced as a dental hygienist and dentist before joining the faculty 20 years ago. I’ve taught operative dentistry, served as interim chair of Operative and now chair the Department of Patient Management. Patient Management is a microcosm of developing areas in dental education - comprehensive patient care, evidence-based dentistry, ethics, behavioral science, community dentistry, plus an AEGD program. Leading this department requires an understanding of curriculum development and assessment, particularly in light of CCI best practices and new CODA requirements. We collaborate across disciplines and I lead by communicating, connecting, promoting, and representing.

From my first experiences on the administrative board of the SIG for Career Development of the New Educator to a stimulating year in the Leadership Institute, mentors, coupled with ADEA resources have supported my development as a leader. Working as a member of the Council of Faculties, on the COF administrative board and as Vice President for Faculties has engendered a strong appreciation for the needs and capacities of a broad range of faculty members. As a member of the ADEA Board of Directors I balanced representation of an individual council with promotion of the broader mission and directions of the Association. Representing the ADEA Board at meetings with the ADA and ACP deepened my appreciation of issues affecting dental education and the need for advocacy and collaboration.

As ADEA President-Elect, I would communicate optimism regarding the future of dental education and oral health care. We are facing significant challenges, such as faculty shortages, changing student demographics, the rising cost of dental education, and uncertainty regarding new oral health professionals. But there are also abundant opportunities. ADEA CCI has brought to light needed changes and recommended approaches. To some, the changes may seem threatening, to others exhilarating. Ultimately, it’s about people and making sure they have the information and opportunities for development they need to navigate change and maximize their creative and intellectual capacities. This involves faculty development. There has been much progress in this area, but more can be done to reach educators at their institutions, in their office, through their own computer. Good examples are the ADEA Curriculum Resource Center and MedEdPORTAL. The collective talents of ADEA staff, individual and institutional members will help us make this leap.
As a past member of the Annual Session Planning Committee, please indulge me as I play with session themes to summarize the opportunities we face as ADEA members: It’s not too hard to Imagine an Association Creating Opportunities for Curriculum Change: It’s time now for Interprofessional collaboration, Teaching and Learning Together for Better Health, understanding Access and Diversity, and Exceeding student Expectations.

I thank you for taking the time to read this statement, for your interest in the election and your dedication to ADEA. I believe I have the qualities and experience to best represent the many facets of ADEA and serve as an effective communicator, connector and promoter of the Association and its members.
Sheila H. Koh, D.D.S., MAGD, F.I.C.D.

As a dental educator convinced of the value of the American Dental Education Association, I am honored to be nominated for the position of President-elect. My first active participation with ADEA was in 1994. I attended the Seattle AADS meeting which helped shape my continuing involvement in ADEA. What stands out as particularly valuable was a discussion of the array of issues that faculty face daily. My new colleagues and I realized how similar our institutional challenges were and this helped us see how we could help each other. I still feel that same excitement today!

Since graduating from UT Dental Branch at Houston, I have been actively involved for 20 years in pre-doctoral, post-doctoral, and dental hygiene education as program director and faculty. My diverse experiences have given me the opportunity to see firsthand the importance of ADEA and its collaborations with academic dental, health care and government entities.

My long involvement and service demonstrate my commitment to ADEA and give me a rich background to draw upon. My legislative experiences sharpened my desire for more national involvement. I “graduated” from the Association’s Faculty Legislative Workshop. I was a member of the Legislative Advisory Committee. I served as the 2003-2004 ADEA/Harry W. Bruce Jr. Legislative Fellow. I served as a board member for the Postdoctoral General Dentistry Section, the Council of Hospitals and Advanced Education Programs and then, Vice President. I am a member of the Annual Session Program Committee and was a member of the 2004, 2006, and 2008 planning committees for the Advanced Dental Education Summit. In 2008, I was awarded the Presidential Citation in recognition of my contributions to dental education.

I aspire to give back to ADEA which has meant so much to me personally and professionally. I am committed to building upon the foundation of excellence established by my predecessors nurturing young leaders for the dental profession and academic ranks; promoting stellar educational programming and professional development for every ADEA member; advancing enrichment, recruitment and retention programs for faculty; and promoting inter-professional education, collaborations and understanding across our many councils and sections. I am ready to collaborate with you as we embrace the challenges facing our institutions in these difficult economic times.

ADEA is the true Voice of Dental Education. I am proud of ADEA’s accomplishments and what the organization will continue to do to achieve its goals for individuals and institutions. ADEA is well served by Dr. Valachovic and staff, and I would be honored to work hand in hand with them. If elected I will work with all segment of the ADEA membership to achieve our mission, and establish future strategies for continued growth and vibrancy. I will strive to advance the Association’s strategic goals and to provide the steady hand of leadership based upon my strong work ethic, knowledge and leadership experiences within and outside of ADEA.

I ask for your vote as I seek to give back and share my experiences and commitment to dental education and the Association.
Report of the ADEA Board of Directors on Resolutions for Consideration by the 2011 ADEA House of Delegates

The ADEA House of Delegates will consider the 15 resolutions in this report, plus any additional ones introduced at the Opening Session. The House will act on Resolutions 1H-2011 through 5H-2011 at its Opening Session on Saturday, March 12, 2011, from 4:00 to 5:00 p.m. The House will act on all others at its Closing Session on Wednesday, March 16, 2011, from noon to 1:00 p.m. Both sessions will be held at the Manchester Grand Hyatt, Elizabeth Ballroom Section A-E. The resolutions from the Board of Directors in the report are sequenced as follows:

Resolutions to be Acted on at the Opening Session
1H-2011 ADA Council on Dental Education and Licensure Member
2H-2011 Commission on Dental Accreditation Student Commissioner
3H-2011 Commission on Dental Accreditation Commissioner
4H-2011 2011 ADEAGies Foundation Appointment
5H-2011 Appreciations

Resolutions to be Acted on at the Closing Session
6H-2011 ADEA Council of Allied Dental Program Directors: ADEA Competencies for Entry into the Allied Dental Professions
7H-2011 ADEA Council of Allied Dental Program Directors: Core Competencies for Graduate Dental Hygiene Education
8H-2011 ADEA Policy Statement on the Education of Oral Health Professionals in Emerging Workforce Models
9H-2011 ADEA Council of Students, Residents, and Fellows: Policy for International Student Outreach
11H-2011 ADEA Council of Sections: Foundation Knowledge and Skills for the New General Dentist
12H–2011 ADEA Council of Hospitals and Advanced Education Programs: Membership Bylaws Amendment
13H-2011 Provisional Membership of the Lake Erie College of Osteopathic Medicine (LECOM) School of Dental Medicine
14H-2011 Provisional Membership of the University of New England College of Dental Medicine
15H-2011 Approval of the Fiscal Year 2012 Budget

All of the resolutions in this report that require House action are printed in boldface for delegates’ ease of identification.
Actions at the Opening Session of the ADEA House of Delegates

Resolution 1H-2011
ADA Council on Dental Education and Licensure Member

The current ADEA members to the ADA Council on Dental Education and Licensure (CDEL) and their termination dates (in the fall of the years shown) are:

- Dr. Cyril Meyerowitz, University of Rochester (2011)
- Dr. Patrick M. Lloyd, University of Minnesota (2012)
- Dr. Tariq Javed, Medical University of South Carolina (2013)
- Dr. Teresa A. Dolan, University of Florida (2014)

Dr. Meyerowitz will complete his term on CDEL this fall at the 2011 ADA Annual Session. He is not eligible for an additional term. Thus, the 2011 ADEA House will have to elect a new CDEL member. To replace Dr. Meyerowitz on the Council, the ADEA Board of Directors is recommending that the House elect Dr. Ann Boyle, Southern Illinois University, to a four-year term to expire 2015.

The ADEA bylaws allow delegates to nominate additional candidates for ADA CDEL membership at the Opening Session of the House. (Please note: ADA CDEL members must be active members of the ADA.) Any delegate presenting a nominee must obtain the candidate’s consent to run and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review in the ADEA Registration Area.

*The ADEA Board of Directors asks the House to approve the following resolution:*

1H-2011 Resolved, that the ADEA House of Delegates elect Dr. Ann Boyle to a four-year term on the ADA Council on Dental Education and Licensure with the term to begin at the conclusion of the 2011 ADA Annual Session and end at the conclusion of the 2015 ADA Annual Session.
Resolution 2H-2011
Commission on Dental Accreditation Student Commissioner

Under the rules of the Commission on Dental Accreditation, the American Dental Education Association and the American Student Dental Association jointly appoint one student commissioner every two years. The tradition has been that each association alternates in recommending an individual to be appointed to this position for approval by the governing bodies of both associations. In 2007, ADEA recommended the appointment of Mr. Jason Pickup, University of Nevada, Las Vegas to a two-year term to expire in 2009.

The ADEA Board of Directors recommends that the House elect Mr. Joseph Eliason, University of California, San Francisco, to a two-year term to begin at the conclusion of the 2011 ADA Annual Session and end at the conclusion of the 2013 ADA Annual Session.

The ADEA bylaws allow delegates to nominate additional candidates for CODA Student Commissioner at the Opening Session of the House. (Please note: ADEA appointees to CODA must be active members of the ADA.) Any delegate presenting a nominee must obtain the candidate’s consent to run, and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review in the ADEA registration area.

The ADEA Board of Directors asks the House to approve the following resolution:

2H-2011 Resolved, that the ADEA House of Delegates elect Mr. Joseph Eliason to a two-year term on the Commission on Dental Accreditation with the term to begin at the conclusion of the 2011 ADA Annual Session and end at the conclusion of the 2013 ADA Annual Session.
The current ADEA representatives to the Commission and their termination dates (in the fall of the years shown) are:

- Dr. Karen P. West, University of Nevada, Las Vegas (2011); (Dr. West replaced Dr. Sharon P. Turner, University of Kentucky, in 2010)
- Dr. Richard N. Buchanan, University of Southern Nevada (2012)
- Dr. Yilda Rivera-Nazario, University of Puerto Rico (2013)
- Dr. John N. Williams, Indiana University (2014)

Dr. West will complete her term on the Commission on Dental Accreditation (CODA) this fall at the 2011 ADA Annual Session. Thus, the 2011 ADEA House will have to elect a new Commission member. To replace Dr. West on the Commission, the ADEA Board of Directors is recommending that the House elect Dr. William Dodge, University of Texas Health Science Center at San Antonio, to a four-year term to expire in 2015.

The ADEA bylaws allow delegates to nominate additional candidates for CODA membership at the Opening Session of the House. (Please note: ADEA appointees to CODA must be active members of the ADA.) Any delegate presenting a nominee must obtain the candidate’s consent to run, and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review in the ADEA registration area.

The ADEA Board of Directors asks the House to approve the following resolution:

3H-2011 Resolved, that the ADEA House of Delegates elect Dr. William W. Dodge to a four-year term on the Commission on Dental Accreditation with the term to begin at the conclusion of the 2011 ADA Annual Session and end at the conclusion of the 2015 ADA Annual Session.
In order to enhance its ability to manage the challenges facing dental and allied dental education and research, the William J. Gies Foundation for the Advancement of Dentistry joined with ADEA in 2002 to create the William J. Gies Foundation for the Advancement of Dentistry of the American Dental Education Association (ADEAGies Foundation). The mission of the ADEAGies Foundation is to enhance the oral health of the public through programs that support dental education, research, leadership, and recognition.

According to the bylaws, the Board of Trustees of the ADEAGies Foundation consists of four or more ADEA appointed members, including the Past President, the Executive Director, one member appointed by the ADEA Board of Directors (but who cannot be a Board member), and a member appointed by the ADEA House of Delegates. The appointment by the ADEA House of Delegates is for a two-year term, beginning in July 2011 and ending in July 2013 with the appointment of a new member at the ADEA Annual Session.

The ADEA Board of Directors recommends that the House elect Dr. Connie L. Drisko, Georgia Health Sciences University, to a two-year term to expire in 2013.

The ADEA Board of Directors asks the House to approve the following resolution:

4H-2011 Resolved, that the ADEA House of Delegates appoint Dr. Connie L. Drisko to a two-year term to expire in 2013, as a member of the ADEAGies Foundation Board of Trustees.
ADEA relies significantly on outside support for a number of its activities, and numerous organizations provided much-needed assistance since last year’s ADEA Annual Session & Exhibition. The ADEA Board of Directors expresses its sincere appreciation to the following companies, organizations, institutions, and individuals for their generous support. Those who have supported ADEA activities and events over the past year—from last year’s ADEA Annual Session & Exhibition until the start of this year’s Annual Session—are listed alphabetically. Most of the companies listed are also Corporate Members of ADEA, and we are especially grateful to them.

**ADA Insurance Plans** was a general sponsor of the ADEA sections on Dental School Admissions Officers and Financial Aid and Student Affairs at the ADEA Fall 2010 Meetings and was a general sponsor of the 52nd Annual ADEA Deans’ Conference. The company also sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

ADEA AADSAS cosponsored the meeting of the ADEA sections on Dental School Admissions Officers and Student Affairs and Financial Aid at the ADEA Fall 2010 Meetings.

The **ADEA Corporate Council** sponsored the Opening Plenary at the 2010 ADEA Annual Session & Exhibition.

The **ADEA Council of Students, Residents, and Fellows** cosponsored the 2010 ADEA/ADEA Council of Students, Residents, and Fellows/Colgate-Palmolive Co. Junior Faculty Award.

The **ADEAGies Foundation** funded the ADEA/William J. Gies Foundation Education Fellowship and the ADEA/William J. Gies Foundation Research Scholarship. The Foundation cosponsored the 2010 ADEA Leadership Institute.

**A-dec** was a Gold Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. A-dec sponsored lunch at the 52nd Annual ADEA Deans’ Conference and cosponsored dinner and a reception at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company also sponsored a reception at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference and an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

**ADI Mobile Health** was a general sponsor at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting.

**AEGIS Communications** was a general sponsor of the Fourth ADEA 2010 International Women’s Leadership Conference and a general sponsor of the 2010 ADEA/ASDA National Dental Student Lobby Day. AEGIS Communications was a Gold Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company also sponsored the welcoming reception at the 52nd Annual ADEA Deans’ Conference.
The *Alpha Omega Foundation* funded the ADEA/Alpha Omega Foundation/Leonard Abrams Scholar in the ADEA Leadership Institute.

*The Association of American Medical Colleges* supported the Summer Medical Dental Education Program.

*The American College of Prosthodontists* was a 2010 William J. Gies Awards for Vision, Innovation, and Achievement Donor.

*Aspen Dental Management, Inc.* was a general sponsor of the 52nd Annual ADEA Deans’ Conference. The Company also sponsored Exhibit Hall raffle items at the 2010 ADEA Annual Session & Exhibition.

*axiUm Software* provided a break for the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting.

*Benco Dental* was a general sponsor of the 52nd Annual Deans’ Conference.

*Bien Air USA* was a general sponsor for the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company also sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

*BioHorizons Implant Systems* was a general sponsor of the 52nd Annual Deans’ Conference.

*Boston University* was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

*Brasseler USA* sponsored the golf tournament reception and prizes at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company was a general sponsor at the 52nd Annual ADEA Deans’ Conference and also sponsored a reception at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

*The California Endowment* provided a grant to conduct a three-year evaluation of the California Dental Pipeline Program Phase II, a program designed to increase access to dental care for underserved populations.

*Carl Zeiss Meditec, Inc.* sponsored a break at the 52nd Annual ADEA Deans’ Conference.

*Case Western Reserve University School of Dental Medicine* was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

*Certiphi Screening, Inc.* sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.
Colgate-Palmolive Co. was a Diamond Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company supported the ADEA Leadership Institute Alumni Reception for the Class of 2011 at the 2010 ADEA Annual Session & Exhibition. The company again provided generous support for the ADEA/Colgate-Palmolive Co. Allied Dental Educators’ Fellowship, ADEA/Colgate-Palmolive Excellence in Teaching Award, ADEA/Colgate-Palmolive Co./National Dental Association Dr. Jeanne C. Sinkford Scholar in the 2010 ADEA Leadership Institute, the 2010 ADEA/Colgate-Palmolive Co. Junior Faculty Award, and the 2010 ADEA Invitational Allied Dental Education Summit. Colgate-Palmolive Co. was a founding and continuing supporter of ADEA’s online Journal of Dental Education. The company sponsored the ADEA/Colgate-Palmolive Oral Systemic Link curriculum guideline development project. The company sponsored a lunch at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference and sponsored conference laptop sleeves at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. Colgate-Palmolive Co. sponsored an educational session, conference bags and also sponsored the New Deans’ Workshop, at the 52nd Annual ADEA Deans’ Conference. The company was a general sponsor of the Fourth ADEA International Women’s Leadership Conference.

DentalEZ Group was a Gold Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

The Dental Services Group – DSG, Solutions Laboratory sponsored a breakfast at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company was also a general sponsor of the 52nd Annual ADEA Deans’ Conference.

DENTSPLY International, Inc. was a Diamond Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement and sponsored the student poster awards at the 2010 ADEA Annual Session & Exhibition. The company hosted a reception at the 52nd Annual ADEA Deans’ Conference and was a general sponsor of the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. DENTSPLY International, Inc. was a general sponsor for the 43rd Annual National ADEA Allied Dental Program Directors’ Conference as well.

DEXIS, LLC; GENDEX DENTAL SYSTEMS; ISI cosponsored the welcome reception at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting and a breakfast at the 52nd Annual ADEA Deans’ Conference. The company also supported Faculty Development Workshops at the 2010 ADEA Annual Session & Exhibition.

Discus Dental, Inc. sponsored the keynote address at the 52nd Annual ADEA Deans’ Conference and the golf tournament beverage cart for the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting.

Fortress Insurance Company was a general sponsor of the 52nd Annual ADEA Deans’ Conference.
G. Hartzell & Son sponsored an education session at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

GlaxoSmithKline was a general sponsor of the 43rd Annual National ADEA Allied Dental Program Directors’ Conference and the 52nd Annual ADEA Deans’ Conference. The company also funded the ADEA 2010 Dental School Curriculum Development Program.

Harvard School of Dental Medicine was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Henry Schein, Inc. was a Diamond Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company also sponsored a breakfast at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting, and provided support for a break at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

Hu-Friedy Mfg. Co., Inc. was a Diamond Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored a luncheon at the 52nd Annual ADEA Deans’ Conference and cosponsored a reception and dinner for the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. Hu-Friedy Mfg. Co., Inc. sponsored a reception at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference. The Company also sponsored Exhibit Hall raffle items at the 2010 ADEA Annual Session & Exhibition.

Indiana University was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Institute for Oral Health sponsored lanyards, pens and conference bags at the 2010 ADEA Annual Session & Exhibition. The company also was a general sponsor for the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting and the 52nd Annual ADEA Deans’ Conference. The company also sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

International Federation of Dental Educators and Associations supported the 2010 ADEA/International Federation of Dental Educators and Associations Orna Shanley Prize.

Isolite Systems was a general sponsor of the 52nd Annual ADEA Deans’ Conference and the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

Johnson & Johnson Healthcare Products, Division of McNEIL-PPC, Inc. was a Premier Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored the ADEA/Johnson & Johnson Healthcare Products Preventive Dentistry Scholarships and the ADEA/Johnson & Johnson Healthcare Products/Enid A. Neidle Scholar-in-Residence Program for Women. The company sponsored the keynote address at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference and the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company cosponsored a reception at the 52nd Annual ADEA Deans’ Conference. The company also sponsored the 2010 ADEA Invitational Allied Dental Education Summit, the 2010
ADEA Leadership Institute, as well as the Fourth ADEA International Women’s Leadership Conference.

The Josiah Macy, Jr. Foundation provided a grant to support the Bridging the Gap Program, designed to develop a flexible seven-year dental curriculum as a way to increase the number of underrepresented minority and low-income students going into dentistry.

Kahler Slater sponsored lunches for golfers and the buses to take conference attendees to tour a dental school at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company also was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

Komet USA sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

Liaison International, Inc. was a Gold Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement and cosponsored the meeting of the ADEA Sections on Dental School Admissions Officers and Student Affairs and Financial Aid at the ADEA Fall 2010 Meetings.

Loma Linda University was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Louisiana State University was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Medical Protective was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

Midmark Corporation was a general sponsor of the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting and of the 52nd Annual ADEA Deans’ Conference.

Mosby/Elsevier sponsored Exhibit Hall raffle items at the 2010 ADEA Annual Session & Exhibition.

National Dental Association was a Gold Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement, and cosponsored the ADEA/Colgate-Palmolive Co./National Dental Association Dr. Jeanne C. Sinkford Scholar in the 2011 ADEA Leadership Institute.

National Dentex Corporation was a Donor Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

National Institute of Health/NIDCR was a general sponsor of the 2010 ADEA Fourth International Woman’s Leadership Conference.

New York University was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.
Nobel Biocare AB was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

Oral Health America, the Beauchamp Funds, the George H. Whiteley Memorial Foundation and DENTSPLY International, Inc. supported the ADEAGies Foundation for the ADEA Leadership Institute.

OraPharma, Inc. was a Diamond Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company was a cosponsor of a reception at the 52nd Annual ADEA Deans’ Conference and was a general sponsor at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

Pacific Dental Services, Inc. sponsored the official 2010 ADEA Annual Session & Exhibition poster and was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

PDT, Inc. sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

Pelton & Crane, KaVo, Marus Dental Corporation co-sponsored a reception at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting and breakfast at the 52nd Annual ADEA Deans’ Conference.

Philips Oral Healthcare, Inc. sponsored the conference lanyards at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference and was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

Premier Dental Products Company supported a break at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference. The company also sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

The Procter & Gamble Company was a Diamond Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement. The company also sponsored a breakfast at the 52nd Annual ADEA Deans’ Conference. The Procter & Gamble Company also sponsored the ADEA Allied Dental Hygiene Clinic Coordinators’ lunch and the ADEA Dental Hygiene Graduate Program Directors meeting at the 2010 ADEA Annual Session & Exhibition. The company sponsored a lunch at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting as well as a breakfast at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference and was a general sponsor of the 2010 ADEA Invitational Allied Dental Education Summit. The company is a continuing sponsor of ADEA’s online Journal of Dental Education. The Procter & Gamble Company was a sponsor of the ADEA Fall 2010 meetings and of the 2010 ADEA Leadership Institute. The company also was a general sponsor of the 2010 ADEA/ASDA National Dental Student Lobby Day. The Company sponsored the ADEA/Crest Oral-B Laboratories Scholarship for Dental Hygiene Students Pursuing Academic Careers. The Procter & Gamble Company also was a general sponsor of the Fourth ADEA 2010 International Women’s Leadership Conference and sponsored Exhibit Hall raffle items at the 2010 ADEA Annual Session & Exhibition.
Raffa was a Gold Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

The Robert Wood Johnson Foundation provided grants to support the AAMC/ADEA Summer Medical and Dental Education Program and the ExploreHealthCareers.org website. The Foundation also provided support through the RWJF Dental Pipeline II NPO for Admission Committee Workshops and activities to support efforts to address diversity in the predoctoral accreditation standards.

SDS/Dental Consumables – Kerr, Pentron Clinical, Axis sponsored education sessions at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting and at the 52nd Annual ADEA Deans’ Conference.

Secure Innovations, Inc. sponsored a breakfast at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting

Septodont, Inc. was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

Sigma Phi Alpha, the dental hygiene honor society, sponsored the 2010 ADEA/Sigma Phi Alpha Linda DeVore Scholarship.

Sirona Dental Systems, LLC sponsored educational sessions at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting and at the 52nd Annual ADEA Deans’ Conference. Sirona Dental Systems, LLC also sponsored the Connecting with Colleagues Reception at the 2010 ADEA Annual Session & Exhibition and was a general sponsor of the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

Stage Front Presentation Systems sponsored an educational session at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting. The company was also a general sponsor at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference.

Stony Brook University School of Dental Medicine was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Sunstar Americas, Inc. sponsored the ADEA/Sunstar Americas, Inc. Harry W. Bruce, Jr. Legislative Fellowship and the ADEA Legislative Leadership dinner, as well as the flash drives at the 2010 ADEA Annual Session & Exhibition. The company was a general sponsor of the 2010 ADEA Invitational Allied Dental Education Summit. Sunstar Americas, Inc. was a general sponsor of the 52nd Annual ADEA Deans’ Conference, and support for the 2010 ADEA Leadership Institute.

Texas Association of Community Health Centers sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.
Texas A&M Health Science Center Baylor College of Dentistry was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

3M ESPE was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

Tufts University School of Dental Medicine was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Ultradent Products, Inc. sponsored a break at the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting as well as the 52nd Annual ADEA Deans’ Conference. The company also sponsored an Exhibit Hall raffle item at the ADEA 2010 Annual Session & Exhibition.

University of Alabama at Birmingham was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University at Buffalo was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of California, Los Angeles was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of California, San Francisco sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

University of Connecticut School of Dental Medicine was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Illinois at Chicago was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Kentucky was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Michigan was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Minnesota School of Dentistry was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Missouri-Kansas City was a Donor Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Nebraska Medical Center was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of North Carolina at Chapel Hill was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.
University of Puerto Rico was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Texas Health Science Center at Houston was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Texas Health Science Center at San Antonio was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Virginia Commonwealth University was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement.

Vista Dental Products was a general sponsor at the 43rd Annual National ADEA Allied Dental Program Directors Conference.

VitalSource Technologies, Inc. was a general sponsor of the 52nd Annual ADEA Deans’ Conference.

VOXEL-MAN Group sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

William J. Gies Foundation supported the Academic Dental Careers Fellowship Program and the Predental Advisors Workshop at the 2010 ADEA Annual Session & Exhibition.

W.K. Kellogg Foundation was a Deans’ List Level sponsor of the 2010 William J. Gies Awards for Vision, Innovation, and Achievement and provided a grant to support the ADEA/WWKF Dental School Outreach Program.

Whip Mix Corporation sponsored a luncheon for the Section on Prosthodontics at the 2010 ADEA Annual Session & Exhibition.

Young Dental Manufacturing sponsored an Exhibit Hall raffle item at the 2010 ADEA Annual Session & Exhibition.

Zimmer Dental sponsored education sessions at the 43rd Annual National ADEA Allied Dental Program Directors’ Conference, the ADEA Sections on Business and Financial Administration and Clinic Administration 2010 Mid Year Meeting, the 52nd Annual ADEA Deans’ Conference, and the ADEA Fall 2010 Meetings. Zimmer Dental supported the ADEA Council of Hospitals and Advanced Education Programs and the student-centered plenary at the ADEA 2010 Annual Session & Exhibition and also sponsored the conference keycards, the meetings-at-a-glance, and the ADEA Implant Teaching Award. Zimmer Dental also supported the Fourth ADEA International Women’s Leadership Conference and the 2010 ADEA Invitational Allied Dental Education Summit.

The ADEA Board of Directors asks the House to approve the following resolution:

5H-2011 Resolved, that the American Dental Education Association expresses its sincere appreciation to the following organizations and individuals for their generous support of the Association’s activities and programs.
between the start of the 2010 ADEA Annual Session & Exhibition and the start of the 2011 ADEA Annual Session & Exhibition:

- ADA Insurance Plans
- ADEA AADSAS
- The ADEA Corporate Council
- The ADEA Council of Sections
- The ADEA Council of Students, Residents, and Fellows
- The ADEAGies Foundation
- A-dec
- ADI Mobile Health
- AEGIS Communications
- Alpha Omega Foundation
- Association of American Medical Colleges
- American College of Prosthodontists
- Aspen Dental Management, Inc.
- axiUm Software
- Benco Dental
- Bien Air USA
- BioHorizons Implant Systems
- Boston University
- Brasseler USA
- The California Endowment
- Carl Zeiss Meditec, Inc.
- Case Western Reserve University
- Certiphi Screening, Inc.
- Colgate-Palmolive Co.
- DentalEZ Group
- The Dental Services Group – DSG, Solutions Laboratory
- DENTSPLY International, Inc.
- DEXIS, LLC; GENDEX DENTAL SYSTEMS; ISI
- Fortress Insurance Company
- G. Hartzell & Son
- GlaxoSmithKline
- Harvard School of Dental Medicine
- Henry Schein, Inc.
- Hu-Friedy Mfg. Co., Inc.
- Indiana University
- Institute for Oral Health
- International Federation of Dental Educators and Associations
- Isolite Systems
- Johnson & Johnson Healthcare Products, Division of McNEIL-PPC, Inc.
- The Josiah Macy, Jr. Foundation
- Kahler Slater
- Komet USA
- Liaison International, Inc.
- Loma Linda University
- Louisiana State University
• Medical Protective
• Midmark Corporation
• Mosby/Elsevier
• National Dental Association
• National Dentex Corporation
• National Institute of Health/NIDCR
• New York University
• Nobel Biocare AB
• Oral Health America, the Beauchamp Funds, the George H. Whiteley Memorial Foundation and DENTSPLY International, Inc.
• OraPharma, Inc.
• Pacific Dental Services, Inc.
• PDT, Inc.
• Pelton & Crane, KaVo, Marus Dental Corporation
• Philips Oral Healthcare, Inc.
• Premier Dental Products Company
• The Procter & Gamble Company
• Raffa
• The Robert Wood Johnson Foundation
• SDS/Dental Consumables – Kerr, Pentron Clinical, Axis
• Secure Innovations, Inc.
• Septodont, Inc.
• Sigma Phi Alpha
• Sirona Dental Systems, LLC
• Stage Front Presentation Systems
• Stony Brook University School of Dental Medicine
• Sunstar Americas, Inc.
• Texas Association of Community Health Centers
• Texas A&M Health Science Center, Baylor College of Dentistry
• 3M ESPE
• Tufts University
• Ultradent Products, Inc.
• University of Alabama at Birmingham
• University at Buffalo
• University of California, Los Angeles
• University of California, San Francisco
• University of Connecticut
• University of Illinois
• University of Kentucky
• University of Michigan
• University of Minnesota
• University of Missouri-Kansas City
• University of Nebraska Medical Center
• University of North Carolina at Chapel Hill
• University of Puerto Rico
• University of Texas Health Science Center at Houston
• University of Texas Health Science Center at San Antonio
• Virginia Commonwealth University
• Vista Dental Products
• VitalSource Technologies, Inc.
• VOXEL-MAN Group
• W.K. Kellogg Foundation
• Whip Mix Corporation
• Young Dental Manufacturing
• Zimmer Dental
Introduction

In 1998-99, the Dental Hygiene Section of the American Association of Dental Schools, now the American Dental Education Association (ADEA), developed and presented *Competencies for Entry into the Profession of Dental Hygiene*. These were widely used by the majority of accredited dental hygiene programs in defining specific program competencies.

Following the June 2006 Allied Dental Education Summit, a special Task Force of the ADEA Council of Allied Dental Program Directors was formed to advance the recommendations from the 2006 Summit. One recommendation was to develop similar competency statements for the dental assisting and dental laboratory technology disciplines. Given that charge, the ADEA Task Force on Collaboration, Innovation, and Differentiation (ADEA CID) undertook a comparative review of the draft *Competencies for the New General Dentist* and the *Competencies for Entry into the Profession of Dental Hygiene*. Both documents were analyzed from the perspective of where the allied dental professions should be headed to support an overall health care team concept and a professional model of education and practice and, at the same time, address curriculum innovation and change and better address access to care issues in the spirit of collaboration with multiple health care partners. The Task Force decided to focus its energy on updating and revising the Dental Hygiene Competencies (DHC) document. The final revised document was inclusive of both the dental assisting and dental laboratory technology disciplines and served as a companion to the documents produced by the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI).

The purpose of the original document was to:

- Define the competencies necessary for entry into the respective allied dental professions
- Serve as a resource for accredited allied dental education programs to promote change and innovation within their respective programs
- Support existing and future curriculum guidelines
- Serve as a resource for new and developing accredited programs in the allied dental professions
- Serve as a mechanism to inform other health disciplines about curricular priorities in allied dental education
- Enhance opportunities for intra- and inter-professional collaboration in understanding professional roles of oral health team members and other health care providers
- Support developing new education models for accredited allied dental education programs.

The competencies delineated in the document were written for the three primary allied dental professions and apply to formal, *accredited* programs in higher education.
institutions. While some competencies are common to all three disciplines, application would differ based on the allied discipline, type of program, length of the program, graduate credentialing options, defined scopes of practice, and institutional mission and goals for the program. Program faculty should define actual competencies and how competence is measured for their program(s). While the majority of allied dental professionals work within an oral health care team supporting private practice dentistry, other models have and will evolve. Accredited allied dental education programs have a responsibility to prepare their graduates for the highest level of practice in all jurisdictions.

The competencies outlined in the original document described the abilities expected of allied dental health professionals entering their respective professions. These competency statements were meant to serve as guidelines. It is important for individual programs to further define the competencies they want their graduates to possess, describing (1) the desired combination of foundational knowledge, psychomotor skills, communication skills, and professional behaviors and attitudes required, (2) the standards used to measure the students’ independent performance in each area, and (3) the evaluation mechanisms by which competence is determined.

The five general domains described in the document should be viewed as themes or broad categories of professional focus that transcend specific courses and learning activities. They are intended to encourage professional emphasis and focus throughout the respective discipline-specific curriculum. Within each domain, major competencies expected of the program graduate are identified. Each major competency reflected the ability to perform or provide a particular professional activity, which is intellectual, affective, psychomotor, or all of these in nature. Supporting competencies needed to support the major competencies and specific course objectives delineating foundational knowledge, skills, and attitudes should be further developed by each program faculty, and these should reflect the overall mission and goals of the particular college and program(s). Demonstration of supporting competencies related to a specific service or task is needed in order to exhibit attainment of a major competency.

This document was not intended to be a stand-alone document and should be used in conjunction with other professional documents developed by the professional agencies that support the respective disciplines. This document was not intended to standardize educational programs in allied dental education but rather to allow for future program innovation, growth and expansion. This document was also not intended to serve as a validation for program content within allied dental education or for written or clinical licensing examinations.

It was recommended that program faculty adapt the document to meet the needs of their individual programs and institutions. Given the dynamic nature of science, technology, and the health professions, these competencies should be reviewed and updated periodically.

Domains

(1) Core Competencies (C) reflect the ethics, values, skills, and knowledge integral to all aspects of each of the allied dental professions. These core competencies are foundational to the specific roles of each allied dental professional.

(2) Health Promotion and Disease Prevention (HP) is a key component of health care. Changes within the health care environment require the allied dental
professional to have a general knowledge of wellness, health determinants, and characteristics of various patient communities.

(3) **Community (CM):** Allied dental professionals must appreciate their roles as health professionals at the local, state, and national levels. While the scope of these roles will vary depending on the discipline, the allied dental professional must be prepared to influence others to facilitate access to care and services.

(4) **Patient Care (PC):** The three primary allied dental professionals have different roles regarding patient care. These are reflected in the competencies presented for each discipline. The roles of the allied dental disciplines in patient care are ever changing, yet central to the maintenance of health. Allied dental graduates must use their skills following a defined process of care in the provision of patient care services and treatment modalities. Allied dental personnel must be appropriately educated in an accredited program and credentialed for the patient care services they provide, and these requirements vary by individual jurisdictions.

(5) **Professional Growth and Development (PGD) reflect opportunities that may increase patients’ access to the oral health care system or may offer ways to influence the profession and the changing health care environment. The allied dental professional must possess transferable skills (e.g., in communication, problem solving, and critical thinking) to take advantage of these opportunities.**

The final revised *Competencies for Entry into the Allied Dental Professions* document that was submitted to the 2010 ADEA House of Delegates (Resolution 1H-2010) included both the dental assisting and dental laboratory technology disciplines.

Following discussion on the floor of the House regarding resolution 1H-2010, the section pertaining to dental laboratory technology was returned to the ADEA Board of Directors for further consideration. The final House-approved document consisted of an introduction and competencies for the disciplines of dental assisting and dental hygiene, but not dental laboratory technology.

The ADEA Board of Directors asked that the concerns raised by the 2010 ADEA House of Delegates related to the dental laboratory technology competency statements be considered.

Resolution 6H-2011 reflects the changes made since the 2010 ADEA House of Delegates. The revised Dental Laboratory Technology Competencies document, which follows, is now presented to the 2011 ADEA House of Delegates.

The ADEA Board of Directors asks the House to approve the following resolution:

**6H-2011** Resolved, that the ADEA House of Delegates approves the revised "ADEA COMPETENCIES FOR ENTRY INTO THE PROFESSION OF DENTAL LABORATORY TECHNOLOGY"; Resolved, that it be included in ADEA Competencies for Entry into the Allied Dental Professions; and Resolved, that the glossaries published in the ADEA Competencies for Entry into the Profession of Dental Hygiene and ADEA Competencies for Entry into the Profession of Dental Assisting reflect the additional definition of "Dental Prosthesis."
**Competencies for Entry into the Profession of Dental Laboratory Technology**

Dental laboratory technicians provide laboratory services as prescribed by a dentist within a laboratory setting. These competencies assume this prescriptive authority of the dentist. Dental laboratory technicians may be certified but have no licensing requirements.

**Core Competencies (C)**

C.1 Apply a professional code of ethics in all endeavors.
C.2 Adhere to state and federal laws, recommendations, and regulations in the provision of prosthetic laboratory services.
C.3 Use critical thinking skills, comprehensive problem solving, and evidence based decision making to evaluate emerging technology that can be applied to achieve high-quality, cost-effective patient care.
C.4 Assume responsibility for professional actions and care based on accepted scientific theories, research and the accepted standard of care.
C.5 Continuously perform self-assessment for lifelong learning and professional growth.
C.6 Integrate accepted scientific theories and research into prosthetic laboratory services.
C.7 Promote the values of the dental laboratory technology profession through service-based activities, positive community affiliations, and active involvement in local organizations.
C.8 Apply quality assurance mechanisms to ensure continuous commitment to accepted standards of care.
C.9 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.
C.10 Provide accurate, consistent, and complete documentation for prosthetic laboratory services.
C.11 Manage medical emergencies by using professional judgment, providing life support, and utilizing required CPR and any specialized training or knowledge.

**Health Promotion and Disease Prevention (HP)**

HP.1 Respect the goals, values, beliefs, and preferences of patients and oral health professionals in the delivery of care.
HP.2 Promote factors that can be used to enhance patient adherence to disease prevention or health maintenance strategies.
HP.3 Utilize methods that ensure the health and safety of the patient and the oral health professional in the delivery of care.

**Community Involvement (CM)**

CM.1 Facilitate patient access to oral health services by influencing individuals or organizations for the provision of oral health care.
CM.2 Evaluate the outcomes of community based programs and plan for future activities.
CM.3 Advocate for effective oral health care for underserved populations.
**Patient Care (PC)**

**Assessment**

PC.1 Ensure that adequate information has been supplied by the dentist for the manufacture of custom made dental restorations and dental prostheses.

PC.2 Provide information on the advantages, limitations, and appropriateness of various designs of custom made dental restorations and dental prostheses relevant to proposed treatment plans.

**Planning**

PC.3 Demonstrate interpretation of the dentist’s prescription accurately.

PC.4 Facilitate in the design of custom made dental restorations and dental prostheses.

PC.5 Help guide selection of appropriate materials for manufacture of custom made dental restorations and dental prostheses.

PC.6 Demonstrate an understanding of the manufacturing requirements for dental restorations and dental prostheses.

**Implementation**

PC.7 Use effective infection control procedures.

PC.8 Manufacture dental restorations and dental prostheses in a broad range of areas to an acceptable level adhering to the standards of appropriate regulatory agencies.

PC.9 Recognize and institute procedures to minimize hazards related to the practice of dental laboratory technology.

**Evaluation**

PC.10 Ensure that the dental restoration or dental prosthesis follows the prescription and obtain dentist feedback on meeting clinical acceptance.

PC.11 Determine whether manufactured dental restorations and dental prostheses meet established industry standards.

PC.12 Recognize the importance of quality assurance systems and standards in the manufacturing processes.

PC.13 Demonstrate efficient handling, storage, and distribution of dental restorations and dental prostheses.

**Professional Growth and Development**

PGD.1 Pursue career opportunities within health care, industry, education, research and other roles as they evolve for the dental laboratory technician.

PGD.2 Develop practice management and marketing strategies related to the management of a dental laboratory.

PGD.3 Access professional and social networks to pursue professional goals.

**Glossary**

**Access.** Mechanism or means of approach into the health care environment or system.

**Assessment.** Systematic collection, analysis, and documentation of the oral and general health status and patient needs through a variety of methods, including radiographs, diagnostic tools, and instruments.

**Critical thinking.** The disciplined process of actively conceptualizing, analyzing, and applying information as a guide to action; ability to demonstrate clinical reasoning, diagnostic thinking, or clinical judgment.

**Community.** Group of two or more individuals with a variety of oral health needs including the physical, psychological, cognitive, economic, cultural, and educational and compromised or impaired people. The community also includes consumers and health professional groups, businesses, and government agencies.
Cultural sensitivity. A quality demonstrated by individuals who have systematically learned and tested awareness of the values and behavior of a specific community and have developed an ability to carry out professional activities consistent with that awareness.

Dental Assistant (DA). An allied dental health professional who assists the dentist in practice and may choose to specialize in any of the following areas of dentistry: chairside general dentistry, expanded functions dental assisting (restorative) in general or pediatric dentistry, orthodontics, oral surgery, periodontics, assisting in dental surgery at area hospitals, endodontics, public health dentistry, dental sales, dental insurance, dental research, business assisting, office management, or clinical supervision.

Dental Hygiene Care Plan. An organized presentation or list of interventions to promote health or prevent disease of the patient’s oral condition; plan is designed by the dental hygienist based on assessment data and consists of services that the dental hygienist is educated and licensed to provide.

Dental Hygiene Diagnosis. The dental hygiene diagnosis is a component of the overall dental diagnosis. It is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis utilizes critical decision making skills to reach conclusions about the patient’s dental hygiene needs based on all available assessment data.

Dental Hygiene Process of Care. There are five components to the dental hygiene process of care: assessment, dental hygiene diagnosis, planning, implementation, and evaluation. The purpose of the dental hygiene process of care is to provide a framework within which individualized needs of the patient can be met and to identify the causative or influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.

Dental Hygienist (DH). A preventive oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide educational, clinical, research, administrative, and therapeutic services supporting total health through the promotion of optimum oral health.

Dental Laboratory Technician (DLT). An allied dental professional who manufactures custom made dental restoration and dental prostheses according to the prescriptive authorization from licensed dentists using a variety of materials, equipment, and manufacturing techniques in the specialty areas of complete dentures, removable partial dentures, orthodontics, crown and bridge, and ceramics.

Dental Prosthesis. An artificial replacement (prosthesis) of one or more teeth (up to the entire dentition in either arch) and associated dental/alveolar structures. Dental prostheses usually are subcategorized as either fixed dental prostheses or removable dental prostheses; and includes maxillofacial prosthesis.

Evaluate. The process of reviewing and documenting the outcomes of treatment and interventions provided for patients.

Evidenced-based care. Provision of patient care based on the integration of best research evidence with clinical expertise and patient values.

Intervention. Oral health services rendered to patients as identified in the care plan. These services may be clinical, educational, or health promotion related.

Medico-legal. Pertains to both medicine and law; considerations, decisions, definitions, and policies provide the framework for many aspects of current practice in the health care field.

Occupational model. Suggests technical training for a trade or occupation.

Outcome. Result derived from a specific intervention or treatment.
Patient. Potential or actual recipients of health care, including oral health care, and including persons, families, groups, and communities of all ages, genders, socio-cultural, and economic states.

Patient-centered. Approaching services from the perspective that the patient is the main focus of attention, interest, and activity and the patient’s values, beliefs, and needs are of utmost importance in providing care.

Practice. To engage in patient care activities.

Professional model. Requires formal academic education and qualification for entry into a profession through prolonged education, licensure, or regulation, and adherence to an ethical code of practice.

Refer. Through assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner’s competence or area of expertise. It assumes that the patient understands and consents to the referral and that some form of evaluation will be accomplished through cooperation with professionals to whom the patient has been referred.

Reflective judgment. A construct that merges the mental capabilities of critical thinking and problem solving and represents a higher level clinical decision making skill.

Risk assessment. Qualitative and quantitative evaluation gathered from the assessment process to identify the risks to general and oral health. The data provides the clinician with the information to develop and design strategies for preventing or limiting disease and promoting health.

Risk factors. Attributes, aspects of behavior, or environmental exposures that increase the probability of the occurrence of disease.

Resources


Competencies for the General Dentist. ADEA, Commission on Change and Innovation, March 2008.

Competencies for Entry into the Profession of Dental Hygiene, ADEA, March 1999.

Competencies for the Baccalaureate Degree in Dental Hygiene Program. Old Dominion University, College of Health Sciences, School of Dental Hygiene, accessed 8-6-07, http://hs.odu.edu/dental/academics/bs/competencies.shtml.


Resolution 7H-2011
ADEA Council of Allied Dental Program Directors
Core Competencies for Graduate Dental Hygiene Education

Background
Graduate education in dental hygiene is imperative for developing a cadre of dental
hygiene professionals who will lead the profession and assume leadership roles in
healthcare and education, as well as developing scholars to participate in the generation
and dissemination of knowledge. Dental hygiene graduate education is based on a body
of knowledge that is specific to the roles of the dental hygienist. In addition, a master's
degree program must meet the diverse needs and interests of its students, as well as
prepare graduates capable of meeting the complex oral health needs of a diverse
population. Therefore, the master's degree program should consist of a multifaceted
education composed of theory and practical application that provides an expanded
education and the opportunity to develop additional skills in emphasis areas. In addition,
technology should be utilized to make graduate education accessible to students
regardless of geographic location.

Ultimately, the dental hygiene graduate program should prepare graduates to
assume roles in various employment environments and provide them with the tools to
initiate as well as to adapt to change. It is imperative these programs promote advanced
communication and interpersonal skills, critical and reflective thinking, evidence-based-
decision making, problem solving, technology and information literacy, interdisciplinary
and inter-professional collaboration, scholarly inquiry and application, ethical and
professional behavior, and the value of life-long learning.

The intent of this document is to further define the body of professional knowledge,
and to establish an educational foundation for all graduate level dental hygiene
programs. Competencies describe the knowledge, skills and attitudes expected of the
graduate, establish benchmarks for outcomes assessment, and guide the development
of relevant curriculum content. The defined core competencies for the master's degree
in dental hygiene are intended to support the educational quality of existing, developing,
and future graduate education programs.

There are several purposes for the creation and use of this document. One purpose
is to concisely establish the competencies that are expected of graduates. Educational
competencies serve to inform and guide faculty, students and other stakeholders to have
a common understanding of the knowledge, skills, abilities, and characteristics of
program graduates. Second, is to offer direction to graduate dental hygiene programs
with respect to curriculum development and enhancement and to establish a benchmark
of educational quality. Another purpose is to assist new professionals by defining what it
means to be a graduate of a master's degree program in dental hygiene, and offers
direction to those seeking a graduate degree in the profession.

Core competencies also provide direction to faculty for designing learning
experiences for students, while informing stakeholders to the expectations of the
graduate. The core competencies for the master's degree in dental hygiene assist in
defining the profession of dental hygiene. In addition, all masters level dental hygienists
should understand how oral health and the profession of dental hygiene align with a

1 Developed as a collaboration between ADEA and the American Dental Hygienists' Association
global perspective on overall health, regardless of the roles they assume after graduation, e.g., education, teaching, community health, administration or others,

Since 2008, both the American Dental Education Association (ADEA) and the American Dental Hygienists' Association (ADHA) have discussed the development of competencies through their respective structures – the ADEA Graduate Dental Hygiene Program Directors Special Interest Group and the ADHA Council on Education. Both organizations have missions that support the development of graduate competencies for the profession. ADEA’s mission is “to lead individuals and institutions of the dental education community to address contemporary issues influencing education, research, and the delivery of oral health care for the improvement of the health of the public.” For ADHA - “To improve the public’s total health, the mission of the American Dental Hygienists’ Association is to advance the art and science of dental hygiene by ensuring access to quality oral health care; increasing awareness of the cost-effective benefits of prevention; promoting the highest standards of dental hygiene education, licensure, practice and research; and representing and promoting the interests of dental hygienists.”

In early 2010, the ADEA and the ADHA agreed to collaborate in the development of competencies for graduate dental hygiene education programs. A working group comprised of three representatives from each association was appointed to develop draft core competencies for dental hygiene education. It was agreed that this endeavor is an excellent opportunity for ADEA and ADHA to work in partnership to support graduate dental hygiene education.

The Core Competencies for the Master’s Degree in Dental Hygiene recognizes the complex and diverse range of dental hygiene graduate programs. The development of these Core Competencies reflects current trends in the profession and the educational and health care system needs of the future. The intent of this document is to serve as a guide and provide a foundation for all graduate level dental hygiene programs irrespective of areas of emphasis, e.g., administration/management, advanced clinical practice, community health, oral health sciences, teaching/education, and/or research. Individual programs could modify the core as is appropriate to achieve individual program and institutional mission and goals. For example, if the primary goal of a graduate program is to produce dental hygiene faculty, some core domains would be emphasized more than others and additional competencies would be added to reflect education.

The organization of the document includes eight core domains, which are general categories of content, and competencies within each domain delineating more specific skills, knowledge and behaviors for the particular domain. Each of the content areas need not be a specific course within the curriculum. Threaded through multiple domains are themes related to critical thinking, life-long learning, communication, collaboration, advocacy, evidence-based decision making, and ethics. Graduate education provides the opportunity to enhance a professional’s analytical and communication skills with evidence to connect theory to practice. To this end, a culminating experience in the format of a scholarly project is strongly recommended.
To assist programs the following guidelines are suggested:

1. The dental hygiene graduate program should be offered within an institution of higher learning and build on a foundation of baccalaureate education.

2. The dental hygiene graduate program should consist of a coherent pattern of courses culminating in a scholarly project such as a thesis or equivalent experience.

3. The core curriculum should ensure a basic knowledge/skill framework necessary to support specialization in designated emphasis areas and provide for supervised experience to facilitate the attainment of core competencies.

4. Behaviors expected of graduates will consist of behaviors expected of all graduates of master level programs, as well as the behaviors for the chosen emphasis area.

5. Adequate advanced preparation at the master’s level must include education from the dental hygiene discipline as well as from other compatible disciplines (i.e., education, business, basic sciences, humanities, public health, advanced clinical procedures, health care management, etc.). An interdisciplinary approach is encouraged as much as feasible. However, the primary focus of graduate education in dental hygiene must be in the discipline of dental hygiene.

6. Outcome behaviors will, to varying degrees, reflect the various roles of the dental hygienist: administrator/manager, educator, researcher, clinician, advocate and health promoter. Additionally, these roles will be influenced by changes in societal and professional expectations, in the health care delivery system, and the oral health care needs of the public.

The ADEA Board of Directors asks the House to approve the following resolution:

7H-2011  Resolved, that the ADEA House of Delegates approves the “CORE COMPETENCIES FOR GRADUATE DENTAL HYGIENE EDUCATION.”

CORE COMPETENCIES

Diversity, Social & Cultural Sensitivity refers to the ability to engage and interact with individuals and groups across and within diverse communities and cultures in an effective and respectful manner.

1. Recognize the impact of health status and ability, age, gender, ethnicity, social, economic, and cultural factors on health and disease, health beliefs and attitudes, health literacy and the determinants of health.

2. Model cultural sensitivity in all professional endeavors.

3. Identify the needs of vulnerable populations and communities to prevent and control oral diseases and reduce health disparities.

4. Develop programs and strategies responsive to the diverse cultural and ethnic values and traditions of the communities served.

Health Care Policy, Interprofessional Collaboration & Advocacy refers to the understanding of policy and its development, the value of collegiality and interprofessional collaboration and advocacy related to the promotion of health, education and the profession of dental hygiene.

1. Examine legislative and regulatory processes that determine policy, health priorities and funding for healthcare and education programs.
2. Identify principles related to the organization and financing of various health care delivery systems.

3. Evaluate the impact of legislation, regulation and policy on oral and general health, education, policy issues, and trends at the national, state and local levels.

4. Participate in the public policy process to influence consumer groups, businesses, and governmental agencies to support education and oral health care initiatives.

5. Determine evidence and data needed to support the development of new workforce models including their impact on oral health and overall health from a policy perspective.

6. Examine methods of facilitating access and partnerships to enhance healthcare and education.

7. Establish and promote interprofessional collaborations with other professionals, interest groups and social service agencies to promote and restore health.

Health Informatics & Technology relates to the ability to recognize and utilize technology to advance research, healthcare, teaching and education.

1. Demonstrate the ability to access, evaluate, and interpret data from various information systems.

2. Identify existing and emerging technologies and their applications.

3. Determine the appropriate technology and software systems in the design, implementation and evaluation of community or educational programs.

4. Demonstrate knowledge of the legal, ethical and social issues related to emerging technology and communication/social networks.

5. Utilize information technology and health informatics in health care, educational, business and/or other employment settings.

6. Use information technology to promote and advocate for programs and policies.

7. Demonstrate effective written, oral and electronic communication skills.

Health Promotion & Disease Prevention refers to all aspects of health promotion, risk assessment and reduction, and education of individuals, families and communities in the promotion of optimal oral health and its relationship to general health.

1. Design programs to reduce risks and promote health that are appropriate to health status and ability, age, gender, ethnicity, social, economic, cultural factors, and available resources.

2. Use epidemiological, social and environmental data to evaluate the oral health status of individuals, families, groups, and communities.

3. Incorporate health promotion theories and translational research in developing teaching and oral health counseling strategies that preserve and promote health and healthy lifestyles.

4. Foster inter-professional collaborations to optimize health for individuals and/or communities.

5. Evaluate the impact of oral disease on overall health to determine patient or community risk and in the development of intervention and prevention strategies to optimize positive health outcomes.

Leadership refers to the ability to inspire individual, community and/or organizational excellence, create and communicate a shared vision and successfully manage change to attain an organization’s strategic ends and successful performance.
1. Examine the dynamic interactions of human and social systems and how they affect relationships among individuals, groups, organizations and communities.

2. Disseminate new knowledge and contribute to best practices in the profession.

3. Apply leadership skills, theories and principles in interactions with groups and organizations to enhance innovation and change.

4. Advocate for the advancement of the dental hygiene profession and oral health improvement through service activities and affiliations with professional associations.

5. Develop strategies to motivate others for collaborative problem solving, decision-making, and evaluation.

6. Demonstrate team building, negotiation and conflict management skills.

7. Demonstrate knowledge of coaching, mentoring and networking skills in interactions with individuals, groups, organizations, and/or communities.

**Professionalism** refers to the ability to demonstrate, through knowledge and behavior, a commitment to the highest standards of competence, ethics, integrity, responsibility, and accountability in all professional endeavors.

1. Apply self-assessment skills and lifelong learning to enhance professional development.

2. Demonstrate a commitment to standards of excellence in any role of the dental hygienist.

3. Employ a professional code of ethics in all endeavors.

4. Demonstrate responsibility and accountability for actions within the various roles of the dental hygienist according to defined standards, regulations and policies.

5. Recognize one’s obligation to take action to enhance the health, welfare and interest of a diverse society.

6. Promote high standards of personal and organizational integrity, honesty and respect for all people and communities.

**Program Development & Administration** relates to the assessment, planning implementation, and evaluation of programs and systems related to an area of emphasis such as teaching, education, community outreach, or other area.

1. Demonstrate a program development process to include assessment, planning, implementation, and evaluation to meet the goals of a developed program.

2. Develop collaborative partnerships to accomplish program goals.

3. Select program development models to meet specific program objectives.

4. Apply outcomes assessment and quality improvement models that apply to and evaluate programs.

5. Examine financing and resource management processes within organizational systems.

6. Formulate a comprehensive strategic plan for a department, organization, association or other entity.

7. Employ basic managerial, administrative, interpersonal and human relations skills in a team-based environment.

**Scholarly Inquiry and Research** relates to the ability to utilize scientific theory, research methodology and research findings, as well as critical and reflective thinking for clinical and/or organizational evidence-based decision making.

1. Apply the research process to an identified problem.
2. Demonstrate professional writing and presentation skills in the dissemination of research findings.

3. Conduct a comprehensive systematic literature search relevant to a specific topic and critically evaluate the evidence gathered.

4. Demonstrate skill in proposal development and writing.

5. Analyze and interpret quantitative and qualitative data from the research literature to guide problem solving and evidence-based decision making.

6. Synthesize information from evidence-based literature to apply to a community health, education, clinical practice, and/or research problem.

7. Design and implement a scholarly project in an area of emphasis.

References


Resources


ADEA Policy Statement on the Education of Oral Health Professionals in Emerging Workforce Models

Background
In 2003, the U.S. Surgeon General called upon stakeholders in his National Call to Action to Promote Oral Health to expand both the flexibility and capacity of the U.S. oral health workforce. Numerous national groups and organizations beyond the professional oral health community are now responding to this call, including the U.S. Congress, federal agencies, and independent national organizations such as the Institute of Medicine (IOM), the W.K. Kellogg Foundation, and the Children’s Dental Campaign of the Pew Charitable Trusts. States are making substantial workforce changes as well; already one state (Minnesota) has adopted a new workforce model for oral health professionals, and several other states are poised to take action in 2011.

The following list of activities indicates the swiftness with which new workforce models are gaining public attention and acceptance.

2002—The dental health aide therapy (DHAT) program was adopted in Alaska to address the oral health, geographic, and cultural needs of Alaskan Natives. The DHAT provides intermediate restorative procedures under the remote supervision of a dentist.

2004—The American Dental Hygienists Association approved the development of an advanced dental hygiene practitioner (ADHP), a masters-level degree program for experienced dental hygienists to become clinicians in public health settings and programs.

2006—The American Dental Association approved the creation of a community dental health coordinator (CDHC), a one-year, entry-level position (with a six-month internship) focusing on community outreach, prevention, and coordination of care that will help patients navigate the public dental system.

2008—The U.S. Congress, in reauthorizing the Children’s Health Insurance Program, called on the General Accountability Office to study and report on the “feasibility and appropriateness” of employing “qualified, mid-level dental health providers.”

2009—“The U.S. Oral Health Workforce in the Coming Decade: A Workshop” report by the IOM examined several new workforce models, including the CDHC, DHAT, Oral Health Practitioner (OHP), Registered Dental Hygienists in Alternative Practice (RDHAPs), and Pediatric Oral Health Educator.

2009—Governor Tim Pawlenty (R) signed legislation authorizing the certification of the advanced dental therapist (ADT) and dental therapist (DT) in Minnesota, who may perform intermediate restorative procedures including drilling.

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filling, and non-surgical extractions of permanent teeth in a collaborative
management agreement supervised by a dentist.

2009—The Pew Center on the States and the National Academy for State
Health Policy released Help Wanted: A Policy Maker’s Guide to New Dental
Providers, which described three types of new allied dental provider models (dental
therapists, community dental health coordinators, and advanced dental hygiene
practitioners) and provided steps for policy makers to consider as they develop
new models in their states.

2009—The Health Resources and Services Administration (HRSA) provided
$2.4 million to the National Academy of Sciences to conduct a study of oral
health care in the United States. According to HRSA, the study will guide federal
investments in service delivery models that expand access to oral health care
and improve quality.

2010—President Barack Obama signed the health care reform bill (P.L. 111-148),
which authorized $60 million for 15 demonstration projects to train or employ
“alternative dental health care providers” to increase access to dental services in
rural and underserved communities.

2010—A two-year study by researchers at RTI International reported that dental
therapists in Alaska are capable of providing safe and competent care and are
acceptable alternatives when a dentist is not available. (The study was sponsored by
the W.K. Kellogg Foundation.)

2010—The W.K. Kellogg Foundation funded a four-year, $16 million initiative
that will support the development of new workforce models (similar to the
dental therapist in Alaska) in five states: Kansas, New Mexico, Ohio, Vermont,
and Washington.

2010—The Pew Center on the States released a report examining the impact new
workforce models can have on profits of private practice dentists and found that
new types of dental care providers can improve dentists’ productivity and
financial bottom line.

2010—Finally, states are rapidly expanding the function and scope of practice for
dental hygienists and other allied dental professionals. This effort has led to the
adoption of laws in 45 states in which a dental hygienist in a dental office or
other setting may provide care without the constant presence of an on-site
dentist. In 15 states, Medicaid can reimburse hygienists.

In light of these developments and the subsequent national debate about new workforce
models, the ADEA Institute for Policy and Advocacy (ADEA IPA), consisting of ADEA’s
four policy advisory committees, convened in September 2009 to discuss ADEA’s role.
The ADEA IPA made a formal recommendation to the ADEA Board of Directors that
ADEA take a leadership role in the educational preparation of oral health professionals

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2 The ADEA Institute for Policy and Advocacy consists of the ADEA Women’s Affairs Advisory Committee (ADEA WAAC), the ADEA Minority Affairs Advisory Committee (ADEA MAAC), the ADEA Center for Educational Policy and Research Advisory Committee (ADEA CEPRAC), and the ADEA Legislative Advisory Committee (ADEA LAC).
in emerging workforce models. The ADEA Board of Directors met that same month and endorsed the ADEA IPA recommendations. In March 2010, the Board approved the formation of the ADEA Task Force on the Education of Oral Health Professionals in Emerging Workforce Models (see attached membership list) and charged it to "enunciate a set of principles to guide the educational preparation of oral health professionals in emerging workforce models."

The document, *ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models*, is the result of the work of that Task Force. The process for drafting the Principles included three face-to-face meetings and numerous revisions, phone exchanges, and emails among its members. Throughout the year, the Task Force also solicited and received extensive feedback from ADEA constituency groups. It used this feedback to refine the final set of Guiding Principles (see attached). ADEA’s ultimate goal in the entire process is to ensure high standards for the education, preparation, and competency of oral health professionals in emerging workforce models.

The ADEA Board of Directors asks the House to approve the following resolution:

8H-2011 Resolved, that the ADEA House of Delegates approves, accepts, and endorses the recommendations of the ADEA Task Force on the Education of Oral Health Professionals in Emerging Workforce Models as contained in the document entitled “ADEA GUIDING PRINCIPLES FOR THE EDUCATION OF ORAL HEALTH PROFESSIONALS IN EMERGING WORKFORCE MODELS” as official policy of the American Dental Education Association.

Attachments:

1. *ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models*
2. Membership of the ADEA Task Force on the Education of Oral Health Professionals in Emerging Workforce Models
3. Summary of the ADEA Member Online Survey Results

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3 Constituency groups in 2010 provided feedback to the Task Force through ADEA’s ARS (Automatic Response System) at the 2010 ADEA Allied Dental Education Summit; the 43rd Annual National ADEA Allied Dental Program Directors’ Conference; the ADEA Institute for Public Policy and Advocacy meeting; the ADEA Fall 2010 Meetings (which included members of ADEA AFASA; ADEA Council of Faculties; ADEA Council of Hospitals and Advanced Education Programs; ADEA Council of Sections; and ADEA Council of Students, Residents, and Fellows; as well as an ADEA meeting of academic deans); and the 52nd Annual ADEA Deans’ Conference.
ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models

Introduction
In September 2009, the Board of Directors of the American Dental Education Association (ADEA) approved the creation of the ADEA Task Force on the Education of Oral Health Professionals in Emerging Workforce Models. Its charge was to “enunciate a set of principles to guide the educational preparation of oral health professionals in emerging workforce models.” The core values and key assumptions that guided the Task Force’s work are articulated below, followed by the ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models.

Core Values
ADEA believes that with appropriate levels of education and supervision oral health professionals in emerging workforce models can provide quality care, contribute to increasing access to oral health services for all, and help to improve the oral health of the nation.

ADEA acknowledges the reality that most of the emerging workforce models are intended to increase access to oral health care for underserved populations. ADEA believes that expanding the capacity of the oral health workforce will increase access to oral health care for all and, consequently, have a positive impact on access to care for underserved populations.

ADEA believes that its role, in collaboration with its member institutions, is to anticipate and prepare for changes to the curriculum and the academic environment that emerging workforce models will require as states modify their practice acts to increase the capacity of the oral health workforce. The Association’s role is not to develop new workforce models, but to ensure the quality of the educational preparation of oral health professionals in these emerging models.

Notwithstanding the creation of emerging workforce models, ADEA believes that the extended use of existing allied dental professionals can contribute to expanding the capacity of the oral health workforce, thereby further increasing access to oral health care for all.

Key Assumptions

- Demographic shifts in society have major implications for the future composition of the oral health workforce. Professionals in the workforce of the future should possess values, attitudes, knowledge, and skills that enable them to competently meet changing societal needs.
- A single standard of quality should apply when the same service is provided by different members of the oral health team.
- The creation of new workforce models will require modification to the educational preparation of existing oral health team members to support the successful integration of emerging models.
- The Guiding Principles articulated for emerging workforce models have application to and implications for the education of all oral health professionals.
The document, *ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models*, aims to maintain high standards for the education, preparation, and competency of oral health professionals in emerging workforce models. As states modify their dental practice acts to expand the capacity of the oral health workforce, these principles can inform and influence the education of oral health professionals in emerging workforce models to ensure they possess the values, attitudes, knowledge, and skills needed to provide quality oral health care to all.

The American Dental Education Association encourages institutions, organizations, and policymakers that are designing oral health workforce models, and those who are developing educational programs to prepare these professionals, to incorporate these Guiding Principles into their planning and decision-making.

**Principle 1**

Educational programs for oral health professionals in emerging workforce models should be based on clearly defined goals and desired educational outcomes. These programs should be competency-based, providing learning experiences to ensure that students attain the values, attitudes, knowledge, skills, and experiences needed to provide quality care in a collaborative, interprofessional environment.

- Competency domains should be consistent across educational programs and should align with the *ADEA Competencies for Entry into the Allied Dental Professions*. Where the scope of practice for emerging workforce models extends beyond the allied dental competencies, competency domains should align with the *ADEA Competencies for the New General Dentist*. Competency domains for oral health professionals in emerging workforce models should include communication, culture and diversity, evidence-based patient care, health policy and advocacy, health promotion and disease prevention, professionalism and ethics, and systems thinking and financial management. Specific competencies within each domain should reflect the scope of practice of each professional position.

- The academic dental community should be involved in decisions regarding the length and rigor of educational programs. The academic dental community possesses the expertise and experience to ensure that graduates have sufficient time to achieve competencies and demonstrate the values, attitudes, knowledge, experience, and skills (including critical thinking, ethical decision-making, teamwork, communication, and cultural competency) needed to provide care at the level defined by their scope of practice.

- Curricula should include instruction in biomedical, clinical, behavioral, social, and economic sciences. Educational programs should expose students to experiences working with dental, allied dental, and other health professionals in integrated clinical settings to ensure that all members of the oral health team understand the roles and responsibilities of each member of the team.

**Principle 2**

Educational programs for oral health professionals in emerging workforce models should have appropriate processes to ensure program quality and assessment of graduates’ competencies.
National accreditation standards should be developed and implemented by an entity approved by the U.S. Department of Education to ensure ongoing quality and continuity across educational programs. National accreditation, or universally accepted certification or credentialing, is needed to ensure consistency and quality across educational programs.

The education, knowledge, skills, and experience needed to safely provide oral health services, as defined by scope of practice, should inform decisions about the appropriate level of supervision. These decisions should be made with input from the academic dental community.

Principle 3
Educational programs for oral health professionals in emerging workforce models should ensure that students attain the skills necessary to engage individuals from diverse populations in decisions about their oral health.

- Educational programs should emphasize the principles of population-based public health science as a means of engaging diverse populations and communities in the prevention and control of oral diseases and in reducing oral health disparities.
- Educational programs should ensure that graduates attain the values, attitudes, knowledge, and skills needed to provide care that is respectful of a patient’s culture, class, race, and ethnic and socioeconomic background.
- Educational programs should implement strategies to recruit, retain, and promote individuals from diverse backgrounds.

Principle 4
Educational programs for oral health professionals in emerging workforce models should be evaluated continuously to determine their success in meeting their defined goals and educational outcomes.

- Educational programs should ensure that graduates are educated in a timely, efficient, and equitable manner, and possess the values, attitudes, knowledge, and skills needed to provide safe, appropriate, patient-centered care.
- Educational programs should prepare graduates to meet a single standard of quality for the same service provided by different members of the oral health team.

Conclusion
The American Dental Education Association believes that with appropriate education and preparation, oral health professionals in emerging workforce models can provide quality care and make meaningful contributions to expanding the capacity of the oral health workforce, thereby increasing access to oral health care for all. ADEA encourages institutions, organizations, and policymakers that are designing oral health workforce models, and those who are developing educational programs to prepare these professionals, to incorporate these Guiding Principles into their planning and decision-making.
ADEA Task Force on the Education of Oral Health Professionals in Emerging Workforce Models

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Overview of ADEA Online Survey Results

Measuring ADEA Members’ Support for the ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models

The following are observations regarding the opinions of ADEA members who responded to this survey.

- There is 86% overall agreement with the ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models.

- There is very strong support with over 90% agreeing with Principles 1, 2, 3, and 4 of the ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models:
  - Principle 1 = 97% agree
  - Principle 2 = 97% agree
  - Principle 3 = 90% agree
  - Principle 4 = 92% agree

- 86% support the statement that educational preparation of oral health professionals is the appropriate focus for ADEA’s involvement in the emergence of new workforce models.

- 86% support the statement that institutions, organizations, policymakers that are designing oral health workforce models, and those who are developing educational programs to prepare these professionals, should be encouraged to incorporate the ADEA Guiding Principles into their planning and decision-making.

Regarding competency domains:

- 74% agree and 5% disagree that competency domains should be consistent across educational programs and should align with the ADEA Competencies for Entry into the Allied Dental Professions. Where the scope of practice for emerging workforce models extends beyond the allied dental competencies, competency domains should align with the ADEA Competencies for the New General Dentist.

- 88% agree and 5% disagree that competency domains for oral health professionals in emerging workforce models should include communication, culture and diversity, evidence based patient care, health policy and advocacy, health promotion and disease prevention, professionalism and ethics, and systems thinking and financial management. Specific competencies within each domain should reflect the scope of practice of each professional position.

- 88% agree that the education, knowledge, skills, and experience needed to safely provide oral health services, as defined by scope of practice, should inform decisions about the appropriate level of supervision for oral health professionals in emerging workforce models.
• 84% of respondents support the statement that decisions about the appropriate level of supervision for oral health professionals in emerging workforce models should be made with input from the academic dental community.

Regarding educational programs for new oral health professionals in emerging workforce models:

• 85% believe it is important that educational programs emphasize the principles of population-based, public health science as a means of engaging diverse populations and communities in the prevention and control of oral diseases and in reducing oral health disparities.

• 89% feel it is important that educational programs ensure that graduates attain the values, attitudes, knowledge, and skills needed to provide care that is respectful of a patient’s culture, class, race, ethnic, and socioeconomic background.

• 77% find it important that educational programs implement strategies to recruit, retain, and promote individuals from diverse backgrounds.

• 89% consider it important that educational programs prepare graduates to meet a single standard of quality for the same service provided by other members of the oral health team.

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ADEA Online Survey Questions and Responses

Please indicate whether you agree or disagree with the following statements from the ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models.

Principle 1

• Educational programs for oral health professionals in emerging workforce models should be based on clearly defined goals and desired educational outcomes. These programs should be competency-based, providing learning experiences to ensure that students attain the values, attitudes, knowledge, skills, and experiences needed to provide quality care in a collaborative, interprofessional environment.
  o 97% agree and less than 1% disagrees with Principle 1.

Principle 2

• Educational programs for oral health professionals in emerging workforce models should have appropriate processes to ensure program quality and assessment of graduates’ competencies.
  o 97% agree and less than 1% disagrees with Principle 2.

Principle 3

• Educational programs for oral health professionals in emerging workforce models should ensure that students attain the skills necessary to engage individuals from diverse populations in decisions about their oral health.
  o 90% agree and 2% disagree with Principle 3.
Principle 4

- Educational programs for oral health professionals in emerging workforce models should be evaluated continuously to determine their success in meeting their defined goals and educational outcomes.
  - 92% agree and 2% disagree with Principle 4.

Please indicate whether you agree or disagree with the statements below.

- Educational preparation of oral health professionals is the appropriate focus for ADEA's involvement in the emergence of new workforce models.
  - 86% agree and 3% disagree.

- Institutions, organizations, and policymakers that are designing oral health workforce models, and those who are developing educational programs to prepare these professionals, should be encouraged to incorporate the ADEA Guiding Principles into their planning and decision-making.
  - 86% agree and 2% disagree.

- Competency domains should be consistent across educational programs and should align with the ADEA Competencies for Entry into the Allied Dental Professions. Where the scope of practice for emerging workforce models extends beyond the allied dental competencies, competency domains should align with the ADEA Competencies for the New General Dentist.
  - 74% agree and 5% disagree.

- Competency domains for oral health professionals in emerging workforce models should include communication, culture and diversity, evidence based patient care, health policy and advocacy, health promotion and disease prevention, professionalism and ethics, and systems thinking and financial management. Specific competencies within each domain should reflect the scope of practice of each professional position.
  - 88% agree and 5% disagree.

- The education, knowledge, skills, and experience needed to safely provide oral health services, as defined by scope of practice, should inform decisions about the appropriate level of supervision for oral health professionals in emerging workforce models.
  - 88% agree and 2% disagree.

- Decisions about the appropriate level of supervision for oral health professionals in emerging workforce models should be made with input from the academic dental community.
  - 84% agree and 5% disagree.
How important is it that educational programs for oral health professionals in emerging workforce models:

- Emphasize the principles of population-based, public health science as a means of engaging diverse populations and communities in the prevention and control of oral diseases and in reducing oral health disparities.
  - 85% responded it is important and 3% responded it is not important.

- Ensure that graduates attain the values, attitudes, knowledge, and skills needed to provide care that is respectful of a patient’s culture, class, race, ethnic, and socioeconomic background.
  - 89% responded it is important and 3% responded it is not important.

- Implement strategies to recruit, retain, and promote individuals from diverse backgrounds.
  - 77% responded it is important and 5% responded it is not important.

- Prepare graduates to meet a single standard of quality for the same service provided by other members of the oral health team.
  - 89% responded it is important and 1% responded it is not important.

Overall, what is your level of agreement with the ADEA Guiding Principles for the Education of Oral Health Professionals?

- 86% agree and 2% disagree.
RESOLUTION 9H-2011
ADEA Council of Students, Residents, and Fellows
Policy for International Student Outreach

Background:
Participation in international outreach provides valuable learning opportunities for all participants; however, there is some potential for unethical and unprofessional behavior. Many students are now taking advantage of international opportunities where regulations governing the practice of health professions are less stringent and often less well defined than in the United States and Canada; additionally, existing local regulations may not be fully enforced. While international outreach can provide beneficial educational experiences for students and dental care for those in need, the potential for harm and abuse in these situations cannot be ignored. Predental, dental, and other students who have not been properly trained and /or supervised pose a serious threat to patients, themselves, and the ethical standards of dentistry. In June 2010, this issue was brought to the ADEA Board of Directors who subsequently voted to post the Guidelines for International Predental Experiences on the ADEA AADSAS website. The ADEA Council of Students, Residents, and Fellows (CoSRF) recognizes that participating in international outreach is a privilege but there is a need to properly address this growing concern.

Therefore, the ADEA Council of Students, Residents, and Fellows supports expanding ADEA Policy Statement IV. Access and Delivery of Care, to include an additional policy statement, as follows:

E. Student International Outreach.
Dental educators and ADEA should advocate for the following guidelines related to participation in international programs

1. **Awareness.** All participants in an international outreach program should be informed of and adhere to legal, ethical and professional standards of care.

2. **Procedures performed.** Predental, dental, and other students who participate in an international dental outreach program should perform procedures for which they have received an appropriate level of education and training, and thus minimize risk for patients and themselves.

3. **Irreversible procedures.** Predental and other students may only perform reversible procedures for which they have appropriate education, training and supervision (for example: fluoride application, oral hygiene instruction, and chairside assisting).

4. **Supervision.** Predental, dental, and other students who participate in an international dental outreach program should be supervised by an appropriate licensed dental health care provider.

5. **Promotion.** Dental institutions, students and organizations that promote international outreach activities should be informed of this policy through appropriate avenues.

The ADEA Board of Directors asks the House to approve the following resolution.

9H-2011 Resolved, that the ADEA House of Delegates approves the "INTERNATIONAL STUDENT OUTREACH" policy; and Resolved, that this policy be included as item E in ADEA Policy Statement IV. Access and Delivery of Care.
Background
ADEA’s current Policy Statement III. Licensure and Certification, needs to be strengthened and a definitive date needs to be set for the elimination of live patients. It is proposed that a new policy on the elimination of the use of patients in clinical examinations be added to ADEA Policy Statement III. Licensure and Certification.

The new policy would read:

**B. Live Patient Examination.** By the year 2015, the live patient exam for dental licensure should be eliminated and all states should offer methods of licensure in dentistry that includes advanced education of at least one year, portfolio assessment, and/or other non-live patient based methods. Independent third party assessment for licensure should be implemented.

The ADEA Board of Directors asks the House to approve the following resolution.

**10H-2011 Resolved, that the ADEA House of Delegates approves the "ELIMINATION OF LIVE PATIENT EXAM BY 2015" policy; Resolved, that this policy be added as item B to the ADEA Policy Statement III. Licensure and Certification; and Resolved, that items B through D in the current ADEA Policy Statement III. Licensure and Certification be re-lettered C through E.**
Resolution 11H-2011
ADEA Council of Sections
Foundation Knowledge and Skills for the New General Dentist

Background
Under the direction of the ADEA Board of Directors, the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI) and a special ADEA Council of Sections Task Force created a new document upon which dental school curriculum committees might build a curriculum that best meets the mission of each institution. The document is directly linked to “ADEA’s Competencies for the New General Dentist,” which was last approved by the ADEA House of Delegates in 2008. Each of the 39 competencies from the “ADEA Competencies for the New General Dentist” is listed, and the supporting foundation knowledge/skills are cited below each competency.

The ADEA Council of Sections Task Force developed this document over a two-year period. The Task Force solicited comments from the Administrative Boards of each ADEA Section and SIG. The process and the development was discussed at open member forums and a meeting was held in January 2010 in Chicago to synthesize all of the comments and input from the wide variety of audiences that contributed to the building of the Foundation Knowledge and Skills document. After drafts were completed, the document was returned to ADEA Sections and SIGS as well as the ADEA Council of Faculties Administrative Board.

The ADEA Board of Directors, the ADEA CCI, and the ADEA Council of Sections Task Force recognize that each dental school has its own curriculum and competency statements. The purpose of this document is to provide a scaffold upon which dental school curriculum committees may build a curriculum that best meets the specific mission of each institution. As such, it is deliberately non-prescriptive, providing broad headings under which each institution may construct content-specific instruction for the present while allowing that content to evolve with the discovery of new knowledge and technology. Just as the competencies are complex behaviors and skills encompassing knowledge, experience, critical thinking and problem-solving skills, professionalism, ethical values, and technical and procedural skills, the foundation knowledge and skills that support such competencies are equally complex. It integrates specific content from multiple biomedical, clinical, and behavioral science sources into a flexible framework upon which each lifelong learner assembles an ever-evolving body of information through experience, outcomes assessment, and critical contemplation.

In competency-based dental education, what students learn is founded upon clearly articulated competencies with the assumption that all behaviors/abilities are supported by foundation knowledge and psychomotor skills in biomedical, behavioral, ethical, clinical dental science and informatics areas that are essential for independent and unsupervised performance as an entry-level general dentist. Foundation knowledge comprises the basic, essential information that supports the attainment of one or more competencies and is intended to help guide curriculum development in dental schools, assist educators in removing irrelevant or archaic material from current curricula, aid in incorporating important new knowledge to curricula, and help test construction committees develop examinations based upon generally-accepted, contemporary information. Foundation knowledge for the practice of dentistry is broad-based, integrating information from multiple biomedical science and clinical discipline sources,
is concept-oriented, and clinically-focused toward the desired patient care and outcome and other supporting competencies requisite for the new general dentist.

It is the expectation of the authors of this document of supporting foundation knowledge and skills that these competencies and foundations will long stand as useful guides for organizing, teaching, and reevaluating the curriculum content of our rapidly changing profession. The authors have attempted to create competency goals and foundation knowledge and skill underpinnings that will support dental education content as it grows and changes in ways that we, the dental educators of today, cannot fully conceive or predict.

The ADEA Board of Directors asks the House to approve the following resolution:

11H-2011 Resolved, that the ADEA House of Delegates approves “FOUNDATION KNOWLEDGE AND SKILLS FOR THE NEW GENERAL DENTIST.”

Foundation Knowledge and Skills for the New General Dentist

Critical Thinking

Competency Number

1.1 Evaluate and integrate emerging trends in healthcare as appropriate.

- Trends in healthcare
- Healthcare policy
- Economic principles of healthcare delivery
- Healthcare organization and delivery models
- Quality assessment and quality assurance
- Demographics of the oral healthcare workforce
- Interprofessional healthcare relationships
- Relationship of systemic health to oral health and disease
- Impact of political and social climate on healthcare delivery
- Critical evaluation of healthcare literature

Competency Number

1.2 Utilize critical thinking and problem-solving skills.

- Application of scientific method to clinical problem-solving
- Evidence-based delivery of oral healthcare
- Clinical reasoning skills
- Diagnostic skills
- Treatment planning
- Self-assessment
- Reading comprehension
- Verbal and written communication skills
- Computer literacy

Competency Number

1.3 Evaluate and integrate best research outcomes with clinical expertise and patient values for evidence-based practice.

- Application of scientific method to clinical problem-solving
- Evidence-based delivery of oral healthcare
• Critical thinking and problem-solving skills
• Cultural competence
• Communication skills, verbal and written
• Reading comprehension
• Ethics
• Statistics literacy
• Computer literacy
• Epidemiological methods

Professionalism

Competency Number

2.1 Apply ethical and legal standards in the provision of dental care.
• Ethical decision-making and conflicting obligations
• Legal and regulatory principles and standards

Competency Number

2.2 Practice within one's scope of competence and consult with or refer to professional colleagues when indicated.
• Self-assessment of competence
• Standards of care
• Communication skills, both orally and in writing, with patients, patients’ families, colleagues, and others with whom other health care providers must exchange information in carrying out their responsibilities
• Scope of practice of dental and medical specialties and social support services
• Identification of community resources for referrals

Communication and Interpersonal Skills

Competency Number

3.1 Apply appropriate interpersonal and communication skills.
• Communication theory and skills
  o Interpersonal (one-on-one) communication principles
  o Verbal and nonverbal communication principles
  o Conflict resolution
  o Reflective listening
• Collaborative team work
• Emotional, and behavioral development and sensitivity
• Physiological and psychological indications of anxiety and fear
• Addressing patient concerns/issues/problems
• Behavior modification and motivation techniques
• Special needs/diversity of patients
• Health literacy
• Language barriers
• Cognitive barriers

Competency Number

3.2 Apply psychosocial and behavioral principles in patient-centered health care.
• Counseling skills and motivational interviewing principles
• Social and behavioral applied sciences
• Behavior modification
• Fear and anxiety management
• Pain management (acute and chronic pain)
• Geriatrics
• Special patient needs
• Cultural competence

Competency Number
3.3 Communicate effectively with individuals from diverse populations.
• Influence of culture on health and illness behaviors
• Culture related to oral health
• Complementary and alternative therapies
• Communication with patients in a culturally sensitive manner
• Communication in overcoming language barriers
• Communication with special needs patients
• Communication skills to address diversity-related conflict

Health Promotion
Competency Number
4.1 Provide prevention, intervention, and educational strategies.
• Patient and family communication
• Education of patient and/or family
• Risk assessment
• Prevention strategies (intervention, motivation, nutrition)
• Clinical evaluation

Competency Number
4.2 Participate with dental team members and other health care professionals in the management and health promotion for all patients.
• Various practice settings (community settings)
• Organizational behavior of team
• Professional communication
• Collaborative and leadership skills
• Interprofessional education

Competency Number
4.3 Recognize and appreciate the need to contribute to the improvement of oral health beyond those served in traditional practice settings.
• Cultural competence
• Alternative oral health delivery systems
• Barriers to improving oral health
• Global health
• Population trends
• National and international health goals

Practice Management and Informatics
Competency Number
5.1 Evaluate and apply contemporary and emerging information including clinical and practice management technology resources.
197  • Data analysis for disease trends
198  • Basic understanding of computer software
199  • Basic computer utilization skills
200  • Evidence-based literature on practice management
201  • Models of dental practice and types of delivery systems
202  • Application of contemporary electronic information systems
203  • Computer systems for practice management

Competency Number
5.2 Evaluate and manage current models of oral health care management and delivery.
   • Business models of dental practice
   • Effects of governmental health policy decisions
   • Workforce models
   • Auxiliary utilization principles
   • Application of contemporary clinical information systems

Competency Number
5.3 Apply principles of risk management including informed consent and appropriate record keeping in patient care.
   • Principles of record keeping/documentation
   • Concepts of professional liability
   • Risk management protocols
   • Legal responsibilities in patient care management
   • Legal responsibilities in personnel management
   • Management of patient information
   • Quality assurance

Competency Number
5.4 Demonstrate effective business, financial management, and human resource skills.
   • Effective functioning of the oral health care team
   • Principles of business management
   • Employment laws and regulations
   • Reimbursement systems
   • Basic communication skills
   • Leadership and motivation skills
   • Organizational behavior

Competency Number
5.5 Apply quality assurance, assessment and improvement concepts.
   • Self assessment for quality improvement
   • Concepts and principles of quality assurance and quality assessment
   • Awareness of continuous professional development (life-long learning)

Competency Number
5.6 Comply with local, state, and federal regulations including OSHA and HIPAA.
   • Elements of applicable local, state, and federal regulations
• Methods of effective application and pursuance of local, state, and federal regulations

Competency Number

5.7 Develop a catastrophe preparedness plan for the dental practice.

• Emergency response planning
• Emergency evacuation planning
• Preparedness measures and emergency response skills

Patient Care

A. Assessment, Diagnosis, and Treatment Planning

Competency Number

6.1 Manage the oral health care of the infant, child, adolescent, and adult, as well as the unique needs of women, geriatric and special needs patients.

• Human development (structure and function)
• Pathophysiology of oral and systemic disease
• Patient and social/family assessment
• Communication
• History taking
• Exam techniques
• Diagnostic tests and evaluation
• Diagnosis
• Risk assessment
• Treatment Planning
• Implementation
• Outcomes assessment

Competency Number

6.2 Prevent, identify, and manage trauma, oral diseases and other disorders.

• Epidemiology of trauma, oral diseases, and other disorders
• Patient motivation/education for prevention
• Prevention principles and therapies
• Patient assessment and treatment planning
• Risk analysis
• Lab findings
• Systemic conditions
• Diagnostic skills
• Pharmacology and patient medications
• Clinical evaluation
• Applied biomedical sciences related to trauma, oral diseases, and other disorders

Competency Number

6.3 Select, obtain and interpret patient/medical data, including a thorough intra/extra oral examination, and use these findings to accurately assess and manage all patients.

• History acquisition and interpretation
• Pharmacotherapeutics
• Clinical Evaluation
• Medical and dental referrals
• Diagnostic test interpretation
• Risk assessment
• Assessment and management of patient behaviors
• Assessment and management of patient social context

Competency Number

6.4 Select, obtain and interpret diagnostic images for the individual patient.
• Diagnostic imaging modalities
• Interpret forms of imaging used in dental practice
• Differential diagnosis
• Imaging safety protocols
• Imaging technologies and techniques

Competency Number

6.5 Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.
• Systemic manifestations of oral disease
• Systemic medical conditions that affect oral health and treatment
• Oral conditions that affect systemic health

Competency Number

6.6 Formulate a comprehensive diagnosis, treatment and/or referral plan for the management of patients.
• Clinical evaluation
• Diagnostic skills and techniques
• Risk assessment and analysis
• Patient assessment
• Sequencing of treatment
• Critical thinking and analysis
• Evidence based healthcare
• Treatment presentation, communication and considerations
• Treatment alternatives and financial considerations
• Self-assessment of clinical competence and limitations
• Referrals
• Case management

B. Establishment and Maintenance of Oral Health

Competency 6.1 Serves as an “Umbrella” Competency for all Competencies (6.7 - 6.21)
Under Establishment and Maintenance of Oral Health Care

Competency Number

6.7 Utilize universal infection control guidelines for all clinical procedures.
• State/ federal regulatory guidelines
• Universal infection control protocols
• Applied biomedical sciences related to transmission of disease
Competency Number

6.8 Prevent, diagnose and manage pain and anxiety in the dental patient.
- Psychological and social manifestations of pain
- Pathophysiology of pain
- Pharmacotherapeutic management of pain and anxiety
- Behavioral management of pain and anxiety

Competency Number

6.9 Prevent, diagnose and manage temporomandibular disorders.
- Epidemiology of temporomandibular disorders.
- Physical, psychological, and social factors
- Multidisciplinary approaches
- Outcomes assessment
- Applied biomedical sciences related to temporomandibular health and disorders

Competency Number

6.10 Prevent, diagnose and manage periodontal diseases.
- Epidemiology of periodontal disease
- Pharmacologic management
- Behavioral modification
- Nonsurgical management
- Surgical management
- Applied biomedical sciences related to the periodontium and periodontal diseases

Competency Number

6.11 Develop and implement strategies for the clinical assessment and management of caries.
- Caries risk factors and assessment
- Pharmacotherapeutic management
- Mechanical management
- Behavioral modification
- Applied biomedical sciences related to dental hard tissues, disease transmission, and caries

Competency Number

6.12 Manage restorative procedures that preserve tooth structure, replace missing or defective tooth structure, maintain functions that are esthetic and promote soft and hard tissue health.
- Biomechanical concepts.
- Principles of biomaterial sciences
- Behavioral modification
- Applied biomedical sciences related to soft and hard tissues

Competency Number

6.13 Diagnose and manage developmental or acquired occlusal abnormalities.
- Principles of biomaterial sciences
- Multidisciplinary approaches
• Behavioral modification
• Applied biomedical sciences related to health and pathology of dental hard tissues

**Competency Number**

**6.14** Manage the replacement of teeth for the partially or completely edentulous patient.

• Principles of biomaterial sciences
• Multidisciplinary approaches
• Behavioral modification
• Principles of biomechanics
• Applied biomedical sciences related to oral tissues

**Competency Number**

**6.15** Diagnose, identify and manage pulpal and periradicular diseases.

• Epidemiology of pulpal and periradicular disease
• Principles of endodontic therapy
• Applied biomedical sciences related to the pulpal and periradicular tissues and associated diseases

**Competency Number**

**6.16** Diagnose and manage oral surgical treatment needs.

• Multidisciplinary approaches
• Behavioral modification
• Principles of biomaterials
• Applied biomedical sciences related to oral surgery

**Competency Number**

**6.17** Prevent, recognize and manage medical and dental emergencies.

• Emergency protocols
• Pharmacotherapeutics
• Multidisciplinary approaches
• Non-pharmacologic approaches
• Applied biomedical sciences related to emergency care

**Competency Number**

**6.18** Recognize and manage patient abuse and/or neglect.

• Signs and symptoms of abuse and/or neglect
• Cultural awareness
• Behavioral modification
• Multidisciplinary approaches
• Ethical/legal principles and responsibilities

**Competency Number**

**6.19** Recognize and manage substance abuse.

• Signs and symptoms of substance abuse
• Cultural awareness
• Behavioral modification
• Multidisciplinary approaches
• Ethical/legal principles and responsibilities
• Applied biomedical sciences related to substance abuse

Competency Number

6.20 Evaluate outcomes of comprehensive dental care.
• Criteria for evaluation
• Evaluation methods
• Mechanisms for continuous quality improvement

Competency Number

6.21 Diagnose, identify and manage oral soft tissue and osseous diseases.
• Epidemiology of oral soft tissue and osseous diseases
• Multidisciplinary approaches
• Pharmacotherapeutic management
• Nonsurgical management
• Surgical management
• Applied biomedical sciences related to the health and pathology of oral soft tissue and osseous tissues
Resolution 12H–2011
ADEA Council of Hospitals and Advanced Education Programs
Membership Bylaws Amendment

Background
The ADEA Council of Hospitals and Advanced Education Programs has evolved since its original incarnation as the AADS Council of Hospitals. The current constituency of the Council is almost entirely those involved in the direction of advanced dental education programs. The ADEA Council of Hospitals and Advanced Education Programs (ADEA COHAEP) would like to extend membership to all advanced education faculty, residents, and fellows enrolled in advanced education programs. Further, ADEA COHAEP would also like to eliminate the restriction related to representation from non-recognized specialties as it is no longer necessary. To that end, ADEA COHAEP proposes an amendment to the ADEA Bylaws Chapter VIII, Section B, Number 4, paragraph 1.

While these proposed changes may increase the number of individual members in ADEA COHAEP, voting rights, the number of delegates, and the makeup of the ADEA COHAEP Administrative Board would not change.

The ADEA COHAEP proposed a membership bylaws amendment at the 2010 ADEA House of Delegates, but withdrew it on the floor during the Closing of the House, asking that it be returned to the ADEA Board of Directors for further consideration. Resolution 12H-2011 reflects the changes made since the 2010 ADEA House of Delegates.

Proposed Amendment:
The ADEA Council of Hospitals and Advanced Education Programs supports amending ADEA Bylaws Chapter VIII, Section B, Number 4, paragraph 1, which currently reads:

The Council of Hospitals and Advanced Education Programs consists of the chief of hospital dental service and directors of each accredited residency program in active or provisional member institutions (including hospitals under the same governance as a dental school) and in hospitals that are affiliate members, in addition to any members of the council Administrative Board who are no longer in the above categories and one representative of all non-recognized specialty programs at each institution described above. Each ADEA-member federal dental service may appoint a nonvoting representative to attend meetings of the Council of Hospitals and Advanced Education Programs.

To read:

Membership in the ADEA Council of Hospitals and Advanced Education Programs includes the program director, faculty, residents, and fellows in Commission on Dental Accreditation (CODA) accredited advanced dental education programs located in ADEA-member institutions, and any former member of the Council’s Administrative Board. Eligibility for election to the Council’s Administrative Board is limited to Program Directors of Commission on Dental Accreditation (CODA) accredited advanced dental education programs located in ADEA-member institutions.
The ADEA Board of Directors asks the House to approve the following resolution:

12H-2011 Resolved, that the ADEA House of Delegates approves the amendment to the ADEA Bylaws, Chapter VIII, Section B, Number 4, paragraph 1 so it reads as follows:

Membership in the ADEA Council of Hospitals and Advanced Education Programs includes the program director, faculty, residents, and fellows in Commission on Dental Accreditation (CODA) accredited advanced dental education programs located in ADEA-member institutions, and any former member of the Council’s Administrative Board. Eligibility for election to the Council’s Administrative Board is limited to Program Directors of Commission on Dental Accreditation (CODA) accredited advanced dental education programs located in ADEA-member institutions.
The ADEA Bylaws provide that a developing dental school planning to grant a D.D.S. or D.M.D. degree as part of an accredited college or university in the United States, Puerto Rico, or Canada is eligible to apply for Provisional Membership. Applications for Active and Provisional Membership are to be presented in writing at least 60 days before an Annual Session. An institution is elected to membership by a majority affirmative vote of the House of Delegates. Membership becomes effective on July 1 following House approval.

The Lake Erie College of Osteopathic Medicine (LECOM) School of Dental Medicine has made a timely application for ADEA Provisional Membership in writing and does meet the criteria for Provisional Membership. Its first dental school class is expected to begin in the fall of 2012.

The ADEA Board of Directors asks the House to approve the following resolution:

Resolved, that the ADEA House of Delegates accepts the Lake Erie College of Osteopathic Medicine (LECOM) School of Dental Medicine’s Application for Provisional Membership in ADEA.
The ADEA Bylaws provide that a developing dental school planning to grant a D.D.S. or D.M.D. degree as part of an accredited college or university in the United States, Puerto Rico, or Canada is eligible to apply for Provisional Membership. Applications for Active and Provisional Membership are to be presented in writing at least 60 days before an Annual Session. An institution is elected to membership by a majority affirmative vote of the House of Delegates. Membership becomes effective on July 1 following House approval.

The University of New England College of Dental Medicine has made a timely application for ADEA Provisional Membership in writing and does meet the criteria for Provisional Membership. Its first dental school class is expected to begin in the fall of 2012.

The ADEA Board of Directors asks the House to approve the following resolution:

14H-2011 Resolved, that the ADEA House of Delegates accepts the University of New England College of Dental Medicine’s Application for Provisional Membership in ADEA.
Resolution 15H-2011  
Approval of the Fiscal Year 2012 Budget

In addition to the following overview, delegates should refer to Exhibits 1-2011 and 2-2011 below. Exhibit 1-2011 shows revenue for fiscal years 2008 through 2011 and Exhibit 2-2011 shows expenses for the same years. The ADEA fiscal year runs from July 1 through June 30.

The ADEA Board of Directors asks the House to approve the following resolution:

15H-2011 Resolved, that the ADEA House of Delegates approves the ADEA Fiscal Year 2012 (July 1, 2011 through June 30, 2012) operating budget.
Overview of the American Dental Education Association
Proposed Fiscal Year 2012 Budget

Prepared for the ADEA Finance Committee and Board of Directors, January 11, 2011

The proposed FY 2012 (July 1, 2011 - June 30, 2012) Association budget was developed over the last four months through a collaborative process involving staff, the Association’s outside accountants, the ADEA Finance Committee, and the ADEA Board of Directors. Based on these discussions among staff, accountants, and leadership, the proposed FY 2012 budget reflects the current level of programming and services with a focus on ADEA’s 2011-2014 Strategic Directions as well as overall cost efficiencies. The contribution to reserves is estimated at $400,000, as scheduled by the ADEA Board of Directors in September 2002. As much as possible, budget projections are based on historical information from FY 2010 and FY 2011 (note that less than half of FY 2011 was complete when the proposed FY 2012 budget was prepared).

Documents Attached
The spreadsheet accompanying this memo includes the following comparative data:
- Actual revenue and expense for fiscal years 2008, 2009, and 2010
- The ADEA House of Delegates-approved budget for fiscal year 2011
- The staff-proposed budget for fiscal year 2012

Revenue
The proposed total budgeted revenue for the Association in FY 2012 is $19,014,633. This figure represents a 9% increase from the FY 2011 budget and a 3% increase from actual FY 2010 revenue. The growth is primarily driven by an increase in projected application fee revenue and positive investment returns expected in FY 2012.

Membership Dues
Modest changes in total dollars by category are driven by changes in number of members based on staff estimates. There is no proposed change to the Association’s membership dues.

Active
Based on 61 U.S. dental schools and 1 provisional dental school.

Affiliate
Budgeted affiliate dues are based on the current affiliate institutional membership and the continuing recruitment campaign. The proposed budget is based on 155 allied members at $945, 37 advanced members at $984, 5 non-hospital members at $3,998, and 5 federal members at $3,922. Also included in this budget are 10 Canadian Schools at $1,850 each. Canadian Dental Schools are reported under this category by ADEA’s membership system.

Corporate
The proposed total budgeted dues revenue in this category is based on 65 corporate members at $3,400.
Individual

Proposed total budgeted dues revenue in this category is based on the current individual member count of 305 individual members at $125, as well as retiree and ADEA Leadership Institute Alumni Association dues.

Student

A modest amount of student dues is budgeted for members not affiliated with an ADEA member institution who therefore pay for their memberships. Proposed total budgeted dues revenue in this category is based on 90 student members at $40.

Publications Revenue

The proposed total budgeted publications revenue for FY 2012 is higher than the FY 2011 budget revenue in this category by 17% or $111,000. The change is based on FY 2010 actual figures which reflect advertising revenue in all media.

Journal of Dental Education and Bulletin of Dental Education Subscriptions Sales

The proposed JDE/BDE subscription sales budget is based on maintaining revenue consistent with FY 2010 actual revenue.

ADEA Official Guide to Dental Schools

Publication sales of $80,000 are based on actual FY 2010 revenue.

ADEA Directory of Institutional Members

Publication sales of $2,400 are based on actual FY 2010 revenue.

JDE Advertising

The proposed budget of $162,600 for FY 2012 represents 90% of FY 2010 actual results, based on current trends that favor advertising in other media over print advertising.

BDE Advertising

The proposed FY 2012 budget is $45,700, based on recent actual revenue and experience in FY 2010.

Other Publications/Reprints

Other publications such as ADEA’s ExploreHealthCareers website, JDE reprints, pay per view, and continuing education, webinars and sales of ADEA branded items are budgeted at $264,900 for FY 2012.

Application Fees

ADEA AADSAS and CAAPID

Projected revenue for ADEA AADSAS and CAAPID is $9,941,250.

Revenue for AADSAS projected at $9,476,500 is based on 11,100 applicants, including the Fee Reduction Program budget. Revenue is increased 6% from the FY 2011 budget.

The proposed budget includes an increase in the initial designation fee from $228 to $235 and an increase in the additional designation fee from $73 to $75. This increase supports the transformation of the application service from a paper-based system to a web-based multidirectional portal that is comprehensive, user-friendly and provides the
efficient delivery of applicant data to ADEA’s end users (applicants, admissions officers, and health professions advisors). A Fee Reduction Program budget of $125,000 considers the needs of applicants with extreme financial constraints.

Projected revenue for ADEA CAAPID of $464,750. This figure is based on a projected 1,100 applicants selecting an average of 3.5 designations. Applicant fees for ADEA CAAPID are identical to those of ADEA AADSAS.

ADEA PASS

Projected revenue for ADEA PASS is $3,104,400 based on 3,900 applicants. The initial designation fee increases from $180 to $185 for the initial designation and from $60 to $65 for each additional designation. This secondary-fee increase is necessary to meet the current operational costs of the application service. The continued growth in ADEA PASS revenue is attributable to the increasing number of applicants and programs participating as a result of marketing initiatives.

ADEA PASS also serves as the registration site for the Dental Match. ADEA PASS collects Dental Match fees, reserves $7 per registration to cover credit card and operational costs, and passes the remaining $73 per registrant to the National Matching Service. ADEA’s net PASS-Match revenue is projected to be $21,000 based on an estimated 3,000 Match registrants at $80 per registrant.

ACLIENT User Fee

Income of $166,000 has been budgeted for FY 2012 which is an increase of 53% compared to the FY 2011 budget. FY 2012 is based on actual levels in FY 2010 of 46 participating schools.

Grants & Contributions

Foundation Support

Budgeted support of $427,500 is based on anticipated continued support from the Robert Wood Johnson Foundation (RWJF) for the American Association of Medical Colleges/ADEA Summer Medical and Dental Education Program, and a grant from the RWJF Dental Pipeline II National Program Office for Admission Committee Workshops.

Fellowships and Scholarships

This category is budgeted at $168,250 based on ADEA’s portfolio of annual fellowships and scholarships.

Meetings Registration Income

ADEA Annual Session & Exhibition Fees

Registration and exhibitor fees for the 2012 ADEA Annual Session & Exhibition in Orlando, Florida are budgeted at $777,254 based on a conservative estimate of the exhibit hall space.

Association meetings have been budgeted for FY 2012 based on the ADEA Board of Directors’ goal of financial neutrality while taking into account specific subsidies as approved by the Board of Directors. The FY 2012 subsidy for Association meetings is less than $500,000.
ADEA Deans' Conference Fees

Proposed budgeted revenues include a Deans' Conference Assessment of $750 that is paid by all U.S. and Canadian dental schools.

Sponsor Fees

Budgeted at $679,800, this figure includes sponsorship of the 2012 ADEA Annual Session & Exhibition in the amount of $77,800 and other conferences and programs in the amount of $602,000. These figures are based on prior year actual figures, commitments already made for FY 2011 and the current economic climate. ADEA will continue to seek additional sponsorships for FY 2012 meetings.

Other Conferences

ADEA will hold a number of meetings at the ADEA Fall 2011 Meetings in October 2011. The ADEA Fall Meetings concept came from a recommendation of the ADEA Board of Directors to promote more interaction among member groups, sections and committees outside of the ADEA Annual Session & Exhibition. The 2011 set of meetings will include at least the following components and other groups as determined:

- ADEA Council of Faculties Interim Meeting
- ADEA Council of Students, Residents and Fellows Interim Meeting
- ADEA Council of Sections Interim Meeting
- ADEA Meeting of Academic Deans
- ADEA Advanced Education Summit
- ADEA AFASA Meeting

The total meeting registration revenue for the ADEA Fall 2011 Meetings, excluding the ADEA Deans' Conference, is budgeted at $329,765.

Investment and Other Income

Investment Income has been conservatively projected at $493,000 in FY 2012 based on the 12 month trailing and long term (since 1926) annualized return of a basic 60%/40% asset allocation portfolio.

Expenses

Total expenses recommended in the proposed FY 2012 budget are $19,014,633. This figure represents a 9% increase from the FY 2011 expense budget and a 16% increase from actual expenses for FY 2010 not including the proposed reserve contribution expenses of $400,000 in FY 2012 and FY 2011.

Personnel Costs and Fees

Total Personnel Costs and Fees are projected at $8,986,208 in the proposed FY 2012 budget. This figure is a 9% increase from the FY 2011 budget and an 18% increase from FY 2010 actual personnel costs.

Full-time Salaries

A 4.5% pool is budgeted for salary adjustments in FY 2012. The salary adjustment pool was set at this rate since the FY 2012 budget does not include any new FTE’s, and to accommodate potential changes created by ADEA’s 2011-2014 Strategic Directions.
Temporary Salaries

Expenses for temporary staff are budgeted at $224,700 based on projections for FY 2012.

Payroll Taxes and Other Benefits

Employee benefits are conservatively budgeted at 23% of salaries, assuming that all vacant positions will be filled and that employees filling these positions will be eligible for all benefits during FY 2012.

Legal Fees

Legal fees are based on historical experience and projections of required services in FY 2012 and recent actuals.

Consultants

Consultant expense is budgeted at $1,725,455 and includes expenses for consulting services, honoraria and stipends. The proposed consultant budget includes services for outsourced accounting, human resources, and editorial and production services, as well as consultants for ADEA’s ExploreHealthCareers programmatic and website initiatives. The proposed budget was increased from FY 2010 actual expenses and the FY 2011 budget.

Travel

Travel expenses are consistent with the FY 2011 budget and based on the estimated number of people traveling and the number of ADEA meetings in FY 2010.

Other Costs

Bank and Credit Card Charges

The budget is $414,373 for credit card processing fees for FY 2012. The projection is based on projected credit card revenue for FY 2011.

Developmental Programming and Data Processing

The combined budget for both categories is approximately $3.3M compared to $2.9M in the FY 2011 budget. The 13% combined increase is driven by the outsourcing of additional services to Liaison International and includes expense for additional enhancements.

Computer Operations

This expense is budgeted at $431,143 and includes payments for AClient user fees; legislative monitoring services; hosting ADEA’s association management system, Association Anywhere; hosting the online Journal of Dental Education and strategic investment in the security and reliability of ADEA’s information technology systems.

Office Supplies

This is budgeted at $73,541 for FY 2012, which is 7% less than the FY 2011 budgeted amount. The FY 2012 budget is based on projected purchases.

Rent and Refurbishing Expense

The budget for rent is $741,618 based on the 10-year office lease effective as of September 1, 2004.
Depreciation and Amortization

Depreciation and amortization expense of $316,012 is based on ADEA’s current fixed assets balances as well as expected upgrades to computer hardware and ADEA’s network system and other IT projects.

Equipment Rental

The budget for equipment rental is $42,000 for office equipment that is leased and used at ADEA’s office.

Insurance

Insurance expense is budgeted at $65,000 based on actual expenses from FY 2010.

Memorials and Contributions

This category is budgeted at $62,500 and includes $25,000 for administrative support for the home institution of the ADEA President, stipends for the 2012 ADEA Annual Session & Exhibition Faculty Development Workshop presenters, and other miscellaneous memorials and contributions typically paid by the Association.

Employee Professional Development

Employee Professional Development is budgeted based on the number of ADEA staff.

Meetings Expense

Meetings Expense is budgeted at $2,352,378, which is 17% higher than the FY 2011 budgeted expense. These costs are related to the on-site meeting expenses such as food and beverage, hotel room nights, audiovisual equipment and services and meeting room expenses. Estimates are based on anticipated local expenses for the relevant meeting locations and take into account cost efficiencies projected by staff.

Awards and Fellowships

This is budgeted at $165,250 based on ADEA’s portfolio of annual fellowships and scholarships.

Marketing

This is budgeted at $155,308 for existing advertising sales expense, as well as expenditures for advertising; marketing and affinity items; new products, services, and technology; and attendance marketing.

All other budgeted expenses, such as telephone and fax, postage and freight, printing and reproduction, repairs and maintenance, dues, subscriptions, membership fees, recruitment, retention, and miscellaneous expenses, are based on FY 2010 actual expenses as well as initiatives related to ADEA’s 2011-2014 Strategic Directions.
## ADEA: Exhibit 1-2011

### Revenue Budget

#### Fiscal Year 2012

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<td>AADSAS and CAAPIPD</td>
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<td>106,900</td>
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<td>983,611</td>
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<td>595,750</td>
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<td><strong>MEETINGS REGISTRATION AND SPONSORSHIPS</strong></td>
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<td>Annual Session/Exhibits Fees</td>
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<td>Deans’ Conference Fees</td>
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<td>Sponsor Fees</td>
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<td>732,050</td>
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<td>Other Meetings</td>
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<td>163,025</td>
<td>309,785</td>
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<td><strong>TOTAL MEETINGS REGISTRATION AND SPONSORSHIPS</strong></td>
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<td>Investment &amp; Other Income</td>
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<td>(587,434)</td>
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<td>$ 15,123,618</td>
<td>$ 18,432,327</td>
<td>$ 17,409,976</td>
<td>$ 19,014,633</td>
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|                      | (2011 ADEA House of Delegates Manual) |
### ADEA: Exhibit 2-2011

#### Expense Budget

**Fiscal Year 2012**

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<td>7,643,555</td>
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<td>11,000</td>
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<td>NET SURPLUS (DEFICIT)</td>
<td>$ (165,337)</td>
<td>$ (720,718)</td>
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2011 ADEA House of Delegates Manual 105
Report by the ADEA Executive Director to the
2011 ADEA House of Delegates

The Power of Many, The Power of One

Ten years ago, the American Association of Dental Schools or AADS, as ADEA was known at the time, made a conscious decision to transform itself from an organization primarily serving dental schools into an association representing each of the unique communities within dental education. That transformation has set the stage for growth beyond our wildest imaginings. The size of our membership is just its most visible expression. The concurrent acquisition of abundant talents and diverse perspectives has expanded our Association’s outlook, our capacity, our mandate, and our reach. Today we stand as one—One ADEA—a unified voice for dental education.

What do I mean by One ADEA?

- Members of ADEA’s seven different Councils are welcome under one big tent, and their value is affirmed by their equal representation on the ADEA Board of Directors.
- ADEA fosters interconnected community experiences that leverage our collective strengths while enabling members to meet their individual goals.
- ADEA gathers and shares information on what is happening throughout our community to inform member decision-making.
- ADEA creates forums where different approaches to addressing our community’s most pressing challenges can be debated and acted upon.
- ADEA invests in partnerships with outside groups that benefit our members and impact the world beyond.

You might say that ADEA’s constituencies coming together as one has brought us full circle. I touched upon this theme in addressing the 2010 ADEA Annual Session & Exhibition, when I spoke of my belief in the power of the individual and the power of the many. Adopting a unified approach to representing the dental education community has yielded demonstrable benefits, both for dental education as a whole and for each of our members as individuals. In the process, the One ADEA concept has positioned our Association to better meet member needs now and in the future. How? Let’s start with some numbers.

A Decade of Advancement

In 2000, we changed our name, our mission statement, and our governing structure, but the vision embodied in those changes saw its full realization with the adoption of Open Membership in 2005. We believed creating a new membership structure would more fully engage the entire dental education community in ADEA’s programming and activities. This is reflected not just in the expansion of our membership ranks from about 2,000 at the start of the decade to more than 19,000 in 2010, but in a parallel surge in member engagement.
Attendance at our national meetings continues to grow despite the economic downturn, because members receive tangible rewards when they come together. ADEA membership offers thriving communities of interest, opportunities to take part in an impressive array of leadership and other programs, and an open invitation to everyone in our community to take part in policy conversations.

Collaboration has become almost second nature in this new environment. Since 2006, the ADEA Fall Meetings have fostered connections across ADEA’s constituencies and promoted dialogue on key issues. The ADEA Commission on Change and Innovation in Dental Education (ADEA CCI) promotes the sharing of curricular resources and models across campuses, with ADEA CCI Liaisons spreading the word. Twenty ADEA Field Advocacy Workshops have galvanized students, faculty, and administrators to contribute to a variety of policy and advocacy efforts. The ADEA Scholarship of Teaching and Learning (SoTL) movement has brought together a community of faculty and students who want to discuss ideas, share knowledge, and stimulate thinking. And ADEA members are connecting with one another, supporting each other’s work, and encouraging other collaborations in countless, less visible ways.

Because the Association so broadly represents the diverse interests within the academic dental community, ADEA is perceived as an authoritative voice on educational matters. ADEA was a leading contributor to the recent revision of the Commission on Dental Accreditation’s (CODA) Accreditation Standards for Dental Education Programs. These revisions broke new ground, incorporating new language related to critical thinking, professionalism, diversity, research, evidence-based practice, interprofessionalism, lifelong learning, and the assessment of overall competency. Many of these ADEA priorities might not have received such a warm reception without the reputation ADEA has earned as the Voice of Dental Education.

Over the last decade, ADEA has also raised the profile of dental education on Capitol Hill and garnered the respect of prominent legislators on both sides of the aisle. ADEA’s quest to position access to oral health as a core health benefit for all Americans was partially met with the passage of the Affordable Care Act (ACA) in 2010. Building on our advocacy for the inclusion of pediatric dental benefits in the 2009 reauthorization of the Children’s Health Insurance Program, we championed the successful effort to include pediatric oral health services as an essential health benefit that insurers must provide under ACA. Our work has also been critical in obtaining an expansion of Title VII funding for dental education and direct Graduate Medical Education payments for the time residents spend in didactic learning activities.

These legislative victories offer a clear demonstration of the power that comes from having a unified voice for dental education and reflect ADEA’s ability to forge alliances with others who share our goals. We joined forces with organizations representing seniors, consumers, religious institutions, small businesses, Fortune 500 companies, hospitals, and pension funds during the national health care reform process, and year in and year out, we seek to build bridges with our allies in dentistry, the other health professions, higher education, and beyond.

The “relentless pursuit of strategic partnerships” has become a hallmark of how ADEA does business. Among other things, this means partnering with the nation’s leading foundations, which have begun directing their giving in new ways to reshape the health care delivery system. Their leadership is visible in new models of oral health care
delivery and in the increased presence of students from underrepresented minorities and low-income groups in our schools and programs and of women in our leadership ranks. Summer Medical and Dental Education Program, ADEA’s Admissions Committee Workshops, the ADEAW.K. Kellogg Access to Dental Careers Program, and the ADEA Minority Dental Faculty Development program represent just a few of the successful foundation partnerships that support common goals. Of special note, our Association’s involvement in foundation-sponsored pipeline initiatives has helped to spread the knowledge and understanding of community-based education. In just a few short years, this innovative practice has become a mainstream experience that now reaches almost all predoctoral students.

ADEA is extremely fortunate to have well-established relationships with the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, the Josiah Macy, Jr. Foundation, and the California Endowment, without which many of our most influential initiatives would not be possible. Likewise, strong corporate partnerships undergird several significant ADEA endeavors.

ADEA is the only association within the dental community in North America that fully integrates its corporate partners in the organization’s governance structure through a Corporate Council. As a result, corporate involvement in ADEA programs extends well beyond financial support and benefits all ADEA constituencies. Our corporate partners provide educational materials, support research within our schools, and consult with educators around product development to support innovation. The ADEA Curriculum Resource Center, a state-of-the-art Web portal launched in 2010 to provide access to timely dental educational resources, is the latest manifestation of this fruitful collaboration.

Our longstanding collaboration with the American Dental Association (ADA) has also brought many member benefits including access for students, residents, fellows, and faculty to interactive, web-based, live-patient education courses through Education in the Round at the ADA Annual Session. On the political front, our partnership with the ADA and with the American Association for Dental Research proved especially valuable in 2010 when our combined efforts resulted in preserving the autonomy of the National Institute for Dental and Craniofacial Research during the reauthorization of the National Institutes of Health.

Similarly, strong bonds connect us to our sister associations in health professions education. We collaborate with these organizations around legislative and other issues of common concern. Our participation in the Health Professionals for Diversity Coalition is furthering our Association's interest in promoting diversity within our institutions and our professions, as is our stewardship of the Summer Medical and Dental Education Program (SMDEP). SMDEP gives students from educationally disadvantaged backgrounds intensive academic enrichment, clinical experiences, and advice on financial and career planning to assist them in gaining admission to dental or medical school. This joint venture was first initiated by the American Association of Medical Colleges (AAMC), a continuing partner in SMDEP and several other ADEA endeavors. The most visible of these is MedEdPORTAL. This free peer-reviewed repository for medical and oral health teaching materials is playing an increasingly important role in disseminating some of the best curricula across institutional boundaries.
We also reach out to our colleagues in the other health professions and in higher education. ADEA has been the leader in encouraging the health professions to make common cause as they recruit students to their various disciplines. Our participation in the National Association of Advisors for the Health Professions has enhanced our relationship with advisors across the country and led to more strategic and focused recruitment efforts. We have also joined in interprofessional workgroups seeking to further professionalism in all of the health professions. ADEA has joined with other Federation of Associations of Schools of the Health Professions members to examine health literacy across health professions education. Finally, ADEA has contributed financial resources and brainpower to the College Board Collaborative. This initiative has brought medical, dental, law, and graduate schools together to tackle the problem of increasing workforce diversity by increasing access to the professions.

The ability to work well together characterizes not just external relationships, but also those within our Association. Nowhere is this more evident than in ADEA CCI. Created in 2005, ADEA CCI has brought together some of the most visionary thinkers and boldest innovators within our community to build consensus and lead our Association’s educational change efforts. ADEA CCI has been so influential, it is hard to believe that it didn’t even exist six years ago. Its accomplishments include the publication of 15 white papers that articulate a vision for the future of dental education and the recruitment of numerous ADEA CCI Liaisons, who are actively promoting change and innovation on almost every dental school campus in North America. ADEA CCI has spurred a concurrent interest in pursuing innovation within the allied and advanced dental education communities and promises to remain influential in the years ahead.

Another major accomplishment of the past decade is undoubtedly the elevation of the value of diversity in our community. In recent years, a clear consensus has emerged that diversity improves the quality of education for all students and produces a workforce better able to address the nation’s needs. ADEA has played a central role in advancing this understanding, articulating its nuances for our members and other stakeholders through a series of groundbreaking policy statements and taking concrete steps to disseminate best practices in this area.

In addition to overseeing the dental portion of the SMDEP program, which has prepared thousands of minority and low-income students for entry into dental school in just a few short years—and deans report they are thriving there, I might add—ADEA has shepherded funding from the W.K. Kellogg Foundation, the Robert Wood Johnson Foundation, and the California Endowment to underwrite the educational costs for more than 200 dental students from underrepresented minorities. Our Association has also demonstrated its commitment to diversity in the health professions by hosting www.ExploreHealthCareers.org. This widely respected and frequently visited website funded by the Robert Wood Johnson Foundation, strives to disseminate information about all of the health professions in order to increase access for everyone to the health care workforce. ADEA also recently established the nation’s first online mentoring program for dental students and the communities they work with. Now that the importance of mentoring in the recruitment of URMs has been established, we plan to launch the program nationally.
ADEA’s diversity efforts extend beyond the student body. Over the last six years, the ADEA Minority Dental Faculty Development program allowed us to establish academic community models for the recruitment and retention of a more diverse faculty. With funding from the W. K. Kellogg Foundation, the program supported 124 potential faculty members in 85 communities, developed seven models that can be replicated at other dental schools throughout nation, and authored a Grow Your Own manual to share best practices among our institutions.

Concurrently, ADEA held seven successful recruitment and retention conferences that created a national network and served as a forum for diversity issues. The conferences will continue to be held biennially to strengthen the national network of minority recruitment officers, allow for exchanges related to best practices, and seek additional resources and fresh ways to address the recruitment of URMs to careers in dentistry.

ADEA has also nurtured the development of several women’s leadership programs begun in the 1990s. As a result, women have a stronger presence today in leadership roles within our institutions and our Association and on the international stage. This past September, 100 dental educators and other oral health advocates gathered in Brazil for the Fourth ADEA International Women’s Leadership Conference, exploring ways in which women can take the lead in advancing global health. Closer to home, we soon will embark on a study of how women’s health and gender-related issues are taught in U.S. dental schools with funding from the Office of Research on Women’s Health at the National Institutes of Health. It has been more than ten years since our last study on this topic, and we hope to find that significant progress has been made in preparing future oral health practitioners to provide appropriate care for women and girls.

ADEA’s efforts to elevate the value of diversity in dental education culminated with last year’s adoption of new predoctoral dental education standards by the Commission on Dental Accreditation. The new standards recognize diversity as an essential component of academic excellence and require dental schools to graduate dentists with the interpersonal and communication skills needed to manage a diverse patient population. The standards further assert that diversity of the student body, faculty, and staff and the inclusion of diversity in the curriculum are essential to creating a diverse learning environment that improves the patient outcomes of those from all backgrounds.

The creation of ADEA and its evolution have brought myriad internal changes that enrich the member experience as well. In the past six years, our staff has focused on delivering value to our members. In addition to creating opportunities that allow individuals and groups to network and collaborate around common issues, ADEA has created two new divisions and transformed a third to better serve you.

As the leading U.S. repository for information on dental education, ADEA takes seriously its responsibility to provide an easily accessible, go-to collection of reliable, up-to-date information. We also provide links to ADA and government information sources and assist members with searches. The ADEA Division of Knowledge Management, created in 2005, conducts surveys to keep our members abreast of the latest trends and makes this data available through print publications and the ADEA Online Library. Surveys are not new to our Association, but in recent years, the division has refined and improved the tools it uses to track and measure the various needs of our constituencies. This knowledge-gathering enterprise is having a discernable impact. In no small
measure, our ability to give voice to the concerns of the dental education community stems from the consistent efforts we make to ask our members what is going on in their world.

Among the division’s greatest accomplishments is the delivery of MedEdPORTAL, which gives our members access to dental curricular resources and advances interprofessionalism by sharing them with our medical counterparts.

The evolution of the ADEA Center for Education Policy and Research (ADEA CEPR) marks a pivotal change for our Association. The Center functions as a “think tank,” giving ADEA the ability to assess the broader higher educational policy landscape and determine its intersection with the dental policy landscape. ADEA CEPR has been instrumental in championing change on behalf of ADEA members, whether in discussions with bodies such as CODA or through the ongoing work of ADEA CCI. Like the ADEA Division of Knowledge Management, ADEA CEPR provides the knowledge and understanding ADEA needs in order to speak on behalf of the dental education community.

In 2008, a third ADEA division took on a broader portfolio and a new title, the ADEA Division of Educational Pathways (ADEA DEP). The name change reflects the Division’s new emphasis on ensuring that our professions remain attractive career options and continue to draw a robust and diverse applicant pool. The Division still processes applications through ADEA AADSAS and ADEA PASS, although the cumbersome systems in place a decade ago have been replaced by one that is multidirectional, user friendly, and paperless; and ADEA DEP’s mandate has expanded to include interacting with advisors, admissions officers, and other health professions associations to ensure a healthy flow of applicants into the pipeline.

Toward this end, ADEA has joined with AAMC in calling for the adoption of holistic admissions policies with a goal of admitting students who possess the full range of traits needed to meet tomorrow’s practice needs. ADEA DEP’s Admissions Committee Workshops, funded by the Robert Wood Johnson Foundation, represent an almost revolutionary departure from the rigid, numerically driven practices of the past. The workshops train schools in the nuts and bolts of implementing holistic admissions, and they have produced a measurable increase in the number of students from underrepresented minority and low-income backgrounds who are being accepted to dental school.

The last decade has also witnessed the transformation of our scholarly publication, the Journal of Dental Education (JDE), from a respected but modest purveyor of academic research to a substantial monthly outlet for the latest peer-reviewed papers and insightful commentary on academic dentistry. In the first year of the transition from AADS to ADEA, we halted a downward trend in submissions to the journal by soliciting manuscripts from highly respected and more junior educators. The following year we created awards for the best JDE articles authored by junior faculty. Submissions began to rise.
Today readers view the JDE as an indispensable source for the latest ideas and developments in dental education, from research findings to best practices. In recent years, the JDE has played a key role in disseminating the work of ADEA CCI. In addition, it has published several influential supplements on groundbreaking developments in academic dentistry.

In 2007, Thompson Scientific announced that it would begin evaluating the JDE for its impact in the research community, enhancing the publication’s prestige and stature and increasing its value as a vehicle for professional advancement. Thanks to online distribution, the JDE now reaches ten thousand readers—each day!

**New Strategic Directions**

While the accomplishments of the last decade position ADEA to be the leading authority in shaping the future of dental education, we need a plan to achieve this, and we have devised one. Embracing our leadership role is the first in a new set of strategic directions for 2011-14 developed by the ADEA Board of Directors.

1. **Leadership.** This strategy reflects our commitment to devoting energy and resources to ensuring the sustainability of academic dental institutions. It involves deepening the connection between our schools and programs and their parent institutions, identifying cost-effective means of delivering education, providing guidance in the education of new oral health professionals, and providing leadership development opportunities targeted to emerging academic leaders.

2. **Teaching and Learning.** This second strategic priority will guide us in providing professional development opportunities for new educators, encouraging the integration of interprofessional education, developing high-quality curricular tools and guidance, and promoting the scholarship of teaching and learning as an integral part of the institutional culture.

3. **Research.** Our third strategic direction shines a light on the foundations of dental education. We are committed to supporting the integration of research in the mission of all academic dental institutions, promoting opportunities for research collaborations, and advocating for increased funding for research and research training. We will also continue to produce our own relevant and timely research products on key issues in dental education to support informed decision-making by the dental education community and policymakers.

4. **Service.** Finally, preparing the oral health workforce that will be needed in our increasingly diverse society dictates that service be our fourth strategic direction. This means supporting the recruitment of individuals from underrepresented minorities and low-income backgrounds into our professions, helping academic dental institutions contribute to improving access to care, and disseminating ADEA’s programs, products, and services to strengthen the quality of dental education worldwide.
Challenges Ahead

How will these new strategic directions move us forward? As we continue to navigate a rapidly changing landscape, our institutions must look at where they fit in the larger picture of health professions education. The pressures on higher education and the health care delivery system are enormous. Unless we prepare our students to be interprofessional, to engage in robust scientific research, and to take a patient-centered approach to care, we could cease to be relevant.

Dentists are particularly challenged in the new health care environment. They can no longer afford to see themselves solely as highly skilled practitioners, but must appreciate their larger role as leaders in addressing the oral health care needs of an increasingly diverse and challenging patient population.

Nonetheless, we know we can craft a vital role for dental education as we move into the future of academia, the health professions, and health care. Among the factors we will need to consider:

- The entry of new dental schools and the rapid expansion in the number of dental hygiene programs
- The creation of new members of the oral health care team and new ways of delivering care, including a shift toward patient-centeredness
- The development of new approaches to teaching and learning and the integration of new technologies in the classroom and clinic
- A renewed emphasis on the importance of research as the foundation of our work

I have no doubt the engaged ADEA membership and our volunteer leaders will guide us well as the Association addresses these and other emerging issues. I want to thank our President, Sandra Andrieu, and the other members of the ADEA Board of Directors, including Susan Crim, Lily Garcia, Ronald Hunt, Evelyn Lucas-Perry, Barbara Nordquist, Leo Rouse, Michael Siegel, Todd Thierer, and John Williams, for their work, especially in envisioning the future of academic dentistry. I would also like to thank all of the volunteers who serve in leadership positions on our councils, committees, and commissions, and as our representatives to other associations and organizations.

Moving Forward As One

As discussions arise in connection with the challenges ahead, ADEA’s seven unique constituencies will each play a vital role in mapping the Association’s road forward. We will continue to offer a public square where members can engage in informed, evidence-based dialogue around controversial issues and form strategic partnerships to facilitate solutions to problems of mutual concern. Decisions made by individual members, our member institutions, and the Association as a whole will find solid grounding in a growing collection of evidence and information. Experiences that connect our community will enable members to meet their individual goals. And partnerships will leverage our collective strength to produce even greater achievements for our community in the years ahead. That is the power of the many when we come together as one.
While ADEA retains the best elements of AADS, its predecessor organization, there can be no doubt that our Association has undergone a profound transformation. Today ADEA is invested not in maintaining the turf of any one specific group, but in improving the playing field for all of our constituents. The Association that has emerged in the course of the last 10 years reflects this unity of purpose and an understanding that the future of the oral health professions lies in making common cause with all those who seek to further the health and well-being of people the world over. That's the promise embodied in the idea of One ADEA. Together we have the potential to produce the best-prepared oral health care workforce in the world and achieve our ultimate goal: meeting the needs of the public we serve.

Respectfully submitted,

Richard W. Valachovic, D.M.D., M.P.H.
ADEA Executive Director
New Chief Administrators at Member Institutions

New Dental School Deans
Since the 2010 Annual Session, U.S. and Canadian dental schools have appointed the following new deans whose service began between the end of the 2010 ADEA Annual Session & Exhibition and the beginning of the current ADEA Annual Session & Exhibition. The Board of Directors congratulates these members and wishes them success in their assignments.

Dr. Richard N. Buchanan, Dean, University of Southern Nevada
Dr. Nader A. Nadershahi, Interim Dean, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Gary Reeves, Interim Dean, University of Mississippi
Dr. Humberto J. Villa Rivera, Acting Dean, University of Puerto Rico
Dr. David S. Sarrett, Dean, Virginia Commonwealth University
Dr. Janet H. Southerland, Dean, Meharry Medical College
Dr. John Stamm, Interim Dean, University of North Carolina at Chapel Hill
Dr. John Williams, Dean, Indiana University

New Federal Dental Chiefs
U.S. Federal Government agencies have reported the following appointments since the 2010 ADEA Annual Session & Exhibition. The Board of Directors congratulates these new Dental Services Chiefs.

Dr. Patricia E. Arola, Assistant Under Secretary for Health for Dentistry, Department of Veterans Affairs
RADM William Bailey, Chief Dental Officer, United States Public Health Service / Nat'l Center for Disease Prevention
Maj. Gen. Gerard A. Caron, Assistant Surgeon General for Dental Services, United States Air Force Dental Service
Capt. Elaine C. Wagner, Dental Corps Chief of Naval Operations, United States Navy Dental Corps
Maj. Gen. M. Ted Wong, Chief, United States Army Dental Corps

Other New Administrators at Member Institutions
Other ADEA Member Institutions have reported the following appointments since the 2010 ADEA Annual Session & Exhibition. The Board of Directors congratulates these new administrators.

Dr. Ritchie Chosen, Director of Admissions, Louisiana State University
Dr. Patrick J. Ferrillo, Jr., Interim Provost, University of the Pacific
Dr. Da Fonseca, Post-Graduate/Residency Program Director Department of Pediatric Dentistry, University of Washington
Dr. Dennis R. Higginbotham, Dr. Raymond W. Shaddy Endowed Chair in Operative Dentistry, Creighton University
Dr. Dean R. Justmann, Executive Director for Administration, University of Illinois at Chicago
Dr. Zenon P. Kossak, Chair of the Department of Oral and Maxillofacial Surgery, University of Detroit Mercy
Dr. Dennis Tarnow, Director of Implant Education, Columbia University
Dr. Robert M. Trombly, Associate Dean of Academic Administration, University of Detroit Mercy
Dr. Hans-Peter Weber, Chair of Prosthodontics and Operative Dentistry, Tufts University
Dr. Deidre D. Young, Director of Multicultural Affairs, University of Detroit Mercy

New Affiliate Members
Since March 16, 2010, these programs and schools have become Affiliate Members. The Board of Directors welcomes them to ADEA.

Canadian Academy of Dental Hygiene, Prof. Indu Dhir, Director, Dental Hygiene Program (Mississauga, Ontario, Canada)
Cuyahoga Community College, Ms. Mary Lou Gerosky, Director, Dental Hygiene Program (Cleveland, Ohio)
Denver Health and Hospital Authority, Dr. Stephen MacLeod, Program Director, Oral and Maxillofacial Surgery (Denver, Colorado)
Eastern New Mexico University-Roswell, Dr. Michelle Luikens, Director, Dental Hygiene Program (Roswell, New Mexico)
Manhattan Area Technical College, Dental Hygiene (Manhattan, Kansas)
Sanford Brown Institute - Orlando, Ms. Debra A. Dixon, Director, Dental Hygiene Program (Orlando, Florida)
Sanford-Brown College - Dallas, Dr. Sheila Vandenbush, Director, Dental Hygiene Program (Dallas, Texas)
Sanford-Brown Institute - Fort Lauderdale, Dr. Jorge Velasquez, Director, Dental Hygiene Program (Fort Lauderdale, Florida)
St. Charles Hospital, Dr. Keri A. Logan, Director, General Practice Residency-12 Program (Port Jefferson, New York)
Thomas Nelson Community College, Dr. Harold Marioneaux, Director, Dental Hygiene Program (Williamsburg, Virginia)
University of Arkansas - Fort Smith, Ms. Mitzi Efurd, Director, Dental Hygiene Program (Fort Smith, Arkansas)
Valencia Community College, Ms. Pamela J. Sandy, Director, Dental Hygiene Program (Orlando, Florida)

New Corporate Members
These companies have become ADEA Corporate Members since March 16, 2010. The Board of Directors welcomes them to ADEA.

G. Hartzell & Son
HealthFirst
Instrumentarium
Isolite Systems
Medical Protective Company
PennWell Corporation
Sequoia Dental Studio, LLC
Vident, A VITA Company
In Memoriam

With regret, the ADEA Board of Directors announces these deaths of faculty and staff as reported by ADEA Member Institutions.

Dr. Lehman D. Adams, Jr., Indiana University
Dr. Carl J. Andres, Indiana University
Dr. Orasa Anusaksathien, University of Michigan
Prof. Claudia Ann Beard, St. Petersburg College
Dr. Samir Bishara, University of Iowa
Dr. Arnold Bleiweis, University of Florida
Dr. George A. Blount, Loma Linda University
Dr. Hal Jay Board, University of Texas Health Science Center at Houston
Dr. Robert L. Bogan, Indiana University
Dr. Malcolm E. Boone, Indiana University
Dr. Charles Bower, University of Nebraska Medical Center
Dr. Rosita Brown Long, University of Oklahoma
Dr. Paul Jones Cain, University of Texas Health Science Center at Houston
Dr. George W. Campbell, University of Pittsburgh
Prof. James R. Clark, University of Washington
Dr. Harold Clough, University of Nebraska Medical Center
Dr. Harold Clough, University of Nebraska Medical Center
Dr. Frank Collins, University of Florida
Dr. Billy I. Dippel, University of Texas Health Science Center at Houston
Dr. Thomas Dudley, University of Oklahoma
Dr. Homer Dyer, University of Washington
Dr. Henry Elsbach, Southern Illinois University
Dr. Dan E. Faulk, Indiana University
Dr. Robert J. Fexa, Lehigh Valley Health Network
Dr. Charles M Friedman, Nova Southeastern University
Dr. George Garrington, University of Florida
Dr. Stephen B. Gold, St. Charles Hospital
Dr. Albert A. Gordon, University of Texas Health Science Center at Houston
Dr. Gerald N. Green, New York University
Mr. William S. Green, New York University
Dr. Robert D. Gross, University of Washington
Dr. Robert Guild, University of Washington
Dr. Terry M. Guzallis, Creighton University
Dr. Earl C. Harrison, University of Southern California
Dr. Hudson D. Heidorf, Case Western Reserve University
Dr. Lawrence Herman, New York University
Dr. Eugene Hittelman, New York University
Prof. Diane E. Huntley, Wichita State University
Dr. Charles H. Julienne, University of Southern California
Prof. Christine Klausner, University of Michigan
Dr. Henry E. Lancaster, Jr., Indiana University
Dr. David Locker, University of Toronto
Dr. Armand Lugassy, University of the Pacific Arthur A Dugoni School of Dentistry
Dr. Samuel Lusk, University of Texas Health Science Center at Houston
Dr. Parker Mahan, University of Florida
Dr. Rita Mehra, University of Medicine and Dentistry of New Jersey
Dr. Bryan Melvin, University of Nebraska Medical Center
Prof. Kay Mescher, University of Iowa
Prof. Therese Miranda, Hudson Valley Community College
Dr. John D. Piro, Columbia University
Dr. John F. Ricciani, University of Medicine and Dentistry of New Jersey
Dr. Irwin B. Robinson, University of Illinois at Chicago
Dr. Paul F. Ruskin, University of Pittsburgh
Dr. Harold E. Schnepper, Loma Linda University
Dr. Harris Silverstein, University of Medicine and Dentistry of New Jersey; University of Washington
Dr. Roger B. Simpson, University of Iowa
Dr. Michael Stablein, University of Illinois at Chicago
Dr. John G. Steciw, Lehigh Valley Health Network
Dr. Jay Steinberg, New York University
Dr. James C. Steiner, University of Washington
Dr. Frank Stout, University of Florida
Dr. Svein Toverud, University of North Carolina at Chapel Hill
Dr. George Upton, University of Michigan
Dr. Robert V. Vining, Creighton University
Dr. James Weesner, University of Nebraska Medical Center
Dr. Dan C. West, University of Texas Health Science Center at Houston
Prof. Alla J. Wheeler, New York University
Dr. Robert Bruce Wiggs, Baylor College of Dentistry
Dr. Robert L. Wilkins, Loma Linda University
Dr. Robert Wilson, University of Medicine and Dentistry of New Jersey
Dr. Frederick Q. Wong, University of California, San Francisco
Dr. Stephen Wotman, Case Western Reserve University
ADEA Staff

Staff wear special name badges so they are easy to recognize. They are always willing to assist you.

**Office of the ADEA Executive Director**
Dr. Richard Valachovic, Executive Director
Ms. Abigail Gorman, Deputy Director and Chief Operating Officer
Ms. Novella Abrams, Senior Administrative Assistant to the Deputy Director and COO
Dr. Ronald Rupp, Senior Director, External Relations and Institutional Advancement
Dr. Linda L. Hanlon, Special Liaison to the ADEA Council of Allied Dental Program Directors
Mr. Kent Bryant, Development Associate

**ADEA Division of Finance and Operations**
Ms. Rowena Williams, Associate Director for the Division of Finance and Operations
Ms. Tracey Frazier, Reception and Operations Administrative Assistant
Mr. Reggie Hackett, Technical Support Specialist
Mr. Kevin Hawkins, Operations Services Associate
Mr. Sunu Kc, Senior Manager of Network Operations
Mr. Qi Li, Director, Information Technology
Mr. Satyan Ramanna, Assistant Director, Information Technology

**ADEA Center for Educational Policy and Research**
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Ms. Lauren Bush, Senior Administrative Assistant
Ms. Kim D’Abreu, Associate Director, Center for Educational Policy and Research
Ms. Gloria Gonzalez, Research Associate
Dr. Karen F. Novak, Senior Director for Research and Analysis

**ADEA Center for Equity and Diversity**
Dr. Jeanne Sinkford, Associate Executive Director and Center Director
Dr. David Brunson, Associate Director
Ms. Cassandra Allen, Program Assistant
Ms. Sonja Harrison, Director, Program Services

**ADEA Center for Public Policy and Advocacy**
Mr. Jack Bresch, Associate Executive Director
Ms. Deborah Darcy, Director, Congressional Affairs
Ms. Yvonne Knight, Senior Director
Ms. Monette McKinnon, Director, Legislative Policy Development
Ms. Myla Moss, Director, Congressional Relations and Regulatory Affairs
Ms. Irene Rudyj, Program Assistant
ADEA Division of Knowledge Management
Ms. Sue Sandmeyer, Associate Executive Director
Mr. Emmanuel Asguet, Research Assistant
Dr. Laura Siaya, Director of Survey Research
Ms. Henryne Tobias, Project Director, ExploreHealthCareers.org

ADEA Division of Member Services
Ms. Susan Krug, Associate Executive Director
Ms. Colleen Allen, Publications Manager/Writer
Ms. Allison Begezda, JDE Editorial Coordinator
Mr. Sean Carter, Membership Manager
Ms. Shalonda King, Administrative Coordinator
Mr. Gustavo Mendoza, Art Director
Ms. Merideth Menken, Senior Director of Publications and Communications
Mr. Kevin Morse, Director of Online Services
Mr. Ben Rome, Publications Manager and Staff Writer
Mr. Burt Stanko, Membership, Database, and Publications Coordinator

ADEA Division of Member Services, Office of Professional Development
Ms. Audra F. Franks, Senior Director for Meetings
Ms. Renee Latimer, Meetings Manager
Ms. Cherie Mason, Program Coordinator
Ms. Monique Morgan, Registration and Awards Event Coordinator
Ms. Simone Smith, Meetings Manager
Ms. Rebecca Turner, Professional Development Director

ADEA Division of Educational Pathways
Dr. Anne Wells, Associate Executive Director
Mr. Joshua Hargrove, AADSAS Administrative Service Manager
Ms. Chonté James, Director, AADSAS
Ms. Yolanda Jones, PASS and CAAPID Operations Manager
Ms. Leslie Payne, Senior Administrative Assistant
Mr. Peter Storandt, Director of PASS and CAAPID
Mr. Drake Washington, DEP Project Coordinator
Chapter I: Core Values

Section A
The Association’s core values are:

1. **Promoting and Improving Excellence in All Aspects of Dental Education.** The Association values the development of faculty, staff, and administrators as the key to improving dental education.

2. **Building Partnerships in Support of and Advocating for the Needs of Dental Education.** The Association values partnerships with those who share an interest in improving dental education by ensuring a sufficient flow of resources and favorable policy options.

3. **Serving the Individual Needs of Members and Institutions.** The Association values providing a broad range of services for the benefit of both individuals and institutions.

4. **Encouraging Communication and Sharing of Information Among the Association’s Members.** The Association values intelligent, candid, and efficient communication among Association members, individual and institutional.

5. **Expanding the Diversity of Dental Education.** The Association values diversity and believes that those who populate dental education—students, faculty, staff, administrators, and patients—should reflect the diversity of our society.

6. **Recognizing the Needs of Those the Association Serves.** The Association values responsiveness to the needs of students, alumni, patients, and all other constituents.

7. **Promoting Oral Health.** The Association values oral health care as being integral to the general health and well-being of individuals and society.

Chapter II: Membership

Section A. Categories
The Association has eight membership categories.

1. Institutional membership
   a. Active
   b. Provisional
   c. Affiliate
   d. Corporate

2. Individual membership
   a. Individual
   b. Student
   c. Retired
   d. Honorary

Section B. Qualifications for Institutional Membership

1. **Active.** A dental school granting a D.D.S. or D.M.D. degree as a part of an accredited college or university in the United States, Puerto Rico, or Canada, and having begun instruction of its first class of dental students, is eligible to apply for active membership. (Canadian dental schools have the option of selecting active or affiliate membership.)
2. **Provisional.** A developing dental school planning to grant a D.D.S. or D.M.D. degree as part of an accredited college or university in the United States, Puerto Rico, or Canada is eligible to apply for provisional membership. (Developing Canadian dental schools have the option of selecting provisional or affiliate membership.)

3. **Affiliate.** The following types of institutions in the United States, Puerto Rico, or Canada are eligible to apply for affiliate membership, provided that they are not eligible for active or provisional membership and that their dental and/or allied dental education programs are accredited by the Commission on Dental Accreditation:
   a. Canadian dental schools (may elect active or affiliate membership or provisional membership if a developing institution).
   b. Academic institutions—other than hospitals—conducting postdoctoral dental education programs.
   c. Hospitals that conduct postdoctoral dental education programs and that are not under the same governance as an active or provisional member institution. Hospital programs under the same governance as active or provisional member institutions are included in the parent school’s active or provisional membership.
   d. The United States Air Force, Army, Navy, Public Health Service, and Department of Veterans Affairs and comparable agencies of the Canadian government.
   e. Institutions conducting dental hygiene, dental assisting, and dental laboratory technology education programs. Such programs that are under the administrative control of an active or provisional member institution and that are conducted at the main teaching site of that active or provisional member institution are included in the membership of the active or provisional member institution and are automatically members of the Council of Allied Dental Program Directors. Dental hygiene, assisting, and laboratory technology education programs conducted at the main teaching site of an active or provisional member institution but that are not under the administrative control of that active or provisional member institution and dental hygiene, assisting, and laboratory technology education programs that are under the administrative control of an active or provisional member institution and are conducted away from the main teaching site of that active or provisional member institution must be affiliate institutional members in order to belong to the Council of Allied Dental Program Directors.
   f. Institutions conducting other dental or allied dental education programs recognized by the Association.

4. **Corporate.** A company dealing with products and/or services beneficial to dental education and/or dentistry is eligible to apply for corporate membership.

**Section C. Election to Institutional Membership**
Applications for active and provisional membership should be presented in writing at least sixty days before an annual session. Institutions are elected to membership by a majority affirmative vote of the House of Delegates. Memberships are effective the July 1 following House approval.

Applications for affiliate institutional membership can be submitted at any time for approval by the executive director. Memberships become effective on January 1, April 1, July 1, or October 1, whichever date first follows approval.

Applications for corporate membership can be submitted at any time for approval by the Board of Directors at its next meeting. Memberships become effective on January 1,
April 1, July 1, or October 1, whichever date first follows approval. Corporate memberships are reviewed annually.

Section D. Institutional Membership Dues (effective July 1, 2004)

1. **Active and Provisional Members.** Effective July 1, 2004, annual dues for active- and provisional-member institutions are $25,522.
   a. Active and provisional institutional membership dues include one individual membership from each member institution.

2. **Affiliate Members.** Effective July 1, 2004, annual dues for institutions that conduct allied dental education programs are $945. Effective July 1, 2004, annual dues for Canadian dental schools are $1,815.
   a. Effective July 1, 2000, annual dues for the federal dental services are $3,922.
   b. Effective July 1, 2003, annual dues for hospital-based postdoctoral dental education programs are $984. A portion totaling $76 of each such institutional membership shall be allocated as recommended by the Council of Hospitals and Advanced Education Programs and as approved by the Board of Directors.
   c. Effective July 1, 2003, annual dues for institutions that conduct non-hospital-based postdoctoral dental education programs are $3,998. A portion totaling $76 of each such institutional membership shall be allocated as recommended by the Council of Hospitals and Advanced Education Programs and as approved by the Board of Directors.
   d. Dues are payable by February 1, May 1, August 1, or November 1, whichever date first follows approval. Dues include one individual membership, with the institution to determine the individual member.

3. **Corporate Members.** Effective January 1, 2006, annual dues are $3,400. Dues include up to ten individual members, with the corporation to determine the individual members. $500 of each member’s dues is designated to support the ADEA Annual Session & Exhibition.

Section E. Forfeiture of Institutional Membership

1. Ceasing to meet the membership qualifications specified in Chapter II, Section B, of these Bylaws results in immediate forfeiture of membership.

2. Active or provisional member institutions in arrears in payment of their dues at an annual session forfeit their memberships. Affiliate or corporate member institutions in arrears in payment of their dues more than six months beyond the dues payment date forfeit their memberships.

Section F. Reinstatement of Institutional Membership After Payment of Dues in Arrears

1. Institutional memberships forfeited for nonpayment of dues may be reinstated upon payment and approval of the executive director.

Section G. Qualifications for Individual Memberships

1. **Individual.** Any faculty member or other person employed by a dental, advanced education, hospital, and/or allied dental education ADEA member institution is eligible for individual membership.

2. **Student.** Any student enrolled in a dental school, a postdoctoral dental education program, and/or an allied dental education ADEA member institution is eligible for individual membership.
3. **Retired.** Any individual who has completely retired from dental education and dental practice and who has been an ADEA individual member is entitled to individual membership.

4. **Honorary.** Any individual who has rendered a distinct service to humankind, made outstanding contributions to dentistry, and/or rendered exceptional service to the Association may be nominated by the Board of Directors for honorary membership.

5. **Affinity.** Any individual with a demonstrable interest in dental, allied, or advanced dental education who is not currently a faculty member, employee, or student in an ADEA member institution.

**Section H. Approval of Individual Memberships**

1. **Individual.** An individual membership may be activated at any time during the year. Memberships become effective as soon as the activation is processed and remain in effect for the following twelve months.

2. **Student.** A student membership may be activated at any time during the year. It becomes effective as soon as the activation is processed and remains in effect for as long as the member is enrolled at an ADEA Institutional Member.

3. **Retired.** A retired membership may be activated at any time during the year. Memberships become effective as soon as the activation is processed and remain in effect for the following twelve months.

4. **Honorary.** Individuals are elected to honorary memberships by a majority affirmative vote of the House of Delegates. Honorary members are entitled to all privileges of individual membership except the right to vote. An honorary membership is effective for the member's lifetime.

5. **Affinity.** Applications for Affinity Individual Membership may be submitted at any time during the year. Memberships become effective as soon as the application is processed and remain in effect for the following twelve months.

**Section I. Individual Membership Dues**

1. **Individual Membership.** Effective January 1, 2006, annual dues are $0, and include membership in any Section(s) or Special Interest Group(s).

2. **Student Membership.** Effective January 1, 2006, annual dues are $0, and include membership in any Section(s) or Special Interest Group(s).

3. **Retired Membership.** Effective January 1, 2006, annual dues are $0, and include membership in any Section(s) or Special Interest Group(s).

4. **Honorary Membership.** Honorary members pay no dues.

5. **Affinity Membership.** Effective January 1, 2006, annual dues are $125 for individuals with a demonstrable interest in dental, allied, or advanced dental education and are not currently a faculty member, employee, or student in a member institution. This fee includes membership in any Section(s) or Special Interest Group(s).

6. **Affinity Student Membership.** Effective January 1, 2007, annual dues are $40 for a student who is not enrolled in an ADEA Institutional Member and who has a demonstrable interest in predoctoral, allied, or advanced dental education.

**Section J. Forfeiture of Student Membership**

1. **Student.** Ceasing to meet the membership qualifications specified in Chapter II, Section G.2., of these Bylaws results in immediate forfeiture of student membership. However, the individual may then apply for regular individual membership.
Section K. Membership Voting Rights
1. Voting. The House of Delegates shall represent the membership and shall have the right to vote on their behalf. Except as otherwise may be expressly required by statute or by the Association’s Articles of Incorporation, no class or category of member of the Association shall have any right to vote.

Chapter III: Elected Association Officers

Section A. Names
The Association’s elected officers are:
1. President
2. President-Elect
3. Immediate Past-President
4. Vice President for Allied Dental Program Directors
5. Vice President for Deans
6. Vice President for Faculties
7. Vice President for Hospitals and Advanced Education Programs
8. Vice President for Sections
9. Vice President for Students, Residents, and Fellows
10. Vice President for the Corporate Council

Section B. Qualifications
To be eligible for an elected office, a person must be an individual member of the Association. In addition, a person must be a member of a council to be eligible for the vice presidency of that council, with the exception that past Administrative Board members of the Council of Sections who may no longer be members of the council are eligible for nomination as vice president for sections.

Individuals may not serve simultaneously as a principal officer of ADEA (president, president-elect, or immediate past-president) and as a member of the American Dental Association’s Council on Dental Education and Licensure or the Commission on Dental Accreditation.

Section C. Duties of Officers
1. President
   a. To provide leadership in achieving the Association’s mission, objectives, and ongoing business;
   b. To serve as presiding officer of the House of Delegates and Board of Directors; and
   c. To serve as the Association’s official representative to other organizations.
2. President-Elect
   a. To serve in place of the president at the request or in the absence of the president; and
   b. To perform any duties requested by the president.
3. Immediate Past-President
   a. To serve in place of the president at the request of the president or president-elect or in the absence of both;
   b. To perform any duties requested by the president;
   c. To chair the Finance Committee of the Board of Directors; and
   d. To chair the nominating committee for president-elect.
4. Vice Presidents. The duties of vice presidents are delineated in Chapter VIII (Councils) of these Bylaws.
Section D. Succession
The offices of president-elect, president, and immediate past-president are successive.

Section E. Nominations
By April 1 each year, the Board of Directors invites the general membership to suggest nominees for the office of president-elect. Members should consider women and underrepresented minorities for nomination. Members may nominate as many individuals as they wish, including themselves. The deadline for submitting nominations is November 1. Council administrative boards may also nominate individuals.

Between November 1 and December 31, the immediate past-president and the seven vice presidents meet as a nominating committee to consider all nominations and shall recommend one or more candidates to stand for election. If a vice president or councilor is a nominee, the chair from that vice president’s or councilor’s council serves on the nominating committee to ensure representation from the council. Any delegate may present additional nominations to the ADEA executive director for president-elect no later than thirty days prior to the Opening of the House of Delegates. Any delegate presenting a nomination must obtain the candidate’s consent to run and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review prior to the annual session.

The methods of nominating council vice presidents are delineated in Chapter VIII (Councils) of these Bylaws.

Section F. Election
If there is only one candidate for president-elect, he or she is declared elected at the Opening Session of the House. If there are two or more candidates, delegates cast secret ballots at the annual session during times designated by the Board of Directors. Ballot counting is monitored by two individuals selected by the Board of Directors. A plurality of the votes cast is required for election. The methods of electing council vice presidents are delineated in Chapter VIII (Councils) of these Bylaws.

Section G. Installation
Elected Association officers are installed at annual sessions at the Closing Session of the House of Delegates.

Section H. Terms of Office
The president-elect, president, and immediate past-president serve one-year terms. Individuals who have served a full term as president, president-elect, and/or immediate past-president may not succeed themselves in any of those offices. Each vice president serves for a single three-year term and may not succeed him- or herself. Notwithstanding the foregoing, the vice president for students, residents, and fellows shall serve for a term of office as set forth in Chapter VIII, Section C.8 of these Bylaws.

Section I. Replacement
If a president or president-elect dies, resigns, or is removed for any reason, the Association’s nominating committee nominates one or more candidates to fill the vacancy relating to such officer position. An election is then held by mail ballot of all delegates to the last House of Delegates. Ballots are accompanied by biographical sketches of the candidates. Space is provided on the ballots for write-in candidates. Ballots must be returned within fifteen days after mailing. Ballot counting is monitored by
two individuals selected by the Board of Directors. A plurality of the votes cast is required for election.

If an immediate past-president dies, resigns, or is removed for any reason, the position remains vacant until the president assumes the office at the next annual session, provided, however, that if the person who most recently served as immediate past-president (the “former immediate past-president”) prior to the death, resignation, or removal of the individual that created the vacancy in the office of the immediate past-president is available and willing to serve as the immediate past-president, then the former immediate past-president may be appointed by the president to serve as the immediate past-president until the next annual session when the president assumes such office.

In such a case where a vacancy in the office of immediate past-president is not filled, the president serves as chair of the Finance Committee and the nominating committee for president-elect. In the event of the death, resignation, or removal of one or more of the vice presidents, the vacancy created thereby shall be filled in accordance with the procedures set forth at Chapter VIII, Section C.9 of these Bylaws. An individual may not hold two or more elected Association offices simultaneously.

Chapter IV: House of Delegates

Section A. Function
The House of Delegates is the Association’s governing and legislative body.

Section B. Composition
The House of Delegates consists of the following members:
1. Board of Directors
2. The Council of Deans
3. The Council of Faculties
4. Representatives of the Councils of Allied Dental Program Directors; Hospitals and Advanced Education Programs; Sections; and Students, Residents, and Fellows, as specified in Chapter VIII (Councils) of these Bylaws.
5. Representatives of the Corporate Council, as specified in Chapter IX (Corporate Council) of these Bylaws.

Section C. Powers and Duties
The House of Delegates has the following powers and duties:
1. To enact and, where appropriate, enforce policies of the Association;
2. To approve all resolutions, opinions, and memorials in the name of the Association;
3. To elect active, provisional, and honorary members;
4. To approve changes in the Bylaws, Policy Statements, and Position Papers;
5. To approve new sections;
6. To approve the Association’s operating budgets;
7. To establish branch offices of the Association or change the location of the Central Office;
8. To elect the president-elect of the Association;
9. To elect nominees for membership in other organizations when so requested; and
10. To serve as an advocate on behalf of all Association policies and positions.
Section D. Sessions
The House of Delegates normally convenes at the Association’s annual sessions. Special sessions may be called by the president or by request of the membership as specified in the Bylaws.

Section E. Official Call
1. Annual Sessions. The executive director sends each institutional and individual member delegate an official notice of the time and place of each annual session or other House meeting. The notice is sent no fewer than thirty days before the first day of the session or meeting.
2. Special Sessions. The executive director sends each institutional and individual member delegate an official notice of the time and place of each special session along with a statement of the business to be considered. The notice is sent no fewer than thirty days before the first day of the session. No other business except that provided for in the call may be considered unless the members present unanimously agree to consider additional business.

Section F. Quorum
A majority of the delegates constitutes a quorum for the transaction of business at regular or special sessions.

Section G. Presiding Officer
The president is the presiding officer. In the president’s absence, the president-elect is the presiding officer. In the absence of both, past-presidents, in reverse order of service, are called on to preside.

Section H. Recording Officer
The executive director is the recording officer and custodian of the House records. Staff and/or a professional recorder may be used to obtain a record of the House proceedings. The executive director ensures that a record of the proceedings is published annually in the Association’s Proceedings.

Section I. Parliamentarian
The executive director, with the approval of the Board of Directors, appoints the parliamentarian.

Section J. Order of Business, Regular Session
The order of business at a regular session of the House of Delegates is as follows, unless changed by a two-thirds affirmative vote of the delegates present and voting:
1. Call to order,
2. Report of quorum by executive director,
3. Approval of minutes of previous session,
4. Reports of officers,
5. Report of Board of Directors,
6. Referrals of reports and resolutions,
7. Action on resolutions,
8. Unfinished business,
9. New business,
10. Installation of officers, and
11. Adjournment.
Section K. Order of Business, Special Session
The order of business at a special session is as follows:
1. Call to order,
2. Report of quorum by executive director,
3. Reading of call for special session,
4. Transaction of business as provided in call, and
5. Adjournment.

Section L. Rules of Order
The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the House’s deliberations when not in conflict with these Bylaws.

Section M. Presentation of Resolutions
Resolutions may be presented to the House of Delegates at annual sessions by:
1. The Board of Directors in writing at the Opening Session of the House, and
2. Any delegate in writing at the Opening Session of the House of Delegates.
   Between annual sessions, any individual member may submit a resolution to the Board of Directors, which may forward it to the House of Delegates at the next annual session with a recommendation for action. The Board of Directors may submit resolutions to an appropriate Association component group for advice before forwarding the resolution to the House of Delegates.
   Resolutions proposing expenditure of Association funds must be accompanied by a cost impact statement estimating the amount of funds required and the period of expenditure. Staff assists resolution drafters in estimating expenditures and periods of expenditure, if requested to do so.
   Resolutions proposing changes in the ADEA policies and Bylaws must specify how the ADEA Policy Statements, Position Papers, and Bylaws would be affected.

Section N. Reference Committees
Reference committee members are appointed annually by the Board of Directors. Reference committees hold hearings at the annual sessions on resolutions going to the House of Delegates and make recommendations on those resolutions.

Chapter V: Board of Directors

Section A. Function
The Board of Directors is the Association’s administrative body.

Section B. Composition
The Board of Directors consists of the Association’s elected officers, as specified in Chapter III of these Bylaws, and the executive director (an ex officio member), which comprise a board of eleven members.

Section C. Alternates
A vice president who is unable to attend a Board of Directors meeting may designate one of the other elected council officers to attend in his or her place as a voting member of the Board of Directors for that meeting. The principal officers may not designate alternates.
Section D. Powers and Duties
The Board of Directors has the following powers and duties:
1. To serve as the Association’s administrative body;
2. When the House of Delegates is not in session, to establish ad hoc interim policies, provided that such policies are not in conflict with existing Association policy and are presented for review at the next session of the House;
3. To establish rules and regulations consistent with the Bylaws and to govern the organization, procedure, and conduct of those rules;
4. To report its actions to the House of Delegates at each annual session;
5. To conduct the Association’s planning, including the development of strategic, operational, and related plans, and to apprise the House of Delegates of those plans;
6. To nominate 1) a candidate(s) for ADEA president-elect; 2) candidates for honorary membership; and 3) candidates for membership in other organizations, as well as to appoint representatives to other organizations;
7. To appoint and evaluate the executive director; and
8. To ensure that all accounts of the Association are audited annually and to prepare for House approval of an annual operating budget for the following fiscal year.

Section E. Sessions
1. Regular Sessions. The Board of Directors normally meets at least four times a year either in person or by teleconference.
2. Special Sessions. The president may call a special session at the request of at least three board members, provided that notice of the special session is sent to each member at least ten days before the meeting. No other business except that provided for in the call may be considered unless the members present unanimously agree to consider additional business.

Section F. Quorum
A majority of the board’s members constitutes a quorum for the transaction of business at regular or special sessions.

Section G. Presiding Officer
The president is the presiding officer, and in the president’s absence, the president-elect. In the absence of both, the immediate past-president is the presiding officer.

Section H. Recording Officer
The executive director is the recording officer. Staff and/or a professional recorder may be used to obtain a record of meetings.

Section I. Rules of Order
The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the Board of Directors’ deliberations when not in conflict with these Bylaws.

Section J. Unanimous Consent Mail Ballots
The Board of Directors is authorized to transact business by unanimous consent in the form of mail ballot. Mail ballots may be sent and returned by mail, facsimile transmission (fax), and/or electronic mail (email). The results of mail ballots are as binding as those obtained at official meetings. The following regulations apply to all mail ballots:
1. Mail ballots should be initiated by an officer or appropriate staff member;
2. Each mail ballot should set forth the specific actions to be considered by the Board of Directors and include a line for his or her signature;  
3. A unanimous vote of all the directors then in office is required for approval; and  
4. Ballots not returned within thirty days will not be counted.

Chapter VI: Finance Committee of the Board of Directors

Section A. Functions  
The Finance Committee is responsible for assisting the executive director in preparing the Association’s budget, monitoring the Association’s finances, and reporting progress and recommendations to the Board of Directors and House of Delegates.

Section B. Composition  
The Finance Committee consists of the immediate past-president, who is chair, and the president and president-elect.

Section C. Sessions  
The Finance Committee meets as requested by the Board of Directors and normally in conjunction with Board meetings.

Section D. Quorum  
A majority of the committee’s members constitutes a quorum for the transaction of business.

Section E. Rules of Order  
The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the deliberations of the Finance Committee when not in conflict with these Bylaws.

Section F. Fiscal Year  
The Association’s fiscal year runs from July 1 through June 30.

Section G. Budget  
The Board of Directors at each annual session submits an operating budget for the following fiscal year to the House of Delegates for approval.

Chapter VII: Other Standing and Special Committees of the Board of Directors

Section A. Authority  
The Board of Directors may appoint standing and special committees to assist it in performing its duties. In all such appointments, the Board of Directors should consider women and under-represented minorities to serve on such committees. While committees of the board must always have two or more directors, and directors must constitute a majority of committee membership, the board may also appoint advisory committees. Advisory committees may include any individual member of the association and have no limitations concerning director membership.
Chapter VIII: Councils

Section A. Functions
All but one of the councils (the Council of Sections) represent institutions and programs in each of the Association’s institutional membership categories. The Council of Sections represents the Association’s sections. In addition, each council has the following functions:

1. To represent its constituency within the Association and at the member institutions;
2. To recommend to the Board of Directors how the interests of the council’s constituency might be represented through the federal legislative and regulatory processes;
3. To exchange information among its members, with other ADEA component groups, and among member institutions;
4. To work with other ADEA component groups to encourage coordinated approaches to dental and allied dental education and health care delivery;
5. To identify and provide consultation on projects, studies, and reports that will benefit the membership;
6. To introduce resolutions to the Board of Directors and/or House of Delegates; and
7. To meet at annual sessions.

Section B. Composition
The Association’s councils consist of the following members. All council members must be individual members of the Association.

1. The Council of Allied Dental Program Directors consists of the directors (or their alternates) of dental assisting, dental hygiene, and dental laboratory technology education programs in each active, provisional, and affiliate member institution. In member institutions offering more than one allied dental education program, the person (or an alternate) who is the department/division chair or head is also a member of the council. Council membership may also include the directors (or their alternates) of special allied dental education programs at the post-entry level that lead to a baccalaureate or advanced degree. In addition, a member of the Administrative Board who is no longer in any of the above categories may remain a member of the council for the duration of his or her term(s).

Representation in the House of Delegates. The Council of Allied Dental Program Directors is represented in the House by one delegate for every ten of its member programs (or major portion thereof) in each of its four membership categories—dental assisting education, dental hygiene education, dental laboratory technology education, and special allied dental education. Each category is represented by at least two delegates, except for the category of special allied dental education, which is represented by at least one delegate. Administrative Board members are delegates, even if they are additional delegates in their category. The council Administrative Board nominates two candidates for each delegate position that will not be filled by an Administrative Board member. Delegates are then elected by mail balloting of the entire council. Delegates are elected to one-year terms and may be reelected.

2. The Council of Deans consists of the dean (or an alternate) of each active and provisional member institution, the chief dental administrator (or an alternate) of each affiliate member institution conducting non-hospital-based postdoctoral dental education programs, the chief dental officer or administrator (or an alternate) of each affiliate-member federal dental service, and the president (or an alternate) of the
Association of Canadian Faculties of Dentistry. In addition, the council includes any members of its Administrative Board who are no longer in the above categories. 

**Representation in the House of Delegates.** All members of the Council of Deans serve as delegates in the House.

3. **The Council of Faculties** consists of one faculty member (or an alternate) elected by the faculty of each active and provisional member institution, in addition to any members of the Administrative Board who are no longer in the above category. Members are elected to three-year terms, and approximately one-third of the members are replaced or reelected annually according to a schedule maintained in the Central Office. The methods of electing members, removing members for cause, and electing new members to fill unexpired terms are left to the discretion of individual member institutions. Each faculty electing or reelecting a member in a given year is required to notify the Central Office of the name of its representative by January 1 preceding the annual session at which the incumbent faculty member’s term ends.

**Representation in the House of Delegates.** All members of the Council of Faculties serve as delegates in the House.

4. **The Council of Hospitals and Advanced Education Programs** consists of the chief of hospital dental service and directors of each accredited residency program in active or provisional member institutions (including hospitals under the same governance as a dental school) and in hospitals that are affiliate members, in addition to any members of the council Administrative Board who are no longer in the above categories and one representative of all non-recognized specialty programs at each institution described above. Each ADEA-member federal dental service may appoint a nonvoting representative to attend meetings of the Council of Hospitals and Advanced Education Programs.

**Representation in the House of Delegates.** The Council of Hospitals and Advanced Education Programs is represented in the House by one delegate for every ten of its member programs (or major portion thereof). Regardless of the number of member programs, the Council is represented by at least sixteen delegates (the five members of the Administrative Board and one representative each from the recognized and/or accredited programs by the Commission on Dental Accreditation). All Administrative Board members must serve as delegates. The Council Administrative Board, at its annual interim meeting, nominates at least one candidate for each delegate position beyond the sixteen that will not be filled by an Administrative Board member or a recognized specialty representative. Delegates are elected at the ADEA annual session immediately preceding the year of service. Delegates are elected to one-year terms and may be reelected.

5. **The Council of Sections** consists of the councilor and chair (or their alternates) of each Association section, in addition to any members of the Council Administrative Board who are no longer councilors or chairs of their section. In addition, the chair-elect and secretary from each section are eligible to participate in council meetings and may vote at those meetings. Section chairs-elect and secretaries are not eligible for election to council office.

**Representation in the House of Delegates.** The Council of Sections is represented in the House by the chair of each section and a councilor elected by each section to a three-year term. Councilors may be reelected to one additional three-year term. Council Administrative Board members who are not section chairs or councilors also serve as delegates. If a section chair and/or councilor is unable to serve as a delegate, the section’s chair-elect and/or secretary serve as delegate alternates.
Section chairs-elect and secretaries are not eligible to sit with the council in the House of Delegates unless they have been appointed delegate alternates.

6. **The Council of Students, Residents, and Fellows** consists of students representing any of the following types of programs conducted by each active, provisional, and affiliate member institution: 1) one representative for a program leading to the D.D.S. or D.M.D. degree, 2) one representative for all students enrolled in postdoctoral education programs, 3) one representative for each dental hygiene education program, 4) one representative for each dental assisting education program, and 5) one representative for each dental laboratory technology education program. The methods of electing members, removing members for cause, and electing new members to fill unexpired terms are left to the discretion of individual member institutions. Each member institution’s chief administrator is required to notify the Central Office of the name(s) of its representative(s) within sixty days after an annual session. Members are elected to one-year terms and may be reelected.

**Representation in the House of Delegates.** The Council of Students, Residents, and Fellows is represented in the House by its Administrative Board, in addition to twelve predoctoral dental students, two each from the six regions recognized by the council; four postdoctoral dental students, two from hospital programs and two from non-hospital-based programs; and six allied dental students, two each from dental hygiene, dental assisting, and dental laboratory technology education programs. Delegates are elected to one-year terms and may be reelected. All delegates are elected by the Council of Students, Residents, and Fellows at the annual sessions.

7. **Alternates.** Council members unable to attend a House of Delegates session or a council meeting, or who serve in the House in two or more positions (e.g., as a member of the Council of Faculties and Council of Sections), may appoint alternates to represent them. Members of the Councils of Allied Dental Program Directors; Hospitals and Advanced Education Programs; and Students, Residents, and Fellows must appoint alternates who are members of their council. Members of the Council of Sections must appoint the chair-elect or secretary of their section. Members of the Councils of Deans and Faculties must appoint individuals from their institutions. Delegates representing two or more councils in the House must decide which council they wish to represent and then appoint an alternate(s) for the other council(s) according to the foregoing guidelines. All alternates must be ADEA individual members.

**Section C. Administrative Boards**

1. **Names of Officers.** Each council has an administrative board consisting of a chair, chair-elect (vice-chair for the Council of Students, Residents, and Fellows), secretary, member-at-large, and vice president (ex officio).

2. **Qualifications.** A person must be an individual member of the Association and a member of his or her council to be eligible for a council office, with the exception that past Administrative Board members of the Council of Sections who may no longer be members of the council are eligible for nomination as vice president for sections.

3. **Duties**
   a. **Chairs.** It is the duty of chairs:
      1) To provide leadership in meeting council goals and objectives;
      2) To chair council meetings; and
      3) To plan programs for council meetings.
   b. **Chairs-Elect.** It is the duty of chairs-elect:
      1) To chair council meetings in the absence of the chair;
2) To perform any duties requested by the chair; and
3) To serve as chair of the nominating committee to select candidates for council office.

c. **Secretaries.** It is the duty of secretaries:
   1) To record the minutes of council and administrative board meetings or to see that they are recorded;
   2) To submit the minutes of council annual session meetings to the Central Office within sixty days after the session; and
   3) To perform any duties requested by the chair.

d. **Members-at-Large.** It is the duty of members-at-large:
   1) To perform any duties requested by the chair.

e. **Vice Presidents.** It is the duty of vice presidents:
   1) To serve as ex officio council officers and Association officers;
   2) To represent the councils’ interests on the Board of Directors;
   3) To serve as consultants from the Board of Directors to the councils in conducting their business and meeting their objectives; and
   4) To report Board of Directors’ actions to the council.

4. **Succession.** Except for the Council of Students, Residents, and Fellows, each year, the member-at-large succeeds to the office of secretary, the secretary to the office of chair-elect, and the chair-elect to the office of chair. For the Council of Students, Residents, and Fellows, offices are not automatically successive.

5. **Nominations.** Before each annual session, the chair-elect and two council members who are not officers nominate one or more individuals for the office of member-at-large (and vice president if the incumbent vice president will complete a term at the end of the annual session). For the Council of Students, Residents, and Fellows, the vice-chair and two council members who are not officers nominate one or more individuals for the offices of member-at-large, secretary, vice-chair, chair, and vice president. Additional nominations may be made from the floor at the councils’ annual session meetings.

6. **Election and Appointment.** Council officers are elected at council annual session meetings. The method of voting is left to the discretion of the council chairs. For the Council of Students, Residents, and Fellows, immediately after the annual session, the four members of the new administrative board appoint a council member to serve as a member-at-large.

7. **Installation.** All council officers, except vice presidents, are installed at council annual session meetings. Vice presidents are installed at annual sessions at the Closing Session of the House of Delegates.

8. **Terms of Office.** All council officers, except vice presidents, serve one-year terms. Vice presidents serve three-year terms, except for the vice president for students, residents, and fellows, who may serve up to three consecutive one-year terms if the individual qualifies for membership on the Council of Students, Residents, and Fellows during that entire period. An individual who has served a full term as a vice president (or three consecutive one-year terms as a vice president for students, residents, and fellows), chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.

9. **Replacement.** An administrative board member who ceases to qualify for membership on a council may continue as a council officer for the duration of his or her term(s) on the board. A board member who completely ceases to be active in dental and/or allied dental education must resign his or her office on the council. In the event of the death, resignation, or removal of a council officer, the council administrative board appoints a non-board member of the council to complete the
unexpired term(s) of office; provided, however, that if the vacancy created by such death, resignation, or removal is for the office of the vice president, then the council administrative board shall appoint a non-board member of the council to serve as the vice president until the next annual session meeting of the council, at which annual session an election (in accordance with this Chapter VIII) shall be held to fill the remainder of the term of the office of the vice president that became vacant by reason of such death, resignation, or removal.

10. **Alternates.** Council officers may not send alternates to attend council administrative board or House of Delegates meetings in their place.

**Section D. Sessions**
All councils meet at annual sessions. Administrative boards plan annual session programs and submit program details to the Central Office for publication in the annual session program. The schedule of council programs is determined by the Board of Directors. Councils able to provide funding may hold additional conferences between annual sessions.

**Section E. Quorum**
A majority of the members of a council constitutes a quorum for the transaction of business.

**Section F. Rules**
The rules for councils are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws.

**Chapter IX: Corporate Council**

**Section A. Functions**
The Corporate Council has the following functions:
1. To represent the corporate members within the Association;
2. To apprise corporate members of relevant Association activities;
3. To establish criteria for, and advise the Board of Directors on, approval of applications for corporate membership;
4. To exchange information among its members, with other component groups of the Association, and among the Association’s member institutions;
5. To serve in a liaison role between the corporate and academic members of the Association;
6. To impart corporate members' knowledge to other Association members;
7. To work with other component groups of the Association to encourage coordinated approaches to dental and allied dental education and care delivery;
8. To identify projects, studies, and reports that will benefit the Council’s and/or Association’s membership and to provide consultation on those projects, studies, and reports;
9. To introduce appropriate resolutions to the House of Delegates and/or Board of Directors; and
10. To meet at annual sessions.

**Section B. Composition**
The Corporate Council consists of the official representative of each corporate member.
Section C. Representation in the House of Delegates
The Corporate Council is represented in the House of Delegates by three of its four elected officers: the 1) chair, 2) chair-elect, and 3) vice president.

Section D. Officers
1. **Names.** The Corporate Council has five officers: a chair, chair-elect, secretary, member-at-large, and vice president (ex officio).
2. **Qualifications.** An individual must be a member of the Corporate Council to be eligible for a Corporate Council office.
3. **Duties**
   a. **Chair.** It is the duty of the chair:
      1) To provide leadership in meeting Corporate Council goals and objectives;
      2) To chair Corporate Council meetings; and
      3) To plan programs for Corporate Council meetings.
   b. **Chair-Elect.** It is the duty of the chair-elect:
      1) To chair Corporate Council meetings in the absence of the chair;
      2) To perform any duties requested by the chair; and
      3) To serve as chair of the nominating committee to select candidates for Corporate Council office.
   c. **Secretary.** It is the duty of the secretary:
      1) To record the minutes of Corporate Council meetings or to see that they are recorded;
      2) To submit the minutes of the Corporate Council’s annual session meetings to the Central Office within sixty days; and
      3) To perform any duties requested by the chair.
   d. **Member-at-Large.** It is the duty of the member-at-large to perform any duties requested by the chair.
   e. **Vice President.** It is the duty of the vice president:
      1) To serve as a Corporate Council officer and a voting member of the Board of Directors;
      2) To represent the council’s interests on the Board of Directors;
      3) To serve as a consultant from the Board of Directors to the council in conducting its business and meeting its objectives; and
      4) To report Board of Directors’ actions to the council.
4. **Succession.** Each year, the member-at-large succeeds to the office of secretary, the secretary succeeds to the office of chair-elect, and the chair-elect to the office of chair.
5. **Nominations.** Before each annual session, the Corporate Council nominates one or more individuals for the office of member-at-large and, if necessary, vice president. Additional nominations may be made from the floor at the council’s annual session meeting.
6. **Election and Appointment.** Corporate Council officers are elected at the council’s annual session meetings. The method of voting is left to the discretion of the council chair.
7. **Installation.** All Corporate Council officers are installed at the council’s annual session meetings.
8. **Terms of Office.** All Corporate Council officers except vice presidents serve one-year terms.
9. **Limitation of Terms.** An individual who has served as vice president, chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.

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10. **Replacement.** An officer who ceases to be a member of the Corporate Council must resign the office at the time he or she ceases to be a member. In such an instance, or when a council officer resigns for any other reason, the other officers appoint another council member to serve out the unexpired term (or successive terms) of office. An individual may not hold two or more Corporate Council offices simultaneously.

11. **Alternates.** Corporate Council officers may not send alternates to attend meetings in their place, except that council officers unable to attend a House of Delegates session may appoint alternates to represent them. Such alternates must be members of the Corporate Council.

**Section E. Sessions**
The Corporate Council meets at annual sessions and may meet at other times of the year as appropriate. The officers plan annual session programs and submit program details to the Central Office for publication in the annual session program. The scheduling of the Corporate Council’s program is determined by the Board of Directors.

**Section F. Quorum**
A majority of the members of the Corporate Council constitutes a quorum for the transaction of business.

**Section G. Rules**
The rules for the Corporate Council are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws. In addition, the following rule applies to corporate members: they may not cite corporate membership for commercial purposes, e.g., to imply ADEA endorsement of products and services.

**Chapter X: Sections**

**Section A. Functions**
A Section is a programmatic group that provides an opportunity for its members to exchange information on the Section’s specific academic and administrative interests.

1. Both academic and administrative Sections are periodically asked by the House of Delegates, Board of Directors, president, and executive director to undertake assignments and to comment on appropriate materials.

2. A Section is further encouraged to initiate projects and studies of benefit to the Association and its members.

3. A Section may submit resolutions to the House of Delegates.

**Section B. Participation and Membership in a Section**
Each Section consists of any Individual, Student, Retired, and Honorary ADEA member interested in the Section’s particular academic or administrative area. An ADEA member may join any number of Sections and may vote, hold office, participate in the business affairs, and attend any meeting of a Section to which he or she belongs.

**Section C. Sections Listing**
The Association has the following Sections:
- Academic Affairs
- Anatomical Sciences
- Behavioral Sciences
Biochemistry, Nutrition, and Microbiology
Business and Financial Administration
Cariology
Clinic Administration
Clinical Simulation
Community and Preventive Dentistry
Comprehensive Care and General Dentistry
Continuing Education
Dental Anatomy and Occlusion
Dental Assisting Education
Dental Hygiene Education
Dental Informatics
Dental School Admissions Officers
Development, Alumni Affairs, and Public Relations
Educational Research/Development and Curriculum
Endodontics
Gay-Straight Alliance
Gerontology and Geriatrics Education
Graduate and Postgraduate Education
Minority Affairs
Operative Dentistry and Biomaterials
Oral and Maxillofacial Pathology
Oral and Maxillofacial Radiology
Oral and Maxillofacial Surgery, Anesthesia, and Hospital Dentistry
Oral Biology
Oral Diagnosis and Oral Medicine
Orthodontics
Pediatric Dentistry
Periodontics
Physiology, Pharmacology, and Therapeutics
Postdoctoral General Dentistry
Practice Management
Prosthodontics
Student Affairs and Financial Aid

Section D. Formation of a Section

1. To form a new Section, a group must have begun as a Special Interest Group (SIG; see Chapter XI, Section D. Formation of a SIG). When Section status is desired, the SIG must:
   a. Notify the chair of the Council of Sections Administrative Board and Council of Sections staff liaison of the intent to propose a new Section.
   b. Prepare a proposal to support the case following criteria established by the Council of Sections Administrative Board.
   c. Submit the completed proposal to the chair of the Council of Sections Administrative Board and the Council of Sections staff liaison no later than September 1.

2. The Council of Sections Administrative Board considers each proposal to form a new Section at its interim fall meeting.
   a. If the proposal is approved, the Council of Sections Administrative Board forwards the recommendation to the Board of Directors for consideration at its January meeting.
b. If the recommendation is approved by the Board of Directors, the Board of Directors forwards a resolution to form the new Section to the House of Delegates for hearing at the subsequent annual session.

c. Only the House has the authority to approve a resolution proposing a new Section. Upon approval by the House of Delegates, a new Section begins operation immediately. If the proposal is not approved, the SIG may resubmit its request in a subsequent year.

Section E. Review
The Council of Sections Administrative Board reviews each Section annually. A review of performance is based on criteria established by the Council of Sections Administrative Board and announced annually in advance of the review.

1. The Administrative Board may impose corrective actions, including probation, for those Sections that fail to submit annual reports or perform prescribed functions.
2. The Council of Sections Administrative Board may recommend that a Section be disbanded or suggest that two or more Sections be merged into one Section based on strong similarities.
   a. The Council of Sections Administrative Board forwards a recommendation that a Section be disbanded or merged to the Board of Directors.
   b. If the recommendation is approved by the Board of Directors, the Board of Directors forwards an appropriately worded resolution to the House of Delegates for hearing at the subsequent annual session.
   c. Only the House of Delegates has the authority to disband a Section or merge Sections.

Section F. Officers and Term of Office
Each Section has a councilor, who serves a three-year term of office, and a chair, chair-elect, and secretary, who serve one-year terms in each office in succession.

1. Qualifications. A person must be a member of the Association and a member of the Section to be eligible for office in that Section. In the instance of councilor, the person must first have served through the officer positions, including the chair, to be eligible for election to the councilor position.

2. Duties.
   a. Councilor. The duties of a councilor are to:
      1) provide continuity of leadership for the Section and mentoring of new Section officers;
      2) attend the ADEA annual session and interim fall meetings of the Council of Sections;
      3) serve as a delegate in the House of Delegates during the annual session;
      4) assist in planning, implementing, and assessing Section programs and projects;
      5) prepare and submit the Section annual report after each annual session to the Council of Sections staff liaison; and
      6) serve as Section liaison to the Council of Sections Administrative Board.
   b. Chair. The duties of the chair are to:
      1) provide leadership in the coordination of Section activities;
      2) chair Section meetings;
      3) plan programs for Section meetings; and
      4) serve as a delegate in the House of Delegates during the annual session.
   c. Chair-Elect. The duties of the chair-elect are to:
      1) serve as chair in the absence of the chair;
2) perform any Section-related duties requested by the chair;
3) serve as chair of the nominating committee to select candidates for Section office; and
4) serve as the program chair for the Section and be responsible for submitting program proposals annually to the ADEA Annual Session Planning Committee for review.

d. **Secretary.** The duties of the secretary are to:
   1) record the minutes of Section meetings and disseminate them to the Section membership;
   2) submit the minutes and current officer contact information to the Section councilor for submission with the Section annual report to the Council of Sections staff liaison;
   3) publish and disseminate a Section newsletter; and
   4) perform any Section-related duties requested by the chair.

3. **Succession.** Each year the secretary succeeds to the office of chair-elect, and the chair-elect succeeds to the office of chair. There is no automatic succession to the office of councilor.

4. **Nominations.** Before each annual session, the nominating committee (chair-elect and two Section members who are not officers) nominates one or more individuals for the office of secretary. Every third year, the committee nominates one or more individuals for the office of councilor. Additional nominations for these offices may be made from the floor at the Section annual session business meeting.

5. **Election.** Section officers are elected at the Section business meeting held at the annual session. The method of voting is left to the discretion of the chair.

6. **Installation.** All Section officers take office after the conclusion of the Closing of the House of Delegates at the annual session.

7. **Consecutive and Simultaneous Terms of Office.** A Section councilor may serve two consecutive three-year terms. A person may not hold more than one Section officer position simultaneously or hold office in more than one Section simultaneously.

8. **Replacement of Vacancy.** If the position of chair, chair-elect, or secretary becomes vacant, the remaining Section officers appoint another member of the Section to serve out the unexpired term. If the councilor is unable to serve for any reason, a new councilor will be elected by mail or electronic ballot by the Section members to serve out the unexpired term.

**Section G. Quorum**
Sections have no quorum requirement for the conduct of business.

**Section H. Rules**
The rules for Sections are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws.

**Chapter XI: Special Interest Groups**

**Section A. Functions**
A Special Interest Group (SIG) provides an opportunity for its members to exchange information and work together on specific academic or administrative interests in dental, allied dental, and advanced dental education. The structure of a SIG provides an opportunity and allows a means for a group of ADEA members to focus on areas of common interest.
1. A SIG may be assigned tasks by the Board of Directors, House of Delegates, or the Council of Sections Administrative Board on related studies of benefit to the Association and its members.
2. Each SIG chair may be an active but nonvoting member of the Council of Sections.
3. A SIG is not represented in the House of Delegates and may not submit a resolution to the House of Delegates.

**Section B. Participation and Membership in a SIG**
A Special Interest Group consists of any Individual, Student, Retired, and Honorary ADEA member interested in the SIG’s particular academic or administrative area. An ADEA member may join any number of SIGs and attend any meetings of a SIG to which he or she belongs.

**Section C. Special Interest Groups Listing**
The Association has the following SIGs:
- Career Development for the New Educator
- Dental Hygiene Clinical Coordinators
- Foreign-Educated Dental Professionals
- Graduate Dental Hygiene Program Directors
- Implant Dentistry
- Lasers in Dentistry
- Professional, Ethical and Legal Issues
- Scholarship of Teaching and Learning
- Temporomandibular Disorders
- Tobacco-Free Initiatives

**Section D. Formation of a Special Interest Group**
1. To form a new Special Interest Group, an individual or group must:
   a. Notify the chair of the Council of Sections Administrative Board and the Council of Sections staff liaison of the intent to propose a new SIG.
   b. Prepare a proposal to support the case following criteria established by the Council of Sections Administrative Board.
   c. Submit the completed proposal to the chair of the Council of Sections Administrative Board and the Council of Sections staff liaison.
2. The Council of Sections Administrative Board considers each proposal.
   a. If the proposal is approved, the Council of Sections Administrative Board forwards its recommendation to the Board of Directors for review at the board meeting subsequent to approval of the proposal.
   b. If the proposal is approved by the Board of Directors, the SIG begins operation immediately upon notification by the chair of the Council of Sections Administrative Board.

**Section E. Becoming a Section**
1. After two to five years of viable leadership and sustainable membership, a SIG may apply to form a Section although it is not required to do so.
2. If the SIG chooses to form a Section, it must form a leadership organizational structure similar to that of a Section by electing or appointing a chair, chair-elect, and secretary.
Section F. Review

Each year, the Council of Sections Administrative Board reviews each SIG and its performance based on criteria established by the Council of Sections Administrative Board.

1. The Administrative Board may impose corrective actions, including probation, for a SIG that fails to submit an annual report or perform prescribed functions.
2. The Council of Sections Administrative Board may disband a SIG.

Section G. Officer and Term of Office

Each Special Interest Group must have a chair, who serves a one-year term. The SIG may have a leadership structure similar to that of a Section (i.e., chair, chair-elect, and secretary), but it is not required to do so.

1. Qualifications. A person must be a member of the Association and a member of the SIG to be eligible for office in that SIG.
2. Duties.
   a. Chair. The duties of the chair are to:
      1) provide leadership in the coordination of SIG activities;
      2) chair SIG meetings;
      3) plan programs for SIG meetings;
      4) record the minutes of SIG meetings and disseminate them to the SIG membership; and
      5) submit the SIG annual report, business meeting minutes, and current officer contact information to the Council of Sections staff liaison.
   b. If a SIG chooses to have a leadership organizational structure similar to that of a Section, see Chapter X. Section F. Articles 2b–2d for officer duties.
3. Succession. If a SIG chooses to have a leadership organizational structure similar to that of a Section (i.e., chair, chair-elect, and secretary), the secretary succeeds to the office of chair-elect, and the chair-elect succeeds to the office of chair.
4. Nominations. If a SIG has a leadership organizational structure similar to that of a Section, before each annual session, the nominating committee (chair-elect and two SIG members who are not officers) nominates one or more individuals for the office of secretary.
5. Elections. Each year, a chair is elected to serve a one-year term. SIG officers are elected at the SIG business meeting held at the annual session.
6. Installation. A SIG officer takes office at the conclusion of the annual session.
7. Consecutive and Simultaneous Terms of Office. A SIG chair serves a one-year term. If the SIG chooses to maintain one officer position versus creating the organizational structure of a Section, the position of chair must be reaffirmed by the membership annually. A person may not hold office in more than one SIG simultaneously.
8. Replacement of Vacancy
   a. If the position of chair becomes vacant, the SIG members must nominate and elect another member of the SIG to serve out the unexpired term by mail or electronic ballot.
   b. If a SIG chooses to have a leadership organizational structure similar to that of a Section (i.e., chair, chair-elect, and secretary), the remaining officers will appoint a SIG member to serve out the unexpired term of the officer whose position has become vacant.

Section H. Quorum

Special Interest Groups have no quorum requirement to conduct business.
Section I. Rules
The rules for Special Interest Groups are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws.

Chapter XII: Rules for Councils, the Corporate Council, Sections, and Special Interest Groups

The above groups are hereinafter referred to in this chapter as “component groups” or “groups.”

Section A. Finances
Component groups conduct their own financial affairs; however, records and accounts are maintained in the Central Office. A special allocation, the amount of which is determined annually by the Board of Directors and House of Delegates, is available for the group’s annual expenditures. The allocated funds may be used by a group for any reasonable expenditures. The group may charge annual session expenditures to the Association’s master account, provided that an appropriate request is submitted to the Central Office at least sixty days before an annual session. Groups anticipating expenditures in excess of their annual allocation must submit to the Board of Directors a written request for additional expenditures. In addition, all group requests for funding from outside organizations must receive prior Board of Directors’ approval.

Section B. Employment
Component groups may not employ an individual whose services may require reimbursement by the Association, except on authorization of the Board of Directors.

Section C. Contracts
Component groups may not produce a contract that in any way involves the Association, except on authorization of the Board of Directors.

Section D. Establishment of Policy
Component groups have the privilege of recommending Association policy. However, they are not authorized to initiate or implement a new policy or to alter or extend an existing policy without prior review and approval by the Board of Directors and the House of Delegates.

Section E. Public Statements
Component groups and their members may not issue a public statement in the name of either the group or the Association unless 1) authority has been granted by the Board of Directors, and 2) the statement is clearly in accord with policies of the Association as expressed by the House of Delegates and the Board of Directors.

Section F. Communication
Communications dealing with major component group activities or policy should be sent to all group members by the chair or another officer.

Section G. Relations with Other Organizations and Agencies
No component group is authorized to appoint an official representative to another organization unless authorized to do so by the Board of Directors.
Section H. Relations with Other Component Groups
Component group chairs should refer to the executive director all matters that properly are the concern of another component group. Requests for information or assistance from another component group should be channeled through the executive director’s office.

Section I. Additional Rules for Component Groups
Component groups may prepare additional rules needed to conduct their affairs, provided that those rules are consistent with the Association’s Bylaws. Such additional rules should be transmitted to the executive director for his or her records.

Section J. Rules of Order
The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the component groups’ deliberations in all cases when not in conflict with these Bylaws.

Section K. Mail Ballots
Component groups are authorized to transact business by mail ballot. Mail ballots may be sent and returned by mail, facsimile transmission (fax), and/or electronic mail (email). The results of mail ballots are as binding as those obtained at official meetings. The following regulations apply to all mail ballots:
1. Mail ballots should be initiated by an officer or appropriate staff member;
2. Each mail ballot should include enough information to allow recipients to register an opinion on the issue in question;
3. A majority affirmative vote of the ballots cast is required for approval; and
4. Ballots not returned within thirty days will not be counted.

Chapter XIII: Executive Director

Section A. Function
The executive director is the Association’s appointed chief administrative officer. In the absence of any other persons so appointed or elected by the Association, the executive director shall serve as the secretary and the treasurer of the Association.

Section B. Appointment
The executive director is appointed by the Board of Directors.

Section C. Tenure of Office and Salary
The Board of Directors determines the tenure of office and salary of the executive director. No one term may exceed five years.

Section D. Duties
1. To serve as the principal spokesperson for the Association, along with the president of the Board of Directors, in dealing with the profession and the public;
2. To serve as the chief administrator of the Central Office and all of its branches;
3. To provide for the maintenance of the Central Office and all property and offices owned or operated by the Association;
4. To employ and evaluate all members of the Association’s staff;
5. To coordinate the activities of all committees, councils, administrative boards, standing committees, and other Association component groups;
6. To approve applications for affiliate institutional membership;
7. To serve as the custodian of all monies, securities, and deeds belonging to the Association;
8. To prepare financial reports for the Board of Directors;
9. To disburse the Association’s funds at the direction of the Board of Directors, provided those disbursements are consistent with the annual budget approved by the House of Delegates;
10. To cause all employees entrusted with Association funds to be bonded by a surety company and to determine the amount of the bond;
11. To supervise the publication and distribution of all Association publications;
12. To determine the time and location of annual sessions;
13. To notify individual and institutional members of annual and special sessions of the House of Delegates;
14. To provide a program for annual sessions;
15. To present an annual report of the activities of the Central Office;
16. To publish an annual Proceedings of the Association; and
17. To perform such other duties as may be determined by the Board of Directors and the president.

Chapter XIV: Editor and Official Publication

Section A. Appointment of the Editor
The Association’s editor is appointed by the Board of Directors.

Section B. Tenure of Office and Remuneration
The Board of Directors determines the tenure of office and remuneration for the editor. No one term may exceed five years.

Section C. Duties of the Editor
1. To serve as the editor of the Journal of Dental Education;
2. To consult with the Board of Directors in the selection of the Editorial Review Board;
3. To exercise, with the Editorial Review Board, editorial control over the Journal of Dental Education, subject to the policies and procedures established by the Board of Directors and these Bylaws; and
4. To perform such other duties as may be determined by the Board of Directors.

Section D. Official Publication
1. Title. The Association publishes an official journal under the title of the Journal of Dental Education, hereinafter referred to as “the journal.”
2. Objective. The objective of the journal is to report, chronicle, and evaluate scientific and professional developments and Association activities of interest to dental and allied dental educators.
3. Frequency of Issue and Subscription Rate. The frequency of issue and the subscription rate of the journal are determined by the Board of Directors on recommendations of the editor and the Editorial Review Board.
4. Editor. The Association’s editor is the editor of the journal.
Chapter XV: Representatives to Other Organizations

Section A. Nominees for Membership on the Council on Dental Education and Licensure, Commission on Dental Accreditation, and the Joint Commission on National Dental Examinations

When necessary, the Board of Directors confers between November 1 and December 31 to select a candidate(s) for nomination to membership on the American Dental Association's Council on Dental Education and Licensure, a candidate(s) for nomination to the Commission on Dental Accreditation, and a candidate(s) for nomination to membership on the Joint Commission on National Dental Examinations.

The candidates are nominated at the same time the Board of Directors selects a nominee for president-elect. Additional nominations may be made from the floor at the Opening Session of the House of Delegates. If there are additional nominations, the election procedures are the same as those provided in Chapter III of these Bylaws. If there are no additional nominations, nominees are declared elected at the Opening Session. Individuals may not serve simultaneously as a principal officer of ADEA (president, president-elect, or immediate past-president) and as a member of the American Dental Association’s Council on Dental Education and Licensure or the Commission on Dental Accreditation.

Section B. Representatives to Other Organizations

Representatives to other organizations are appointed by the Board of Directors, which also determines the organizations to which the Association appoints such representatives.

Chapter XVI: Conflicts of Interest

Individuals who serve as Board of Directors members or are appointed or elected to represent the Association in its relations with other private organizations or government agencies; who serve as council, section, and/or special interest group officers; who serve in an advisory or consultative role for the Association individually or through group or committee assignments; or who are otherwise involved in Association policy and administrative matters do so in a representative or fiduciary capacity and, at all times while serving in such positions, shall further the interests of the Association as a whole. Those individuals should avoid:

1. Placing themselves in a position where personal or professional interests may conflict with their duty to the Association;
2. Using information learned through their position for personal gain or advantage; and
3. Obtaining for a third party an improper gain or advantage.

Individuals described in this chapter shall disclose to the executive director any situation that might be construed as placing the individual in a position of having an interest that may conflict with his or her duty to the Association. When doubt exists about whether there is a conflict, the doubt will be resolved by a majority vote of the Board of Directors.

While serving the Association, the individual shall comply with this conflicts of interest policy and avoid even the appearance of impropriety. When the conflict is relevant to a pending matter, the interested individual shall retire from the room, shall not participate in any deliberation or provide any information regarding the matter under consideration, and shall not vote on the matter. These actions should be noted in the meeting minutes. Such individuals have an ongoing duty to promptly inform the
executive director of any potential conflicts relevant to Association matters that have not previously been disclosed.

Chapter XVII: Indemnification and Limitation of Liability

Section A. Indemnification
Unless expressly prohibited by law, the Association shall fully indemnify any person made, or threatened to be made, a party to an action, suit, or proceeding (whether civil, criminal, administrative, or investigative) by reason of the fact that such person, or such person’s testator or intestate, is or was a director, officer, employee, or agent of the Association or serves or served any other enterprise at the request of the Association, against all expenses (including attorneys’ fees), judgments, fines, and amounts paid or to be paid in settlement incurred in connection with such action, suit, or proceeding.

Section B. Limitation of Liability
Provided the corporation maintains liability insurance with a limit of coverage of not less than $200,000 per individual claim and $500,000 per total claims that arise from the same occurrence, officers, directors, and other persons who perform services for the Association and who do not receive compensation other than reimbursement of expenses (“volunteers”) shall be immune from civil liability. Additionally, persons regularly employed to perform a service for a salary or wage (“employees”) shall not be held personally liable in damages for any action or omission in providing services or performing duties on behalf of the Association in an amount greater than the amount of total compensation (other than reimbursement of expenses) received during the twelve months immediately preceding the act or omission for which liability was imposed.

Regardless of the amount of liability insurance maintained, this limitation of liability for volunteers and employees shall not apply when the injury or damage was a result of the volunteer or employee’s willful misconduct, crime (unless the volunteer or employee had reasonable cause to believe that the act was lawful), transaction that resulted in an improper personal benefit of money, property, or service to the volunteer or employee, act or omission that occurred prior to the effective date of the District of Columbia Nonprofit Corporation Amendment Act of 1992, or act or omission that was not in good faith and was beyond the scope of authority of the corporation pursuant to this act or the corporate charter. This limitation of liability shall not apply to any licensed professional employee operating in his or her professional capacity. The Association is liable only to the extent of the applicable limits of insurance coverage it maintains.

Chapter XVIII: Amendments

Section A. Procedure to Amend the Bylaws
These Bylaws may be amended at an annual session of the House of Delegates by a two-thirds affirmative vote of the members present and voting, provided the proposed amendment is presented in writing to the House during the Opening Session. The vote on the amendment, or amendments, is taken during the Closing Session of the House of Delegates.

Section B. Procedure to Amend the Articles of Incorporation
The Articles of Incorporation of the Association may be amended at an annual session of the House of Delegates by a two-thirds affirmative vote of the members present and voting, provided the proposed amendment is presented in writing to the House during
the Opening Session. The vote on the amendment, or amendments, is taken during the Closing Session of the House of Delegates.
ADEA Policy Statements

With changes approved by the 2010 ADEA House of Delegates

Introduction

These policy statements as revised by the 2010 ADEA House of Delegates are intended as recommendations and guidelines for dental and allied dental education institutions and programs and personnel.

When used in this document, “dental education” refers to all aspects of academic dental, allied dental, and advanced dental institutions, unless otherwise indicated.

When used in this document, the term “institution” refers to the academic unit in which the educational program is housed.

The general topic of each policy statement appears in boldface at the beginning of the statement. All policy statements are subject to a sunset review every five years.

I. Education

A. Admissions

All dental education institutions and programs should:

1. Diverse System of Higher Education

Support and help enhance the diverse system of higher education. Continued autonomy and growth in the private and public sectors depend on the preservation of this diversity. The nation’s private and public systems of higher education are complementary and interdependent. Their preservation depends on the continued attention of all institutional members and ADEA itself. Students must have the freedom to choose, from the broad spectrum of dental education institutions and programs, the institution or program best designed to meet the student’s specific needs.

2. Number and Types of Practitioners Educated

Use the public’s need and demand for dental services as the criteria for determining the number and types of practitioners educated at an academic dental institution; and in partnership with appropriate federal, state, and local health agencies and state and local dental societies, constantly assess those needs and demands and the ability of the existing number and distribution of practitioners to meet them. Through ADEA, work with appropriate federal and state agencies to ensure consistent methods for collecting and assessing data to monitor demographic, epidemiological, and professional practice trends, so that dental education institutions and programs do not over- or underproduce practitioners in given areas. Collaborate with state and local dental societies and jointly advocate for federal and state funds and programs that will assist academic dental institutions in meeting projected workforce number and composition requirements, along with incentives and programs designed to achieve a more equitable distribution of practitioners to improve access to oral health care.

3. Preprofessional Recruitment Programs

Encourage their faculty and students to develop and sponsor preprofessional recruitment programs that help potential students assess career options, financial considerations, and various educational programs. Target high school and college students and education counselors at all levels about career options and appropriate academic preparatory requirements and interface with other professional organizations in these efforts.
4. **Admissions Criteria**
   Base admissions policies on specific objectives, criteria, and procedures designed to identify students with high standards of integrity, motivation, and resourcefulness and the basic knowledge and attitudes required for completing the curriculum. Nondiscriminatory policies should be followed in selecting students.

   The American Dental Education Association strongly endorses the continuous use of recruitment, admission, and retention practices that achieve excellence through diversity in American dental education. Dental education institutions and programs should identify, recruit, and retain underrepresented minority students and identify, recruit, and retain women students where inequities exist. Dental education institutions and programs should accept students from diverse backgrounds, who, on the basis of past and predicted performance, appear qualified to become competent dental professionals. Such efforts to achieve a diverse student body are predicated upon a highly qualified applicant pool and the support of private and public funding that benefits qualified disadvantaged individuals regardless of race, religion, ethnic background, gender, or sexual orientation. Dental education institutions should seek to identify and implement best practices in the recruitment and retention of underrepresented groups, including but not limited to:
   a. Commitment and proactive leadership to diversity initiatives from deans and program directors;
   b. Identification and implementation of admissions committee practices that promote diversity;
   c. Identification and use of noncognitive factors in admissions decisions;
   d. Regional collaboration among dental education programs to increase the numbers and qualifications of underrepresented individuals applying to dental education programs; and
   e. Collaboration with other organizations focused on increasing the numbers of under-represented minorities in the health professions.

6. **Institutions and Programs That Are Closing**
   If ceasing to accept new applicants, 1) adhere to the policy of the Commission on Dental Accreditation on termination of accredited education programs, 2) make a strong effort to complete the training of matriculated students, and 3) ensure that the school’s or program’s educational standards are maintained. Should the closing institution/program be unable to maintain a quality program, however, the institution/program should facilitate the transfer of students to other accredited institutions/programs.

7. **Accepting Students from Institutions and Programs That Are Closing.**
   All academic dental institutions should accept students from academic dental institutions/programs that are closing and assist those students in continuing their education in a reasonable amount of time and at reasonable expense.

8. **All predoctoral institutions should**
   a. **Preprofessional Education Requirements**
      - Grant final acceptance only to students who have completed at least two academic years of preprofessional education (which must include all of the prerequisite courses for dental school), and who have completed the Dental Admission Test or the Canadian Dental Aptitude Test. Applicants should be encouraged to earn their baccalaureate degrees before entering dental school.
b. Early Selection Programs
   - Have the option of waiving for students accepted for an early selection program the requirement for at least two years of preprofessional education. An early selection program is one where a formal and published agreement exists between a dental school and an undergraduate institution(s) that a student, either upon the student’s admission to the undergraduate institution or at some time before the completion of the student’s first academic year at the undergraduate institution, is guaranteed admission to the dental school, provided that the student successfully completes the dental school’s entrance requirements and normal application procedures.

c. Class to Which Applied
   - Consider students for acceptance to only the class to which they have applied.

d. Earliest Notification Date
   - Notify applicants, either orally or in writing, of provisional or final acceptance no earlier than December 1 of the academic year prior to the academic year of matriculation.

e. Applicant Response Periods
   - Allow an applicant who has been given a provisional or final acceptance between December 1 of the academic year prior to the academic year of matriculation and January 31 of the year of matriculation a response period of no fewer than thirty days. For applicants accepted on or after February 1, the minimum response period may be reduced to fifteen days. The response period may be lifted after May 15 of the year of matriculation.

f. Applicants Holding Positions at Multiple Institutions
   - Dental schools participating in AADSAS will report to AADSAS by April 1 the names and identification numbers of candidates who have paid a deposit and/or hold a position in their entering class. After April 5, AADSAS will report to each institution the names of candidates in their entering class who are holding acceptance(s) at additional institutions. Dental schools will have the option of rescinding an offer of admission to candidates who have paid deposits and are holding positions at multiple institutions. Dental schools with candidates holding multiple positions on April 1 of the year of admission will give such candidates a minimum fifteen-day notice if they choose to withdraw them from the entering class until May 15, after which notification times may be shortened. This policy will be evaluated every two years by the ADEA Section on Dental School Admissions Officers to assess its impact on applicants and dental schools and provide applicants a reasonable time frame to complete their enrollment process.

B. Ethics and Professionalism
   - Dental education institutions and programs should:
     1. Ethical Behavior
        - Through faculty development and other means, emphasize to faculty the importance of ethical behavior in the profession and emphasize this importance to their students. Further, dental education institutions and programs should implement criteria with appropriate due process procedures for dismissal or other actions when students violate ethical behavior.
2. **Formal Instruction in Ethical and Professional Behavior**
   Provide students with formal instruction in ethics and professional behavior, and make the students aware of acceptable professional conduct in instructional and practice settings. Institutions and programs should ensure that student clinical experiences foster ethical patient care.

3. **The Profession’s Societal Obligation**
   Ensure that both faculty and students are aware of the profession’s societal obligation. Provide formal instruction and faculty role models so that students clearly understand that society grants the privilege of professional education and self-regulation and that in return the oral health professional enters an implicit contract to serve the public good. Market forces, societal pressures, and professional self-interest should not compromise the professional objective of equitable and adequate oral health care for all Americans.

4. **Serving in Areas of Need**
   Offer programs that encourage students to serve in areas of oral health care need. These programs should be equally available to all students at a given educational institution and, when possible, implement an interdisciplinary care model.

5. **Community Service**
   Encourage students to participate in outreach programs and, upon graduation, to participate in community service.

6. **Professional Organizations**
   Encourage students to participate in professional organizations.

7. **Sexual Harassment Policy**
   Work with their parent institutions to have up-to-date policies and well-defined procedures for preventing and responding to incidents involving sexual harassment. Dental education institutions and programs should strive to go beyond legal compliance and risk management considerations to create and sustain a positive learning and working environment. While there are numerous definitions of sexual harassment, institutions and programs are encouraged to develop their own definitions that could be applied in a broad context, including *quid pro quo* and hostile environments.*

Dental education institutions and programs should, in concert with their parent institution, demonstrate their commitment to preventing and dealing with sexual harassment by:
   a. educating faculty, staff, students, and residents about the issue;
   b. employing prompt and equitable grievance procedures;
   c. setting forth formal and informal procedures and sanctions for dealing with instances of sexual harassment;
   d. creating an environment that encourages persons to come forward with problems;
   e. ensuring that policies address sexual harassment by any individuals in an interactive or supervisory role, whether they be peers, patients, students, or a third party;

* Examples of sexual harassment include the following: “Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to such is made either explicitly or implicitly a term or condition of an individual’s employment or academic advancement or when submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual” (ADEA Sexual Harassment Policy Statement, 1998). It also includes verbal or physical conduct that interferes with an individual’s work, professional or academic or career opportunities, or services/benefits. Nonsexual conduct, such as intimidation, hostility, rudeness, and name-calling, and unwelcome behaviors influenced by gender, ethnicity, religion, disability, sexual orientation, or age are also included.
f. including safeguards protecting confidentiality and prohibiting retaliation or reprisals;
g. implementing a process to continually monitor all aspects of the policy; and
h. reviewing and updating the policy periodically.

Information Management.
Dental education institutions and programs should demonstrate their commitment to the ethical and professional management of information by:
a. educating faculty, staff, and students on the issues of copyright and fair use of information both professionally and personally;
b. following copyright and fair use guidelines in the processes of information production and dissemination within the institution;
c. providing faculty, staff, and students with formal instruction on “information privacy” including their rights and responsibilities in safeguarding information that is confidential, both to the institution and individuals; and
d. following recognized guidelines, laws, and standards of care for management of patient information.

8. Confidentiality. Educate staff, students, and faculty to respect and protect patient confidentiality as part of professional interactions.

C. Curriculum
Curriculum Management
All dental education institutions and programs should:

1. Control and Management of Curriculum. Accept the right and responsibility for the curricula and academic programs under their purview, including the elimination of unplanned redundant material and management of the density of the curricula.

2. Flexibility and Experimentation. Support curriculum flexibility, evaluation, and experimentation in teaching methods, and oppose any attempt to change state practice acts that restrict such flexibility and experimentation.

3. Student Performance. Use stated criteria and demonstrated competencies as the primary basis for judging student performance.

4. Course Changes. Defer anticipated changes in the objectives or other aspects of an ongoing course until the course is completed.

5. Examination Policies. Develop institution- and program-wide examination policies. These policies should address such areas as:
a. Examinations reflecting stated course objectives;
b. Informing students of examination results in a timely manner; and
c. Providing for faculty-student discussion of examination content and results.

6. Competencies. Provide all resources, including patient experiences, to allow students to reach competence and demonstrate continuing competence in all areas defined by the institution.

7. Dental Institution/Program Affiliations. Institute and periodically update formal affiliations among dental schools and dental hygiene, assisting, and laboratory technology education programs.

8. Curriculum Length
   a. Predoctoral Dental Programs: should have four academic year curricula or the equivalent of four-year curricula provided in a flexible format.
   b. Dental Hygiene Programs: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.
   c. Dental Assisting Programs: should have curricula in a flexible format that consists of a minimum of one academic year or equivalent.
d. **Dental Laboratory Technology Programs**: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.

9. **Clinical Guidelines.** Provide predoctoral, advanced, and allied students with written clinical guidelines and expectations for graduation as soon as possible.

**Curriculum Content**

All dental education institutions and programs should:

1. **Goals and Objectives.** Base their curricula on sound, current educational philosophy and pedagogy in order to achieve defined goals and objectives that reflect contemporary methods of oral health care delivery.

2. **New Ideas and Methods.** Introduce new ideas and methods in their teaching in order to meet the changing needs of their students and the patients they will serve.

3. **Physical, Biological, Technical, and Behavioral Sciences.** Teach their students the physical, biological, technical, and behavioral sciences relevant to the practice of modern oral health care delivery.

4. **Working Within an Integrated Health System.** Develop and support new models of oral health care that involve other health professionals as team members in assessing the oral health status of patients and teach dental students to assume leadership roles in the detection, early recognition, and management of a broad range of complex oral and general diseases and conditions. When possible, interdisciplinary educational opportunities should be pursued.

5. **Student-Patient Contact.** Develop, review, and maintain appropriate clinical policies to ensure optimum clinical education and patient-centered care.

6. **Dental Research**
   a. **Predoctoral, advanced dental, baccalaureate, and graduate dental hygiene programs**: Teach the value, design, and methodology of dental research so that graduates may evaluate research findings and apply them to their practices.
   b. **Certificate or associate degree dental hygiene, dental assisting, and dental laboratory technician programs**: Teach the value of and apply scientific concepts from research findings.

7. **Basic Cardiac Life Support.** Ensure appropriate training and certification in basic cardiac life support for all students before they begin clinical activity and throughout clinical training. The training should be basic cardiac life support for the health professional and should be provided in accordance with accepted standards and recommended guidelines.

8. **Oral Health Care Team.** Provide experiences working as a member of an interdisciplinary health care team.

9. **Information Technology.** Provide formal instruction, develop skills, and provide opportunities in the use of computer-based applications and information systems. Support the timely access to information by faculty, staff, and students to enhance their knowledge, critical thinking, and decision making processes and promote quality patient care.

10. **Cultural and Linguistic Competence.** Include cultural and linguistic concepts as an integral component of their curricula to facilitate the provision of oral health care services. Cultural and linguistic concepts should be included in the measurable dental curriculum objectives.

11. **Care of Patients with Special Needs.** Work with the American Dental Association Commission on Dental Accreditation to adopt or strengthen accreditation standards at all levels of dental education related to competence in treatment of people with special needs. Include a requirement that graduates of dental education programs be...
able to manage or treat, consistent with their educational level, a variety of patients with complex medical and psychosocial conditions, including those with developmental and other disabilities, the very young, the elderly, and individuals with complex psychological and social conditions.

12. **Preparation for Patients with Special Needs.** Include both didactic instruction and clinical experiences involving special population groups such as the elderly, the very young, and patients with mental, medical, or physical disabilities in pre- and postdoctoral education as well as allied dental education.

**Dental hygiene education programs** should:

1. **Transfer of Credit.** Design curricula that facilitate transfer of credit from certificate and associate degree programs to baccalaureate degree programs in the same or a related discipline.

2. **Prepare Graduates for New and Emerging Responsibilities.** Monitor and anticipate changes in supervision requirements within the state and modify the curriculum and extramural experiences of students so as to prepare them to provide more extended services in a variety of practice settings.

3. **Collegiate-Level Dental Hygiene Curricula.** Develop and maintain curricula that are collegiate-level and lead to an associate or higher degree.

4. **Baccalaureate and Advanced Degree Hygiene Programs.** Be encouraged to offer baccalaureate and advanced degree programs for dental hygienists.

**D. Faculty Recruitment and Retention**

All dental education institutions and programs should:

1. **Faculty Qualifications.** Recruit faculty who have backgrounds in and current knowledge of the subject areas they are teaching and, where appropriate, educational theory and methodology, curriculum development, and test construction, measurement, and evaluation. Full-time dental assisting and dental laboratory technology faculty should hold a minimum of a baccalaureate degree. Full-time dental hygiene faculty should hold a minimum of a master's degree or should be in the process of obtaining a master's degree. Full-time dental faculty should hold a degree that is consistent with their teaching and research responsibilities.

2. **Promotion Criteria.** Develop and utilize promotion criteria that include teaching, research (if appropriate to the type of academic setting), and service, and relate those criteria to the activity assignment profile of each faculty member.

3. **Faculty and Administrative Evaluation.** 1) Evaluate faculty members', including administrative personnel's, effectiveness in order to improve the quality of the educational program; 2) see that evaluation is formal and encompasses all areas of faculty and administrative members' activity assignment profiles; 3) conduct evaluation at scheduled intervals, with input from a broad cross-section of appropriate personnel at the institution; and 4) give evaluation results appropriate emphasis when reappointment, promotion, and tenure are being considered.

4. **Gender and Minority Representation.** Identify, recruit, and retain underrepresented minorities to faculty positions and promote, when qualified, underrepresented minorities to senior faculty and administrative positions, proportional to their distribution in the general population. Appropriate gender equity should be a goal of any faculty recruitment, retention, and promotion plan.

5. **Debt Repayment.** Develop funding sources for debt repayment for young faculty.

6. **Alternative Compensation.** Creatively evaluate and implement nonmonetary incentives valued by faculty.
7. **Allied Dental Faculty.** Employ, as faculty of dental students, allied dental personnel who are graduates of programs accredited by the Commission on Dental Accreditation or the Canadian Dental Association.

8. **Mentoring Programs.** Develop and support formal mentoring programs as a means of recruiting, preparing, and retaining new dental and allied dental faculty, as well as a vehicle for developing and retaining existing faculty.

E. **Faculty Development**

**Introduction.** Faculty development is a continuous process, providing opportunities for professional growth within the academic environment. The purpose of faculty development is to enhance the ability of faculty to perform their expected functions as dental educators. Faculty development programs should 1) cover teaching, research, and service; 2) assist faculty in selecting activities that fulfill their goals and those of the department and institution; and 3) prepare faculty to assume leadership positions in dental and higher education. The institution and faculty share the responsibility for seeking and supporting faculty development. Faculty development programs should be broad-based and meet individual programmatic needs.

Dental education institutions and programs should:

1. **Emphasize Faculty Development.** Emphasize faculty development by providing or making available in-service training, instructional development support, teaching evaluation reports, scholarly activities, academic promotion guidance, and the technical and behavioral skills that facilitate the academic growth of the individual faculty member. Programs to encourage and train additional future dental and allied dental educators should also be available. Programs to train additional dental and allied dental educators should include advanced education in the discipline, as well as educational pedagogy.

2. **Mentoring Programs.** Mentoring programs for junior faculty should be developed and supported as a means of retaining faculty and ensuring their potential for future advancement. Such mentoring programs also have the potential to encourage senior faculty to maintain their currency and to create collaborative research and scholarship opportunities.

3. **Financial Support.** Provide financial support and other needed resources for faculty development programs, including incentives for faculty mentors.

4. **Sabbaticals and Leaves.** Grant faculty sabbaticals and other leaves with the same frequency and on the same basis as for other academicians in the educational institution.

5. **Evaluating Faculty Development Programs.** Periodically evaluate the availability, quality, and observable impact of faculty development initiatives in the departments, programs, sections, divisions, and other components of the institution or program.

F. **Committees**

Dental education institutions and programs should:

- **Student Members.** Allow students to serve as members with full standing on appropriate committees, with the student members’ privileges including, but not limited to, permission to 1) speak on any agenda items, 2) introduce and speak to any new business, and 3) vote on appropriate issues.

G. **Counseling**

Dental education institutions and programs should:
1. **Financial Aid Obligations.** Encourage close working relationships between their admissions and financial aid offices in order to counsel students early and effectively on their financial aid obligations and debt management.

2. **Psychological.** Provide student psychological counseling services by formally trained individuals knowledgeable about the particular problems faced by faculty, staff, and students.

3. **Alcohol, Tobacco, and Other Drug Abuse.** Provide education on alcohol, tobacco, and other drugs of abuse.

4. **Referrals for Substance Abuse.** Provide faculty, staff, and students with confidential referral mechanisms on substance abuse evaluation and treatment.

5. **Advanced Education and Professional Opportunities.** Counsel students on postdoctoral education and professional opportunities, and counsel undergraduate allied dental students on baccalaureate and graduate education opportunities.

6. **Medical.** Provide education and counseling on chronic diseases.

7. **Academic Counseling.** Provide academic counseling, including time and stress management, and study and test-taking skills.

8. **Advanced Education and Career Choices.** Encourage students to consider careers in research, education, administration, dental public health service, and the military.

**H. Accreditation**

Dental education institutions and programs should:

1. **Recognized Agencies.** Participate in an accreditation program conducted by a nongovernmental agency recognized by the secretary of the U.S. Department of Education or its equivalent.

2. **Commission on Dental Accreditation.** Recognize the Commission on Dental Accreditation and the Canadian Dental Association, through its Council on Education, as the official accrediting agencies for those dental and allied dental education programs within the purview of the commission and the Canadian Dental Association.

3. **Non-Recognized Specialties.** Ensure that dental education programs in special areas not recognized by the Commission on Dental Accreditation undergo institutional and external review at intervals comparable to those for recognized programs.

4. **Opposition to Preceptorship Training.** Oppose preceptorship training or other nonaccredited alternative programs for dentists, dental hygienists, dental assistants, and dental laboratory technicians.

**I. Finance**

Federal and state governments should:

1. **Public Funds for Dental Education.** Support public and private dental education institutions and programs, including providing funds to the fullest extent possible for student assistance, faculty salaries, maintenance, modernization, and construction of teaching facilities.

Federal, state, and private entities should:

2. **Funds for Advanced Education.** Provide support for advanced education programs preparing dentists and dental hygienists for careers in education, research, and public service.

Dental education institutions and programs should:

3. **Supplemental Funds.** Seek and use supplemental public and private funds if the conditions for accepting those funds do not jeopardize the quality of education or
result in loss of control of the educational process. Institutions are encouraged to use such funds only for targeted projects and not for ongoing support.

4. **Clinic Fee Schedules.** Adopt clinic fee schedules that adequately reflect the value of given services. Such reimbursement should be the same as that given to other providers in other settings for the same service. Further, dental education institutions and programs should ensure a fee schedule that promotes educational services to the student and provides care to the underserved.

5. **Policies on Patient Debt Management and Fee Collections.** Provide students, before their clinical experience, with a written statement of the school’s policy on patient debt management and fee collection.

6. **Support for Careers in Education, Research, and Public Service.** Provide fellowships, assistantships, loans, and loan forgiveness to support dental and allied dental personnel preparing for careers in education, research, and patient care services.

**J. Advanced Education**

Dental education institutions and programs offering advanced education should:

1. **Classic Education Patterns.** Conform their graduate dental education programs to classic educational patterns applicable to other academic disciplines, terminating in a graduate degree under the auspices of the university’s graduate school or a comparable agency of the university.

2. **Requirements for Master’s and Doctoral Degrees.** Award master’s and doctoral degrees in programs that include research and require a thesis or dissertation.

3. **Specialty Program Requirements.** Not require applicants to complete a general practice residency as a prerequisite for possible admission to a specialty education program.

4. **Advanced Education Program Affiliations.** Affiliate these advanced education programs with teaching hospitals and/or academic health centers, preferably those with dental schools or dental departments.

5. **Promoting the Goal of Advanced Education.** Coordinate the educational goals, objectives, and competencies of predoctoral and advanced dental education to allow for a designed continuum of the educational phases of a dental practitioner and ensure readiness as one moves from phase to phase. Encourage dental graduates to pursue postdoctoral dental education. Facilitate and advocate for the development of high-quality, accredited postgraduate education opportunities that build upon an effective predoctoral curriculum.

6. **Advanced Education and Residency Positions in Primary Care Dentistry.** Work to help ensure that the number of positions in advanced general dentistry and other advanced education programs in primary care dentistry is adequate to provide all dental graduates an opportunity to pursue postdoctoral dental education.

7. **Funding.** Advocate for increased funding and loan forgiveness for General Practice Residency and Advanced Education in General Dentistry Programs and accredited advanced dental education programs, particularly primary care programs, so that the number of positions and funding are sufficient to provide opportunities for all dental graduates to pursue a year of service and learning in an accredited PGY-1 program.

8. **Graduate Medical Education (GME).** Work with hospitals and organized dentistry groups to increase the number of and funding for dental residency training positions through GME.

9. **Stipends.** Whenever possible, provide stipends to dental residents and allied dental students in advanced education and clinical specialty programs.
Dental schools should:

1. **Disclosure of Class Rankings.** Disclose (with student consent) the class rankings, or equivalent measures of performance, of students applying to advanced education programs.

2. **Integration of New Knowledge and Skills.** Allow for dynamic incorporation of new knowledge and skills and/or standards of care.

3. **Interdisciplinary Communication.** Develop mechanisms for effective communication between organizations establishing credentialing and accreditation of advanced dental education training programs/residencies and those administering programs, as well as between the specialties themselves. Develop constructive relations between ADEA sections representing advanced education and specialty boards or organizations bestowing status on practicing members.

K. **Continuing Education**

Dental education institutions and programs should:

1. **Encouragement.** Strongly encourage their students to become lifelong learners and to participate meaningfully in continuing education throughout their professional careers.

2. **Student Attendance.** Give their students an opportunity to attend continuing education courses and professional development opportunities.

3. **Faculty Participation.** Create incentives for their faculty to conduct, attend, or participate in continuing education courses, and recognize attendance at ADEA annual sessions as a continuing education activity.

4. **Content.** Offer continuing education programs in the clinical, technical, behavioral, and biomedical sciences to improve the competencies of practitioners in general and specialty practice areas.

5. **Cooperation with Dental, Allied Dental, and Other Professional Organizations.** Cooperate with appropriate dental organizations in providing continuing education.

6. **Evaluation.** Frequently evaluate their continuing education courses for quality and content, soliciting impressions from appropriate groups about their continuing education needs.

7. **Community Service.** Develop mechanisms for academic dental institutions to encourage learning and to provide ongoing services in the form of information and training to former students and area professionals.

II. **Research**

A. **Fundamental and Applied Research**

Dental education institutions and programs have the right and responsibility to conduct fundamental and applied research in the natural and social sciences and in the area of health services, in particular as it relates to oral health disparities. Dental education institutions and programs should actively foster and support basic and applied clinical research. Incentives should be provided to encourage both faculty and students to actively participate in research as appropriate to the type of academic setting.

B. **Research Findings in Courses**

Dental educators should be expected to include new information and research findings in their courses of instruction and to encourage students to engage in critical thinking and research. Students should be encouraged to contribute to the development of new knowledge for the profession.
C. Commercial Sponsors
ADEA encourages dental education institutions and programs and dental educators to interact with commercial and other extramural sponsors of research, clinical trials, and demonstration projects, under conditions in which the academic rights of faculty are protected. These conditions include rights of publication, ownership of intellectual property, and rights of patent and copyright within institutional policy, subject to appropriate contractual protection of the sponsor’s legitimate interests.

D. Publication of Commercially Sponsored Research
ADEA encourages publication by faculty of the results of research, clinical trials, and demonstration projects supported by commercial and other extramural sponsors. Peer review by scientist/educators with expertise in the relevant field(s) of the research or project is the best means of ensuring the quality of the publication. ADEA discourages submission of manuscripts to any publisher that allows sponsors of the work to influence editorial policy or judgment after the completion of the peer review process.

E. Excellence in Teaching
Dental education institutions and programs should promote excellence in teaching through active programs of research on the teaching/learning process. Faculty members should be encouraged to conduct both quantitative and qualitative studies of educational programming including case studies that examine the impact of these various educational programs on student attainment of outcomes.

F. Scholarship
Dental education institutions and programs should encourage a broad range of scholarship from their faculty. Faculty members should be encouraged and rewarded, if appropriate to the academic setting, through the tenure and/or promotion and review process for systematically developing and validating new educational programs; for evaluating, analyzing, and interpreting the impact of educational programs on students and patients; and for publishing reports of these endeavors.

III. Licensure and Certification

A. Goals
ADEA supports achievement of the following goals for dentists and dental hygienists who are students or graduates of accredited programs and have successfully completed the National Board Dental Examination or the National Board Dental Hygiene Examination: freedom in geographic mobility; elimination of those licensure and regulatory barriers that restrict access to care; elimination of the use of patients in clinical examinations; and high reliability of any licensure examination process and content as well as predictive validity of information used by licensing authorities to make licensing decisions.

B. Achieving Goals
In order to achieve these goals, the Association should work diligently, both independently and cooperatively, with appropriate organizations and agencies, to support appropriate demonstration projects, pilot programs, and other ways to explore development of alternative testing methods and to develop uniform, valid, and reliable methods that can be used nationally to measure the competencies necessary for safe entry into independent practice as licensed dentists and legally authorized practice as licensed dental hygienists. In the interest of ensuring high quality oral health care, ADEA has always supported periodic third-party evaluation of dental and dental hygiene students and graduates through mechanisms like the National Board Dental and Dental Hygiene Examinations. In considering the clinical competence of dental and dental hygiene students and graduates, ADEA also supports the development and
administration of a national clinical examination. ADEA also supports with the American Dental Association the principle that a clinical examination requirement may also be met by successful completion of a postgraduate program in a general dentistry or dental specialty training program, at least one year in length, which is accredited by the Commission on Dental Accreditation.

ADEA also strongly supports development of means for licensing authorities to assess continuing competence. With valid, reliable, and fair methods for continuing competence determinations, initial licensure examinations may become unnecessary.

C. Allied Dental Personnel

In addition, the Association supports the following principles concerning the licensure and certification of allied dental personnel. Qualified dental hygienists should be appointed to all agencies legally authorized to grant licenses to practice dental hygiene. Dental hygienists should participate in the examination of candidates for dental hygiene licensure and be full voting and policymaking members of licensing authorities in all matters relating to the practice of dental hygiene. Successful completion of an accredited program should be a prerequisite for eligibility for the certification examination of the National Board for Certification of dental laboratory technicians and the Dental Assisting National Board for dental assistants.

D. Preparing Students for Licensure in Any Jurisdiction

Institutions that conduct dental and allied dental education programs have the right and responsibility to prepare students for licensure examinations in any jurisdiction in the United States, Puerto Rico, and Canada.

Individuals or students applying for dental hygiene licensure in any jurisdiction must successfully complete the didactic, laboratory, and clinical instruction and meet the competencies for providing patient care as required by the dental education Accreditation Standards of the Commission on Dental Accreditation.

IV. Access and Delivery of Care

A. Health Care Delivery and Quality Review

Dental education institutions and programs and ADEA should be leaders in developing effective health care delivery systems and quality review mechanisms and in preparing their students to participate in them.

B. Scope of Services

Dental education institutions and programs should provide treatment consistent with contemporary standards of care.

C. Dental Health Personnel

Dental educators and ADEA should inform policymakers and the public that:
1. Dental education institutions and programs are important national, regional, state, and community resources.
2. Dental education institutions and programs have a vital role in providing access to oral health care to all, with special consideration for the underserved.
3. Dental education institutions and programs are a vital component of the health sciences segment of universities.
4. Dental education institutions and programs, through their graduates, contribute significantly to meeting the oral health needs of the public.
5. Dental education institutions and programs collaborate and create linkages with community-based agencies to increase access to care.
6. Dental education institutions and programs prepare their graduates to provide services in a variety of settings to reduce barriers to care and provide more accessible care to various population groups.
D. Dental Insurance, Federal, and State Programs

ADEA should be a strong advocate on both the federal and state levels for:

1. Strengthening reimbursement and inclusion of meaningful dental and oral health care services provided under Medicaid and the State Children’s Health Insurance Program.
2. Strengthening Medicare by seeking inclusion of medically necessary oral health care services for populations covered under the program.
3. Encouraging states to appoint a chief dental officer for every state.
4. Educating federal and state policymakers about the lack of dental insurance and its relationship to access to oral health care for underserved and unserved populations.

V. Health Promotion and Disease Prevention

A. Standards

Dental education institutions and programs have the obligation to maintain standards of health care and professionalism that are consistent with the public’s expectations of the health professions.

B. Dental Caries

1. ADEA supports and encourages the education of students, professionals, and the public on behaviors that will promote health by preventing and managing dental caries based on proper disease diagnosis, caries risk assessment, and prognosis, including preventive oral health care measures, proper nutrition, and the management of dental caries utilizing risk-based, minimally invasive nonsurgical and surgical modalities, as dictated by the best evidence available.
2. Fluoride. ADEA supports and encourages fluoridation of community water supplies and the use of topical fluoride. Community water fluoridation is safe, practical, and the most cost-effective measure for the prevention of dental caries.
3. Dental Sealants and Fluoride. ADEA supports and encourages widespread use of dental sealants and fluoride varnishes as a significant cost-effective primary preventive method for the prevention of dental caries.

C. Periodontal Disease

1. Research. ADEA supports and encourages research into the correlation between oral and general health, including the possible link between periodontal disease and heart and lung diseases, stroke, diabetes, low birth rates, and premature births.
2. Education. ADEA supports and encourages the education of students, professionals, and the public on behaviors that will prevent disease and promote health, including preventive oral health care measures, proper nutrition, and tobacco cessation.

D. Infectious Diseases

1. Human Dignity. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.
2. Refusal to Treat Patients. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency virus (AIDS), or hepatitis B or C infections. These patients must not be subjected to discrimination.
3. Confidentiality of Patients. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.
4. Confidentiality of Faculty, Students, and Staff. Dental education institutions and programs are ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious
disease. Dental personnel who pose a risk of transmitting an infectious agent must consult with appropriate health care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty member, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer should take steps consistent with the advice of appropriate health care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any professional activity that would create a risk of transmission of the infection to others.

5. **Counseling and Follow-Up Care.** The chief administrative officer must facilitate appropriate counseling and follow-up care, and should consider establishing retraining and/or counseling programs for those faculty, staff, and students who do not continue to perform patient care procedures. Such counseling should also be available to students who find they cannot practice because of 1) permanent injury that occurs during dental training, 2) illnesses such as severe arthritis, 3) allergies to dental chemicals, or 4) other debilitating conditions. Dental education institutions and programs should make available institutional guidelines and policies in this area to current and prospective students, staff, and faculty.

6. **Protocols.** Chief administrative officers of dental education institutions and programs must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines and must be provided to all faculty, students, and appropriate support staff. To protect faculty, students, staff, and patients from the possibility of cross-contaminations and other infection, asepsis protocols must include a policy in adequate barrier techniques, policies, and procedures.

7. **Testing for Infectious Diseases and Immunization.** Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should 1) demonstrate proof of immunity, 2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or 3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but also other infectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions and programs should require prematriculation and annual testing for tuberculosis.

E. **Alcohol, Tobacco, and Other Drug Hazards**

1. **Discouraging Alcohol, Tobacco, and Other Drug Abuse.** Institutional and individual members are urged to:
   a. discourage use of excessive amounts of alcohol,
   b. discourage the use of illegal and/or harmful drugs,
   c. establish tobacco-free environments and tobacco use policies,
   d. incorporate information about the adverse health effects of all types of tobacco in course offerings and its application to clinical practice, and
e. provide training on general, culturally competent, and gender-specific tobacco prevention and cessation techniques for application in clinical practice.

2. **Tobacco-Free Environments.** Institutional and individual members should have tobacco-free environments on their campuses and in their health science centers and patient-care facilities. Institutions should also encourage and support continued research related to the health effects of tobacco use.

3. **Community Education Programs.** Institutional and individual members are encouraged to participate in the development of community education programs dealing with the health hazards of alcohol, tobacco, and other drug use.

**F. Child Abuse/Neglect and Domestic Violence**

1. **Familiarity with Signs and Symptoms.** Dental and allied dental education institution officials and educators should become familiar with all signs and symptoms of child abuse/neglect and family violence that are observable in the normal course of a dental visit and should report suspected cases to the proper authorities, consistent with state laws.

2. **Instruction in Recognizing Signs.** Dental and allied dental education institution officials and educators should instruct all of their students, faculty, and clinical staff on how to recognize all signs and symptoms of child abuse/neglect and domestic violence observable in a dental visit and how to report suspected cases to the proper authorities, consistent with state laws.

3. **Monitoring Regulations.** Dental and allied dental education institution officials should monitor state and federal legislative and regulatory activity on child abuse/neglect and family violence and make information on these subjects available to all students, faculty, and clinical staff.

**VI. Partnerships**

A. Dental education institutions and programs and ADEA should develop partnerships among health care organizations, corporate entities, and state and federal government to collectively educate the public on the importance of oral health and the significant role it has in total health.

B. Dental education institutions and programs should prepare graduates to work with community-based programs to expand disease prevention and health promotion techniques to meet the needs of various populations including the indigent, minorities, the elderly, and other underserved groups.

C. Dental education institutions and programs and ADEA should create, expand, and enhance awareness and a strong knowledge base among lawmakers and the public about the role of oral disease on total health.

**VII. Public Policy Advocacy**

A. ADEA and its membership should work together to identify and promote emerging issues in public policy and take action to secure federal and state policies and programs that support the mission of ADEA.

B. ADEA should work to form and maintain strategic alliances that will promote the public policy objectives of the Association.

C. Dental educators should participate actively in promoting and securing public policy objectives with federal, state, and local executive branch and legislative bodies that promote and secure the public policy issues of ADEA.
D. Dental educators and students should work to ensure that policy decisions that may critically affect dental education be formulated in conjunction with representatives of appropriate educational institutions and organizations.
ADEA Policy Statement on Health Care Reform

As approved by the 2009 ADEA House of Delegates

Oral Health Care: Essential to Health Care Reform

As the voice of dental education, the American Dental Education Association (ADEA), whose members serve as providers of care for thousands of uninsured, underserved low-income patients, believes that dental and allied dental educators have an ethical obligation to promote access to oral health care. To that end, ADEA believes that any comprehensive reform of the U.S. health care system should provide universal coverage to all Americans and access to high-quality, cost-effective oral health care services. Health care reform must also include investments in dental public health that improve our nation’s capacity to meet the health care needs of patients, communities, and other stakeholders.

Millions Lack Dental Insurance

Ensuring oral health is a shared responsibility of individuals and families, the private sector, and federal, state, and local governments. The United States spends over two trillion dollars annually on health care, more than any other nation in the world. Nevertheless, access to health care is still beyond the reach of more than 47 million Americans. In 2003, the U.S. Surgeon General reported that the number of Americans without dental insurance was more than 2.5 times the number lacking medical insurance. Approximately 130 million adults and children are without dental coverage. Many individuals, particularly those who are uninsured, often delay dental treatment until serious or acute dental emergencies occur. The cost of caring for Americans without health insurance in emergency rooms adds approximately $922 to the average cost of annual premiums for employer-sponsored family coverage. And the cost of providing preventive dental treatment is estimated to be 10 times less than the cost of managing symptoms of dental disease in a hospital emergency room.

Grave Oral Health Disparities Exist

According to the U.S. Surgeon General, dental disease is disproportionately found among individuals with special health care needs, with low incomes, and from underrepresented minorities and among those who live in underserved rural, urban, and frontier communities. Special care patients have more dental disease, missing teeth, and difficulty in obtaining dental care than the rest of the population. These inequities challenge us to make adequate investments in a strong dental public health infrastructure that extends beyond the traditional, economically driven model of care. The current model may well serve a majority of U.S. citizens, but it is not achieving universal coverage and equitable access to oral health for everyone.

Enhancing Productivity and Preserving Employer-Sponsored Coverage

Dental disease significantly impacts the nation’s domestic productivity and global competitiveness. More than 51 million school hours and 164 million hours of work are lost each year due to dental-related absences. More generally, uncompensated care adversely affects American businesses as costs are shifted to private payers. Health care costs added $1,525 to the price of every car produced by the Big Three automakers in 2007. Most workers and families receive health insurance through employer-sponsored coverage. Changes to the health care system should bolster rather erode
businesses’ capacity to purchase health and dental coverage for their employees. Any proposal to reform the U.S. health care system should ensure that the economic viability of American businesses is maintained and that they are able to compete in the global marketplace.

Principles for Health Care Reform

Academic dental institutions are vital public trusts and national resources. They educate the future dental workforce, conduct dental research, inform communities of the importance and value of good oral health, and provide oral health care services and serve as dental homes to thousands of patients. It is within the broad range of oral health expertise and the interests represented by our membership that the American Dental Education Association offers the following principles for providing access to and coverage of affordable oral health care services in health care reform:

1. **The availability of health care, including oral health care, fulfills a fundamental human need and is necessary for the attainment of general health.** Every American should have access to affordable diagnostic, preventive, restorative, and primary oral health care services so as to eliminate pain, suffering, and infection. Coverage must ensure that individuals are able to obtain needed oral health care and provide them with protection during a catastrophic health crisis. Oral health care services are proven to be effective in preventing and controlling tooth decay, gum infections, and pain, and can ameliorate the outcomes of trauma. Oral health services should have parity with other medical services within a reformed U.S. health care system. The equitable provision of oral health care services demands a commitment to the promotion of dental public health, prevention, public advocacy, and the exploration and implementation of new models of oral health care that provide care within an integrated health care system.

2. **The needs of vulnerable populations have a unique priority.** Health professionals, including those providing oral health care services, must individually and collectively work to improve access to care by reducing barriers that low-income families, minorities, remote rural populations, medically compromised individuals, and persons with special health care needs experience when trying to obtain needed services. New integrated models of care that expand roles for allied dental professionals as well as other health professionals, (including family physicians, pediatricians, geriatricians, and other primary care providers) as team members may be needed to address the complex needs of some patients. Statutory language may be needed to clarify and expand coverage of “medically necessary” dental care provided under Medicare to beneficiaries with serious medical conditions in order to prevent complications and death associated with their health condition and treatment.

3. **Prevention is the foundation for ensuring general and oral health.** Prevention and wellness hold the promise of stemming escalating costs and treating diseases at early stages before expensive emergencies occur. Most dental diseases are preventable, and early dental treatment is cost effective. Preventing and controlling dental diseases includes adequate financing of organized activities to promote and ensure dental public health through education, applied dental research, and the administration of programs such as water fluoridation and dental sealants. Improving oral health by multiple preventive approaches (including periodontal disease management) has saved more than $4 billion per year in treatment costs.
Prevention of dental diseases ranks above HIV screening and influenza immunization in cost savings.\textsuperscript{14} Children who receive preventive dental care early in life have lifetime dental costs that are 40 percent lower than children who do not receive care.\textsuperscript{15} Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.\textsuperscript{16} Every dollar invested in community water fluoridation yields approximately $38 in savings on dental treatment costs.\textsuperscript{17}

4. **The financial burden of ensuring coverage for health care, including oral health care coverage, should be equitably shared by all stakeholders.** Access to affordable health care services requires a strong financial commitment that is a responsibility shared by all major stakeholders, including individuals and families, as well as providers, employers, private insurers, and federal, state, and local governments. To ensure health, oral health care services must be an integral component of financing and delivery systems regardless of whether the care is provided by a public or private insurance program or in a community or an individual setting. The burden of uncompensated care and the cost shifting that occurs adversely impacts U.S. businesses, limits governments' capacity to address other pressing economic and social concerns, and strains the health care safety net to the breaking point.

5. **A diverse and culturally competent workforce is necessary to meet the general and oral health needs of our demographically changing nation.** Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.\textsuperscript{18} Proposals to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions. This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. Academic dental institutions, which educate and train oral health care professionals, have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.

6. **Reducing administrative costs and realigning spending can increase quality, improve health, and create savings for additional reforms.** Approximately $700 billion (about a third) of U.S. health care spending is used for administrative and operating costs or to benefit third party payers and does not directly impact health outcomes.\textsuperscript{19} Reducing these administrative burdens in the delivery of health care and creating new payment incentives that reward providers for delivering quality care will improve health care. It also has the potential to enhance provider participation and lower health care costs over time. More dollars would then be available for reforms such as strengthening primary care and chronic care management, increasing the supply and availability of primary care practitioners, and reinvesting in the training of a twenty-first century health care workforce. Targeted tax changes might also be used to improve efficiencies, ensure the even distribution of health care, and promote efficient use of consumers' health care dollars.
The American Dental Education Association (ADEA) represents all fifty-seven dental schools in the United States in addition to 714 dental residency training programs and 577 allied dental programs, as well as more than 12,000 faculty members who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided.

References


19 Orszag PR. Increasing the value of federal spending on health care. Testimony before the U.S. House of Representatives, Committee on Budget, July 16, 2008.
ADEA Statement on Professionalism

As approved by the 2009 ADEA House of Delegates

The American Dental Education Association (ADEA) is committed to developing and sustaining institutional environments within the allied, predoctoral, and postdoctoral dental education community that foster academic integrity and professionalism.

The ADEA Task Force on Professionalism in Dental Education was charged by the ADEA Board of Directors with the development of an ADEA Statement on Professionalism in Dental Education for the dental education community. All seven ADEA Councils endorsed this effort and were represented on the Task Force. Through its work, the Task Force sought to identify and clarify those personal and institutional values and behaviors that support academic integrity and professionalism in dental education and that are aligned with the existing values and codes of the dental, allied dental, and higher education professions.

The Task Force acknowledges and respects that each academic dental education institution has its own unique culture, institutional values, principles and processes, and in some cases, codes of conduct for institutional members. The ADEA Statement on Professionalism in Dental Education is not intended to replace or supersede these codes.

The Task Force hopes that this ADEA Statement on Professionalism in Dental Education stimulates broad discussions about professional behavior in dental education, provides guidance for individual and institutional behavior within dental education, and in so doing supports professionalism across the continuum of dental education and practice.

Values Defining Professionalism in Dental Education

The Task Force identified and developed the following six values-based statements defining professionalism in dental education:

** Competence  
Acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.

** Fairness  
Demonstrating consistency and even-handedness in dealings with others.

** Integrity  
Being honest and demonstrating congruence between one’s values, words, and actions.

** Responsibility  
Being accountable for one’s actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

** Respect  
Honoring the worth of others.
**Service-mindedness**

Acting for the benefit of the patients and the public we serve, and approaching those served with compassion.

A discussion of each of these values follows and includes a more full definition of each value and a description of the behaviors that enactment of the value requires and to which all members of the dental education community can aspire.

In developing the ADEA Statement on Professionalism in Dental Education, the Task Force sought to align the Statement with existing codes of ethics and conduct within the allied, predoctoral, and postdoctoral dental communities. To illustrate the continuity of these values between the dental education community and the practicing community, the discussion of each value includes a reference to the ethical principles espoused by the American Dental Association (*ADA Principles of Ethics and Code of Professional Conduct*) and the American Student Dental Association (*ASDA Student Code of Ethics*), and the values expressed in the American Dental Hygienists’ Association’s *Code of Ethics for Dental Hygienists*.

Finally, examples of how the value applies to different constituencies within the dental education community are provided.

**Detailed Definitions of the Six Values**

**Competence:** *acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.*

**Expanded Definition:** Encompasses knowledge of oral health care (having acquired the unique knowledge, skills, and abilities required for effective provision of clinical care to patients); knowledge about how people learn and skills for effective pedagogy (including developing curriculum and assessments); knowledge of ethical principles and professional values; lifelong commitment to maintain skills and knowledge; modeling appropriate values as both an educator and a dental professional; developing ability to communicate effectively with patients, peers, colleagues, and other professionals; recognizing the limits of one’s own knowledge and skills (knowing when to refer); and recognizing and acting upon the need for collaboration with peers, colleagues, allied professionals, and other health professionals. Includes recognizing the need for new knowledge (supporting biomedical, behavioral, clinical, and educational research) and engaging in evidence-based practice.

**Alignment with:**
- a. *ADA Principles of Ethics: beneficence and nonmaleficence*
- b. *ADHA Code for Dental Hygienists: beneficence and nonmaleficence*
- c. *ASDA Student Code of Ethics: nonmaleficence and beneficence*

**Examples:**
1. *For students:* Learning oral health care is a top priority. Develop the habits and practices of lifelong learning, including self-assessment skills. Accept and respond to fair negative feedback about your performance (recognize when you need to learn). Learn and practice effective communication skills. Know the limits of your knowledge and skills and practice within them; learn when and how to refer.
2. **For faculty:** Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development in oral health care and pedagogy. Ensure curricular materials are current and relevant. Model effective interactions with patients, colleagues, and students; accept and respond to constructive criticism about your performance (recognize when you need to learn). Know the limits of your skills and practice within them; model how and when to refer; acknowledge and act on the need for collaboration.

3. **For researchers:** Generate new knowledge. Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development. Model effective interactions with patients, colleagues, and students; accept and respond to fair negative feedback about your performance (recognize when you need to learn).

4. **For administrators and institutions:** Set high standards. Learn and practice effective self-assessment skills; accept and respond to fair negative feedback (recognize the need for institutional learning and address it); acknowledge and act on the need for collaboration. Support the learning needs of all members of the institution and encourage them to pursue lifelong learning.

**Fairness:** *demonstrating consistency and even-handedness in dealings with others.*

**Expanded Definition:** Encompasses consideration of how to best distribute benefits and burdens (to each an equal share, to each according to need, to each according to effort, to each according to contribution, to each according to merit* are some of the possible considerations); encompasses evenhandedness and consistency; includes setting process standards, striving for just consideration for all parties, ensuring consistency in application of process (following the rules) while recognizing that different outcomes are possible, transparency of process, and calibration; consistent, reliable, and unbiased evaluation systems; commitment to work for access to oral health care services for underserved populations.

**Alignment with:**
   a. ADA Principles of Ethics: justice, beneficence, nonmaleficence
   b. ADHA Code for Dental Hygienists: justice and fairness, beneficence, nonmaleficence
   c. ASDA Student Code of Ethics: justice, nonmaleficence and beneficence

**Examples:**
1. **For students:** Follow institutional rules and regulations. Promote equal access to learning materials for all students and equal access to care for the public.
2. **For faculty:** Use appropriate assessment and evaluation methods for students; view situations from multiple perspectives, especially those that require evaluation; provide balanced feedback to students, colleagues, and the institution. Use evidence-based practices. Promote equal access to oral health care.
3. **For researchers:** Set high standards for the conduct of research and use unbiased processes to assess research outcomes. Generate data to support evidence-based practice and education.
4. **For administrators and institutions:** Set high standards and ensure fair, unbiased assessment and evaluation processes for all members of the institution, including applicants to educational programs. Ensure that institutional policies and procedures are unbiased and applied consistently; ensure transparency of process. Provide leadership in promoting equal access to care for the public.
**Integrity**: being honest and demonstrating congruence between one’s values, words, and actions.

**Expanded definition**: Encompasses concept of wholeness and unity\(^3\); congruence between word and deed; representing one’s knowledge, skills, abilities, and accomplishments honestly and truthfully; devotion to honesty and truthfulness, keeping one’s word, meeting commitments; dedication to finding truth, including honesty with oneself; willingness to lead an examined life; willingness to engage in self-assessment and self-reflection; willingness to acknowledge mistakes; commitment to developing moral insight\(^3\) and moral reasoning skills; recognizing when words, actions, or intentions are in conflict with one’s values and conscience\(^4\) and the willingness to take corrective action; dedication and commitment to excellence (requires more than just meeting minimum standards), making a continual conscientious effort to exceed ordinary expectations\(^1\); encompasses fortitude, the willingness to suffer personal discomfort, inconvenience, or harm for the sake of a moral good\(^3\).

**Alignment with**:
- a. ADA Principles of Ethics: beneficence, nonmaleficence, and veracity
- b. ADHA Code for Dental Hygienists: beneficence, nonmaleficence, and veracity
- c. ASDA Student Code of Ethics: nonmaleficence and beneficence, dental student conduct

**Examples**:
1. *For students*: Strive for personal and professional excellence. Take examinations honestly; make entries in patients’ records honestly.
2. *For faculty*: Strive for personal and professional excellence in teaching, practice, research, or all of these. Represent your knowledge honestly.
4. *For administrators and institutions*: Strive for personal, professional, and institutional excellence. Use appropriate outcomes measures and acknowledge openly when improvements need to be made. Ensure institutional systems and structures are honest, open, and respectful and do not create undue conflicts.

**Responsibility**: being accountable for one’s actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

**Expanded Definition**: Encompasses the concepts of obligation, duty, and accountability; requires an appreciation of the fiduciary relationship (a special relationship of trust) between oral health professionals and patients, and the profession and society. Accountability requires fulfilling the implied contract governing the patient-provider relationship as well as the profession’s relationship to society\(^1\); includes standard setting and management of conflicts of interest or commitment\(^2\) as well as meeting one’s commitments and being dependable. It requires striking a morally defensible balance between self-interest\(^3\) and the interest of those who place their trust in us, our patients and society; keeping one’s skills and knowledge current and a commitment to lifelong learning; and embracing and engaging in self-regulation of the profession, including peer review and protecting from harm those who place their trust in us.
Alignment with:
  a. ADA Principles of Ethics: beneficence and nonmaleficence
  b. ADHA Code for Dental Hygienists: beneficence and nonmaleficence
  c. ASDA Student Code of Ethics: nonmaleficence and beneficence

Examples:
1. For students: Meet commitments; complete assignments on time; make your learning a top priority. Acknowledge and correct errors; report misconduct and participate in peer review.
2. For faculty: Continuously improve as a teacher; stay current; set high standards. Respect time commitments to others; be available to students when assigned to teach; meet commitments. Acknowledge and correct errors; report and manage conflicts of interest or commitment. Ensure that all patient care provided is in the best interest of the patient; ensure that patient care provided is appropriate and complete; protect students, patients, and society from harm. Report misconduct and participate in peer review.
3. For researchers: Know and practice the rules and regulations for the responsible conduct of research; stay current. Meet commitments; report and manage conflicts of interest or commitment; report scientific misconduct and participate in peer review.
4. For administrators and institutions: Continuously improve as administrators. Use appropriate institutional outcomes assessments and continuously improve institutional systems and processes; acknowledge and correct errors. Report misconduct and support institutional peer review systems.

Respect: honoring the worth of others.

Expanded Definition
Encompasses acknowledgment of the autonomy and worth of the individual human being and his/her belief and value system; sensitivity and responsiveness to diversity in patients’ culture, age, gender, race, religion, disabilities, and sexual orientation; personal commitment to honor the rights and choices of patients regarding themselves and their oral health care, including obtaining informed consent for care and maintaining patient confidentiality and privacy (derives from our fiduciary relationship with patients); and according the same to colleagues in oral health care and other health professions, students and other learners, institutions, systems, and processes. Includes valuing the contributions of others, interprofessional respect (other health care providers), and intraprofessional respect (allied health care providers); acknowledging the different ways students learn and appreciating developmental levels and differences among learners; includes temperance (maintaining vigilance about protecting persons from inappropriate over- or undertreatment, abandonment, or both) and tolerance.

Alignment with:
  a. ADA Principles of Ethics: autonomy, beneficence and nonmaleficence
  b. ADHA Code for Dental Hygienists: individual autonomy and respect for human beings, beneficence and nonmaleficence
  c. ASDA Student Code of Ethics: patient autonomy and nonmaleficence and beneficence

Examples:
1. For students: Develop a nuanced understanding of the rights and values of patients; protect patients from harm; support patient autonomy; be mindful of patients’ time
and ensure timeliness in the continuity of patient care. Keep confidences; accept and embrace cultural diversity; learn cross-cultural communication skills; accept and embrace differences. Acknowledge and support the contributions of peers and faculty.

2. **For faculty**: Model valuing others and their rights, particularly those of patients; protect patients from harm; support patient autonomy. Accept and embrace diversity and difference; model effective cross-cultural communication skills. Acknowledge and support the work and contribution of colleagues; accept, understand, and address the developmental needs of learners. Maintain confidentiality of student records; maintain confidentiality of feedback to students, especially in the presence of patients and peers.

3. **For researchers**: Protect human research subjects from harm; protect patient autonomy. Accept, understand, and address the developmental needs of learners. Acknowledge and support the work and contributions of colleagues.

4. **For administrators and institutions**: Recognize and support the rights and values of all members of the institution; acknowledge the value of all members of the institution; accept and embrace cultural diversity and individual difference; model effective cross-cultural communication skills. Support patient autonomy, protect patients from harm, and safeguard privacy; protect vulnerable populations. Create and sustain healthy learning environments; ensure fair institutional processes.

**Service-mindedness**: *acting for the benefit of the patients and the public we serve, and approaching those served with compassion.*

**Expanded Definition**: Encompasses beneficence (the obligation to benefit others or to seek their good[^4] as well as the primacy of the needs of the patient or the public, those who place their trust in us); the patient’s welfare, not self-interest, should guide the actions of oral health care providers. Also includes compassion and empathy; providing compassionate care requires a sincere concern for and interest in humanity and a strong desire to relieve the suffering of others[^5]; empathic care requires the ability to understand and appreciate another person’s perspectives without losing sight of one’s professional role and responsibilities[^6]; extends to one’s peers and co-workers. The expectation that oral health care providers serve patients and society is based on the autonomy granted to the profession by society. The orientation to service also extends to one’s peers and to the profession. Commitment of oral health care providers to serve the profession is required in order for the profession to maintain its autonomy. The orientation to service also extends to encouraging and helping others learn, including patients, peers, and students. Dental education institutions are also expected to serve the oral health needs of society not only by educating oral health care providers, but also by being collaborators in solutions to problems of access to care.

Alignment with:

a. ADA Principles of Ethics: beneficence and justice

b. ADHA Code for Dental Hygienists: beneficence, justice and fairness

c. ASDA Student Code of Ethics: nonmaleficence and beneficence and justice

**Examples**:

1. **For students**: Contribute to and support the learning needs of peers and the dental profession. Recognize and act on the primacy of the well-being and the oral health needs of patients and society in all actions; provide compassionate care; support the
values of the profession. Volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public.

2. **For faculty:** Model a sincere concern for students, patients, peers, and humanity in your interactions with all; volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public. Model recognition of the primacy of the needs of the patients and society in the oral health care setting and, at the same time, support the learning needs of students. Contribute to and support the knowledge base of the profession to improve the oral health of the public.

3. **For researchers:** Generate new knowledge to improve the oral health of the public; contribute to and support the learning needs of students, colleagues, and the dental profession. Model the values of and service to the dental profession and to relevant scientific and research associations; volunteer to serve the public and the profession; engage in peer review.

4. **Administrators and institutions:** Recognize and act on opportunities to provide oral health care for underserved populations. Encourage and support all members of the institution in their service activities; provide leadership in modeling service to the profession and the public.

**Appendix One: ADEA Code of Professionalism in Dental Education Task Force Membership**

*Task Force Chair*
Dr. Richard N. Buchanan, Dean, University at Buffalo

*Representing the Council of Allied Program Directors*
Dr. Susan I. Duley, Associate Professor of Dental Hygiene, Clayton State University

*Representing the Corporate Council*
Mr. Daniel W. Perkins, President, AEGIS Communications

*Representing the Council of Deans*
Dr. Cecile A. Feldman, Dean, University of Medicine and Dentistry of New Jersey

*Representing the Council of Faculties*
Dr. Kenneth R. Etzel, Associate Dean, University of Pittsburgh

*Representing the Council of Hospitals and Advanced Education Programs*
Dr. Todd E. Thierer, University of Rochester

*Representing the Council of Sections*
Dr. Judy Skelton, Associate Professor, University of Kentucky, Division of Dental Public Health

*Representing the Council of Students*
Mr. Matthew MacGinnis, dental student, University of Southern California

*ADA Council on Dental Education and Licensure*
Dr. Frank A. Maggio, American Dental Association

*Representing the ADA Council on Ethics, Bylaws and Judicial Affairs*
Dr. David Boden, American Dental Association
Representing the Commission on Dental Accreditation
Dr. James R. Cole II

Representing the American Student Dental Association
Mr. Michael C. Meru, dental student, University of Southern California

At-Large Representatives
Dr. Marilyn Lantz, Associate Dean, University of Michigan
Dr. Kathleen Roth, ADA Immediate Past President

References

adea competencies for the new general dentist

(as approved by the 2008 adea house of delegates)

preamble
the general dentist is the primary oral health care provider, supported by dental specialists, allied dental professionals, and other health care providers. the general dentist will address health care issues beyond traditional oral health care and must be able to independently and collaboratively practice evidence-based comprehensive dentistry with the ultimate goal of improving the health of society. the general dentist must have a broad biomedical and clinical education and be able to demonstrate professional and ethical behavior as well as effective communication and interpersonal skills. in addition, he or she must have the ability to evaluate and utilize emerging technologies, continuing professional development opportunities, and problem-solving and critical thinking skills to effectively address current and future issues in health care.

as used in this document, a “competency” is a complex behavior or ability essential for the general dentist to begin independent, unsupervised dental practice. competence includes knowledge, experience, critical thinking and problem-solving skills, professionalism, ethical values, and technical and procedural skills. these components become an integrated whole during the delivery of patient care by the competent general dentist. competence assumes that all behaviors are performed with a degree of quality consistent with patient well-being and that the general dentist can self-evaluate treatment effectiveness. in competency-based dental education, what students learn is based upon clearly articulated competencies and further assumes that all behaviors/abilities are supported by foundation knowledge and psychomotor skills in biomedical, behavioral, ethical, clinical dental science, and informatics areas that are essential for independent and unsupervised performance as an entry-level general dentist. in creating curricula, dental faculty must consider the competencies to be developed through the educational process, the learning experiences that will lead to the development of these competencies, and ways to assess or measure the attainment of competencies.

• the purpose of this document and the proposed foundation knowledge concepts is to:
  • define the competencies necessary for entry into the dental profession as a general dentist. competencies must be relevant and important to the patient care responsibilities of the general dentist, directly linked to the oral health care needs of the public, realistic, and understandable by other health care professionals;
  • reflect (in contrast to the 1997 competencies) the 2002 institute of medicine core set of competencies for enhancing patient care quality and safety, and illustrate current and emerging trends in the dental practice environment; they are divided into domains, are broader and less prescriptive in nature, are fewer in number, and, most importantly, will be linked to requisite foundation knowledge and skills;
  • serve as a central resource, both nationally for the american dental education association (adea) and locally for individual dental schools, to promote change and innovation in predoctoral dental school curricula;
  • inform and recommend to the commission on dental accreditation standards for predoctoral dental education;
  • provide a framework for the change, innovation, and construction of national dental examinations, including those provided through the joint commission on national dental examinations and clinical testing agencies;
  • assist in the development of curriculum guidelines, both nationally for adea and locally for individual dental schools, for both foundation knowledge and clinical instruction;
  • provide methods for assessing competencies for the general dentist; and
Through periodic review and update, serve as a document for benchmarking, best practices, and interprofessional collaboration and, additionally, as a mechanism to inform educators in other health care professions about curricular priorities of dental education and entry-level competencies of general dentists.

**Domains**
1. Critical Thinking
2. Professionalism
3. Communication and Interpersonal Skills
4. Health Promotion
5. Practice Management and Informatics
6. Patient Care
   a. Assessment, Diagnosis, and Treatment Planning
   b. Establishment and Maintenance of Oral Health

The statements below define the entry-level competencies for the beginning general dentist.

1. **Critical Thinking**
   Graduates must be competent to:
   1.1 Evaluate and integrate emerging trends in health care as appropriate.
   1.2 Utilize critical thinking and problem-solving skills.
   1.3 Evaluate and integrate best research outcomes with clinical expertise and patient values for evidence-based practice.

2. **Professionalism**
   Graduates must be competent to:
   2.1 Apply ethical and legal standards in the provision of dental care.
   2.2 Practice within one’s scope of competence and consult with or refer to professional colleagues when indicated.

3. **Communication and Interpersonal Skills**
   Graduates must be competent to:
   3.1 Apply appropriate interpersonal and communication skills.
   3.2 Apply psychosocial and behavioral principles in patient-centered health care.
   3.3 Communicate effectively with individuals from diverse populations.

4. **Health Promotion**
   Graduates must be competent to:
   4.1 Provide prevention, intervention, and educational strategies.
   4.2 Participate with dental team members and other health care professionals in the management and health promotion for all patients.
   4.3 Recognize and appreciate the need to contribute to the improvement of oral health beyond those served in traditional practice settings.

5. **Practice Management and Informatics**
   Graduates must be competent to:
   5.1 Evaluate and apply contemporary and emerging information including clinical and practice management technology resources.
   5.2 Evaluate and manage current models of oral health care management and delivery.
   5.3 Apply principles of risk management, including informed consent and appropriate record keeping in patient care.
   5.4 Demonstrate effective business, financial management, and human resource skills.
5.5 Apply quality assurance, assessment, and improvement concepts.
5.6 Comply with local, state, and federal regulations including OSHA and HIPAA.
5.7 Develop a catastrophe preparedness plan for the dental practice.

6. **Patient Care**

A. **Assessment, Diagnosis, and Treatment Planning**
Graduates must be competent to:
6.1 Manage the oral health care of the infant, child, adolescent, and adult, as well as the unique needs of women, geriatric, and special needs patients.
6.2 Prevent, identify, and manage trauma, oral diseases, and other disorders.
6.3 Obtain and interpret patient/medical data, including a thorough intra/extra oral examination, and use these findings to accurately assess and manage all patients.
6.4 Select, obtain, and interpret diagnostic images for the individual patient.
6.5 Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.
6.6 Formulate a comprehensive diagnosis, treatment, and/or referral plan for the management of patients.

B. **Establishment and Maintenance of Oral Health**
Graduates must be competent to:
6.7 Utilize universal infection control guidelines for all clinical procedures.
6.8 Prevent, diagnose, and manage pain and anxiety in the dental patient.
6.9 Prevent, diagnose, and manage temporomandibular disorders.
6.10 Prevent, diagnose, and manage periodontal diseases.
6.11 Develop and implement strategies for the clinical assessment and management of caries.
6.12 Manage restorative procedures that preserve tooth structure, replace missing or defective tooth structure, maintain function, are esthetic, and promote soft and hard tissue health.
6.13 Diagnose and manage developmental or acquired occlusal abnormalities.
6.14 Manage the replacement of teeth for the partially or completely edentulous patient.
6.15 Diagnose, identify, and manage pulpal and periradicular diseases.
6.16 Diagnose and manage oral surgical treatment needs.
6.17 Prevent, recognize, and manage medical and dental emergencies.
6.18 Recognize and manage patient abuse and/or neglect.
6.19 Recognize and manage substance abuse.
6.20 Evaluate outcomes of comprehensive dental care.
6.21 Diagnose, identify, and manage oral mucosal and osseous diseases.

**APPENDIX**

**Glossary of Terms**

**Competency**: a complex behavior or ability essential for the general dentist to begin independent, unsupervised dental practice; it assumes that all behaviors and skills are performed with a degree of quality consistent with patient well-being and that the general dentist can self-evaluate treatment effectiveness.

**Critical thinking**: the process of assimilating and analyzing information; this encompasses an interest in finding new solutions, a curiosity with an ability to admit to a lack of understanding, a willingness to examine beliefs and assumptions and to search for evidence to support these beliefs and assumptions, and the ability to distinguish between fact and opinion.
Curriculum guidelines (content): the relevant and fundamental information that is taught for each category of foundation knowledge; these are to be used as curriculum development aids and should not be construed as recommendations for restrictive requirements.

Domain: a broad, critical category of activity for the general dentist.

Emerging technologies: current and future technologies used in patient care, including technologies for biomedical information storage and retrieval, clinical care information, and technologies for use at the point of care.

Evidence-based dentistry: an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence relating to the patient’s oral and medical condition and history integrated with the dentist’s clinical expertise and the patient’s treatment needs and preferences.

Foundation knowledge and skills: the basic essential knowledge and skills linked to and necessary to support a given competency; these would serve to help guide curriculum in dental schools, assist educators in removing irrelevant, archaic information from current curricula, aid in including important new information, and help test construction committees develop examinations based upon generally accepted, contemporary information.

General dentist: the primary dental care provider for patients in all age groups who is responsible for the diagnosis, treatment, management, and overall coordination of services related to patients’ oral health needs.

Health promotion: public health actions to protect or improve oral health and promote oral well-being through behavioral, educational, and enabling socioeconomic, legal, fiscal, environmental, and social measures; it involves the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health; includes education of the public to prevent chronic oral disease.

Informatics: applications associated with information and technology used in health care delivery; the data and knowledge needed for problem-solving and decision making; and the administration and management of information and technology in support of patient care, education, and research.

Interprofessional health care: the delivery of health care by a variety of health care practitioners in a cooperative, collaborative, and integrative manner to ensure care is continuous and reliable.

Management: includes all actions performed by a health care provider that are designed to alter the course of a patient’s condition; such actions may include providing education, advice, treatment by the general dentist, treatment by the general dentist after consultation with another health care professional, referral of a patient to another health care professional, and monitoring the treatment provided; it may also include providing no treatment or observation.

Patient-centered care: the ability to identify, respect, and care about patients’ differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

Problem-solving: the process of answering a question or achieving a goal when the path or answer is not immediately obvious, using an acceptable heuristic or strategy such as the scientific method.

Special needs care: an approach to oral health management tailored to the individual needs of people with a variety of medical conditions or physical and mental limitations that require more than routine delivery of oral care; special care encompasses preventive, diagnostic, and treatment services.
ADEA Competencies for Entry into the Allied Dental Professions

(As approved by the 2010 ADEA House of Delegates)

Introduction
In 1998–99, the Section on Dental Hygiene of the American Association of Dental Schools, now the American Dental Education Association (ADEA), developed and presented Competencies for Entry into the Profession of Dental Hygiene. These competencies were widely used by the majority of accredited dental hygiene programs in defining specific program competencies. Following the June 2006 Allied Dental Education Summit, a special task force of the ADEA Council of Allied Dental Program Directors was formed to advance the recommendations from the summit. One recommendation was to develop similar competency statements for the dental assisting and dental laboratory technology disciplines. Given that charge, the ADEA Task Force on Collaboration, Innovation, and Differentiation (ADEA CID) undertook a comparative review of the draft Competencies for the New General Dentist and the Competencies for Entry into the Profession of Dental Hygiene. Both documents were analyzed from the perspective of where the allied dental professions should be headed to support an overall health care team concept and a professional model of education and practice and, at the same time, address curriculum innovation and change and better address access to care issues in the spirit of collaboration with multiple health care partners. The task force decided to focus its energy on updating and revising the dental hygiene competencies document. The final revised document that was submitted to the 2010 ADEA House of Delegates included both the dental assisting and dental laboratory technology disciplines and also serves as a companion to the documents produced by the ADEA Commission on Change and Innovation in Dental Education. Following discussion on the floor of the House regarding the resolution, the section pertaining to dental laboratory technology was returned to the ADEA Board of Directors for further consideration; thus, this approved document consists of an introduction and competencies for the disciplines of dental assisting and dental hygiene.

The purpose of this document is to
- Define the competencies necessary for entry into the allied dental professions.
- Serve as a resource for accredited allied dental education programs to promote change and innovation within their programs.
- Support existing and future curriculum guidelines.
- Serve as a resource for new and developing accredited programs in the allied dental professions.
- Serve as a mechanism to inform other health disciplines about curricular priorities in allied dental education.
- Enhance opportunities for intra- and interprofessional collaboration in understanding professional roles of oral health team members and other health care providers.
- Support developing new education models for accredited allied dental education programs.

The competencies delineated in this document are written for two (dental assisting and dental hygiene) of the three primary allied dental professions and apply to formal, accredited programs in higher education institutions. While some competencies are common to these disciplines, application would differ based on the discipline, type of program, length of program, graduate credentialing options, defined scopes of practice, and institutional mission and goals for the program. Program faculties should define actual competencies and how competence is measured for their programs. While the majority of allied dental professionals work within an
oral health care team supporting private practice dentistry, other models have and will evolve. Accredited allied dental education programs have a responsibility to prepare their graduates for the highest level of practice in all jurisdictions.

The competencies describe the abilities expected of allied dental health professionals entering their respective professions. These competency statements are meant to serve as guidelines. It is important for individual programs to further define the competencies they want their graduates to possess, describing 1) the desired combination of foundational knowledge, psychomotor skills, communication skills, and professional behaviors and attitudes required; 2) the standards used to measure the student’s independent performance in each area; and 3) the evaluation mechanisms by which competence is determined.

The five general domains described in this document should be viewed as themes or broad categories of professional focus that transcend specific courses and learning activities. They are intended to encourage professional emphasis and focus throughout the discipline-specific curriculum. Within each domain, major competencies expected of the program graduate are identified. Each major competency reflects the ability to perform or provide a particular professional activity, which is intellectual, affective, psychomotor, or all of these in nature. Supporting competencies needed to support the major competencies and specific course objectives delineating foundational knowledge, skills, and attitudes should be further developed by each program’s faculty, and these should reflect the overall mission and goals of the particular college and program. Demonstration of supporting competencies related to a specific service or task is needed in order to exhibit attainment of a major competency.

This document is not intended to be a stand-alone document and should be used in conjunction with other professional documents developed by the professional agencies that support the disciplines. This document is not intended to standardize educational programs in allied dental education but rather to allow for future program innovation, growth, and expansion. This document is also not intended to serve as a validation for program content within allied dental education or for written or clinical licensing examinations.

Program faculties should adapt this document to meet the needs of their individual programs and institutions. Given the dynamic nature of science, technology, and the health professions, these competencies should be reviewed and updated periodically.

Domains
1. **Core Competencies** (C) reflect the ethics, values, skills, and knowledge integral to all aspects of each of the allied dental professions. These core competencies are foundational to the specific roles of each allied dental professional.
2. **Health Promotion and Disease Prevention** (HP) are key components of health care. Changes within the health care environment require the allied dental professional to have a general knowledge of wellness, health determinants, and characteristics of various patient communities.
3. **Community Involvement** (CM). Allied dental professionals must appreciate their roles as health professionals at the local, state, and national levels. While the scope of these roles will vary depending on the discipline, the allied dental professional must be prepared to influence others to facilitate access to care and services.
4. **Patient Care** (PC). Allied dental professionals have different roles regarding patient care. These are reflected in the competencies presented for each discipline. The roles of the allied dental disciplines in patient care are ever-changing, yet central to the maintenance of health. Allied dental graduates must use their skills following a defined process of care in the provision of patient care services and treatment modalities. Allied dental personnel must be appropriately educated in an accredited program and credentialed for the patient care services they provide; these requirements vary by individual jurisdiction.
5. **Professional Growth and Development** (PGD) reflect opportunities that may increase patients’ access to the oral health care system or may offer ways to influence the profession and the changing health care environment. The allied dental professional must possess transferable skills (e.g., in communication, problem-solving, and critical thinking) to take advantage of these opportunities.

**Competencies for Entry into the Profession of Dental Assisting**

*Entry-level dental assistants work within a private practice or other clinical setting and assist the dentist in providing patient care. They may be certified but have no uniform state licensing requirements. These competencies assume a supervisory relationship.*

**Core Competencies (C)**

C.1 Apply a professional code of ethics in all endeavors.
C.2 Adhere to state and federal laws, recommendations, and regulations in the provision of oral health care.
C.3 Use critical thinking skills and comprehensive problem-solving to identify oral health care needs.
C.4 Use evidence-based decision making to evaluate emerging technologies and materials to assist in achieving high-quality, cost-effective patient care.
C.5 Assume responsibility for professional actions and care based on accepted scientific theories, research, and the accepted standard of care.
C.6 Continuously perform self-assessment for lifelong learning and professional growth.
C.7 Integrate accepted scientific theories and research into educational, preventive, and therapeutic oral health services.
C.8 Promote the values of the dental assisting profession through service-based activities, positive community affiliations, and active involvement in local organizations.
C.9 Apply quality assurance mechanisms to ensure continuous commitment to accepted standards of care.
C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.
C.11 Record accurate, consistent, and complete documentation of oral health services provided.
C.12 Facilitate a collaborative approach with all patients when assisting in the development and presentation of individualized care plans that are specialized, comprehensive, culturally sensitive, and acceptable to all parties involved in care planning.
C.13 Facilitate consultations and referrals with all relevant health care providers for optimal patient care.
C.14 Manage medical emergencies by using professional judgment, providing life support, and utilizing required CPR and any specialized training or knowledge.

**Health Promotion and Disease Prevention (HP)**

HP.1 Promote positive values of overall health and wellness to the public and organizations within and outside the profession.
HP.2 Respect the goals, values, beliefs, and preferences of all patients.
HP.3 Identify individual and population risk factors, and develop strategies that promote health-related quality of life.
HP.4 Evaluate factors that can be used to promote patient adherence to disease prevention or health maintenance strategies.
HP.5 Utilize methods that ensure the health and safety of the patient and the oral health professional in the delivery of care.
Community Involvement (CM)
CM.1 Assess the oral health needs and services of the community to determine action plans and availability of resources to meet the health care needs.
CM.2 Provide educational services that allow patients to access the resources of the health care system.
CM.3 Provide community oral health services in a variety of settings.
CM.4 Facilitate patient access to oral health services by influencing individuals or organizations for the provision of oral health care.
CM.5 Evaluate reimbursement mechanisms and their impact on the patient’s access to oral health care.
CM.6 Evaluate the outcomes of community-based programs, and plan for future activities.
CM.7 Advocate for effective oral health care for underserved populations.

Patient Care (PC)
Assessment
PC.1 Systematically collect, analyze, and record diagnostic data on the general, oral, and psychosocial health status of a variety of patients, using methods consistent with medicolegal principles.
PC.2 Recognize predisposing and etiologic risk factors that require intervention to prevent disease.
PC.3 Recognize the relationships among systemic disease, medications, and oral health that impact overall patient care and treatment outcomes.
PC.4 Identify patients at risk for a medical emergency, and manage the patient care in a manner that prevents an emergency.

Planning
PC.5 Select and assemble the appropriate materials and armamentarium for general and specialized patient care.
PC.6 Collaborate with the patient and other health professionals as required to assist in the formulation and presentation of a comprehensive care plan that is patient-centered and based on the best scientific evidence and professional judgment.

Implementation
PC.7 Utilize universal infection control guidelines for all clinical procedures.
PC.8 Provide, as directed, restorative procedures that preserve tooth structure, replace missing or defective tooth structure, maintain function, are esthetic, and promote soft and hard tissue health.
PC.9 Provide clinical supportive and intraoral treatments within the parameters of general and specialized patient care.
PC.10 Prevent, identify, and manage medical and dental emergencies.

Evaluation
PC.11 Evaluate the effectiveness of the provided services, and modify as needed.

Professional Growth and Development (PGD)
PGD.1 Pursue career opportunities within health care, industry, education, research, and other roles as they evolve for the dental assistant.
PGD.2 Develop practice management and marketing strategies to be used in the delivery of oral health care.
PGD.3 Access professional and social networks to pursue professional goals.
Competencies for Entry into the Profession of Dental Hygiene

Dental hygienists must complete an accredited educational program and qualify for licensure in any state or jurisdiction. They practice in collaboration with dental and other health care professionals in a variety of settings.

Core Competencies (C)

C.1 Apply a professional code of ethics in all endeavors.
C.2 Adhere to state and federal laws, recommendations, and regulations in the provision of oral health care.
C.3 Use critical thinking skills and comprehensive problem-solving to identify oral health care strategies that promote patient health and wellness.
C.4 Use evidence-based decision making to evaluate emerging technology and treatment modalities to integrate into patient dental hygiene care plans to achieve high-quality, cost-effective care.
C.5 Assume responsibility for professional actions and care based on accepted scientific theories, research, and the accepted standard of care.
C.6 Continuously perform self-assessment for lifelong learning and professional growth.
C.7 Integrate accepted scientific theories and research into educational, preventive, and therapeutic oral health services.
C.8 Promote the values of the dental hygiene profession through service-based activities, positive community affiliations, and active involvement in local organizations.
C.9 Apply quality assurance mechanisms to ensure continuous commitment to accepted standards of care.
C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.
C.11 Record accurate, consistent, and complete documentation of oral health services provided.
C.12 Initiate a collaborative approach with all patients when developing individualized care plans that are specialized, comprehensive, culturally sensitive, and acceptable to all parties involved in care planning.
C.13 Initiate consultations and collaborations with all relevant health care providers to facilitate optimal treatments.
C.14 Manage medical emergencies by using professional judgment, providing life support, and utilizing required CPR and any specialized training or knowledge.

Health Promotion and Disease Prevention (HP)

HP.1 Promote positive values of overall health and wellness to the public and organizations within and outside the profession.
HP.2 Respect the goals, values, beliefs, and preferences of all patients.
HP.3 Refer patients who may have physiological, psychological, or social problems for comprehensive evaluation.
HP.4 Identify individual and population risk factors, and develop strategies that promote health-related quality of life.
HP.5 Evaluate factors that can be used to promote patient adherence to disease prevention or health maintenance strategies.
HP.6 Utilize methods that ensure the health and safety of the patient and the oral health professional in the delivery of care.
Community Involvement (CM)

CM.1 Assess the oral health needs and services of the community to determine action plans and availability of resources to meet the health care needs.
CM.2 Provide screening, referral, and educational services that allow patients to access the resources of the health care system.
CM.3 Provide community oral health services in a variety of settings.
CM.4 Facilitate patient access to oral health services by influencing individuals or organizations for the provision of oral health care.
CM.5 Evaluate reimbursement mechanisms and their impact on the patient’s access to oral health care.
CM.6 Evaluate the outcomes of community-based programs, and plan for future activities.
CM.7 Advocate for effective oral health care for underserved populations.

Patient Care (PC)

Assessment

PC.1 Systematically collect, analyze, and record diagnostic data on the general, oral, and psychosocial health status of a variety of patients using methods consistent with medicolegal principles.
PC.2 Recognize predisposing and etiologic risk factors that require intervention to prevent disease.
PC.3 Recognize the relationships among systemic disease, medications, and oral health that impact overall patient care and treatment outcomes.
PC.4 Identify patients at risk for a medical emergency, and manage the patient care in a manner that prevents an emergency.

Dental Hygiene Diagnosis

PC.5 Use patient assessment data, diagnostic technologies, and critical decision making skills to determine a dental hygiene diagnosis, a component of the dental diagnosis, to reach conclusions about the patient’s dental hygiene care needs.

Planning

PC.6 Utilize reflective judgment in developing a comprehensive patient dental hygiene care plan.
PC.7 Collaborate with the patient and other health professionals as indicated to formulate a comprehensive dental hygiene care plan that is patient-centered and based on the best scientific evidence and professional judgment.
PC.8 Make referrals to professional colleagues and other health care professionals as indicated in the patient care plan.
PC.9 Obtain the patient’s informed consent based on a thorough case presentation.

Implementation

PC.10 Provide specialized treatment that includes educational, preventive, and therapeutic services designed to achieve and maintain oral health. Partner with the patient in achieving oral health goals.

Evaluation

PC.11 Evaluate the effectiveness of the provided services, and modify care plans as needed.
PC.12 Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-reports as specified in patient goals.
PC.13 Compare actual outcomes to expected outcomes, reevaluating goals, diagnoses, and services when expected outcomes are not achieved.
Professional Growth and Development (PGD)

PGD.1 Pursue career opportunities within health care, industry, education, research, and other roles as they evolve for the dental hygienist.

PGD.2 Develop practice management and marketing strategies to be used in the delivery of oral health care.

PGD.3 Access professional and social networks to pursue professional goals.

Glossary of terms

**Access.** Mechanism or means of approach into the health care environment or system.

**Assessment.** Systematic collection, analysis, and documentation of the oral and general health status and patient needs through a variety of methods, including radiographs, diagnostic tools, and instruments.

**Critical thinking.** The disciplined process of actively conceptualizing, analyzing, and applying information as a guide to action; ability to demonstrate clinical reasoning, diagnostic thinking, or clinical judgment.

**Community.** Group of two or more individuals with a variety of oral health needs including the physical, psychological, cognitive, economic, cultural, and educational and compromised or impaired people. The community also includes consumers and health professional groups, businesses, and government agencies.

**Cultural sensitivity.** A quality demonstrated by individuals who have systematically learned and tested awareness of the values and behavior of a specific community and have developed an ability to carry out professional activities consistent with that awareness.

**Dental assistant (DA).** An allied dental health professional who assists the dentist in practice and may choose to specialize in any of the following areas of dentistry: chairside general dentistry, expanded functions dental assisting (restorative) in general or pediatric dentistry, orthodontics, oral surgery, periodontics, assisting in dental surgery at area hospitals, endodontics, public health dentistry, dental sales, dental insurance, dental research, business assisting, office management, or clinical supervision.

**Dental hygiene care plan.** An organized presentation or list of interventions to promote health or prevent disease of the patient’s oral condition; plan is designed by the dental hygienist based on assessment data and consists of services that the dental hygienist is educated and licensed to provide.

**Dental hygiene diagnosis.** The dental hygiene diagnosis is a component of the overall dental diagnosis. It is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis utilizes critical decision making skills to reach conclusions about the patient’s dental hygiene needs based on all available assessment data.

**Dental hygiene process of care.** There are five components to the dental hygiene process of care: assessment, dental hygiene diagnosis, planning, implementation, and evaluation. The purpose of the dental hygiene process of care is to provide a framework within which individualized needs of the patient can be met and to identify the causative or influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.

**Dental hygienist (DH).** A preventive oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide educational, clinical, research, administrative, and therapeutic services supporting total health through the promotion of optimum oral health.

**Dental laboratory technician (DLT).** An allied dental professional who manufactures custom-made dental devices according to written authorization from licensed dentists using a variety of materials, equipment, and manufacturing techniques in the specialty areas of complete dentures, removable partial dentures, orthodontics, crown and bridge, and ceramics.
Evaluate. The process of reviewing and documenting the outcomes of treatment and interventions provided for patients.

Evidence-based care. Provision of patient care based on the integration of best research evidence with clinical expertise and patient values.

Intervention. Oral health services rendered to patients as identified in the care plan. These services may be clinical, educational, or health promotion-related.

Medicolegal. Pertains to both medicine and law; considerations, decisions, definitions, and policies provide the framework for many aspects of current practice in the health care field.

Occupational model. Suggests technical training for a trade or occupation.

Outcome. Result derived from a specific intervention or treatment.

Patient. Potential or actual recipients of health care, including oral health care, and including persons, families, groups, and communities of all ages, genders, sociocultural, and economic states.

Patient-centered. Approaching services from the perspective that the patient is the main focus of attention, interest, and activity and that the patient’s values, beliefs, and needs are of utmost importance in providing care.

Practice. To engage in patient care activities.

Professional model. Requires formal academic education and qualification for entry into a profession through prolonged education, licensure, or regulation and adherence to an ethical code of practice.

Refer. Through assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner’s competence or area of expertise. It assumes that the patient understands and consents to the referral and that some form of evaluation will be accomplished through cooperation with professionals to whom the patient has been referred.

Reflective judgment. A construct that merges the mental capabilities of critical thinking and problem-solving and represents a higher level clinical decision making skill.

Risk assessment. Qualitative and quantitative evaluation gathered from the assessment process to identify the risks to general and oral health. The data provide the clinician with the information to develop and design strategies for preventing or limiting disease and promoting health.

Risk factors. Attributes, aspects of behavior, or environmental exposures that increase the probability of the occurrence of disease.

Sources


