

ADEA's Charting Progress has become a place where some of the most thoughtful ADEA members can weigh in on why emerging trends and challenges matter.

In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, remarks on how ADEA's Charting Progress has helped prepare us for the future by shaping vital conversations within our community on issues of concern.



Five Years of Looking Around the Corner

"Sometimes the best way to see the present in sharp focus is to look at the past." With these words, I opened a dialogue with all of you five years ago this month. The vehicle was this very letter, *ADEA's Charting Progress*, a new member service conceived as a vehicle "to inform you about the issues addressed by ADEA and the reasons they are important."

I took some time this month to look back at my earlier letters. I think it's fair to say they are indeed informative, and I was pleased to see how fresh and relevant the topics they address remain. As ADEA Executive Director, I have the privilege of a front-row seat as events unfold in our community. I have tried to take advantage of this, not just to report on current happenings, but to peer around the corner to see what awaits us in the wings.

A review of the first year's articles, beginning in 2006, reveals a lot in this regard. In that 12 months alone, we explored the demographic changes impacting dental education, the knowledge explosion, the importance of advocacy, the need for change and innovation in dental education, the importance of leadership development, the economics of our enterprise, the opportunities provided by globalization, new routes to licensure, developments in advanced dental education, and emerging workforce models—all topics that we have revisited in the years since or will likely address again in the near future.

I also discovered an interesting contradiction. Despite admitting in [August 2006](#) that, "From our current vantage points, none of us can truly see the shape of our profession 50 years from now," in January 2009, I threw caution to the winds and did my best to imagine the future that awaits us in a letter titled ["Dental Education in 2050."](#)

What will be Academy of the future look like? You may not be able to see it at all. In a wired world, where we can share information digitally, reduced costs and increased convenience may well trump the perceived benefits of bringing students, residents, and faculty together under one roof ... The faculties of tomorrow will also evolve. They will become more interdisciplinary in keeping with the practice community, and they will represent expertise in areas we can only start to imagine ... By 2050 a great deal of [clinical dental education] will have moved to sites in the community ... Indeed it's possible that some academic dental institutions will eliminate their bricks and mortar facilities entirely ... [becoming] communication hubs with their professors and learners distributed in ways that suit each individual best.

While I hope this occasional prognostication has given you food for thought, in looking back I noticed that *Charting Progress* has taken on another, equally important dimension. In addition to alerting our community to emerging trends and challenges, it has become a place where some of the most thoughtful ADEA members can weigh in on why these developments matter.

A case in point: Changes occurring within the oral health workforce first made their appearance in our [March 2007](#) letter, where I discussed the Alaska Dental Health Aide Therapist or DHAT, one of several models of allied dental providers that had recently emerged. By the time we [revisited this topic in 2009](#), Minnesota was in the

midst of a major effort to introduce a new provider to the dental workforce. I spoke with Dr. Patrick Lloyd, Dean of the School of Dentistry at the University of Minnesota, which had introduced two new dental therapy degrees. Reflecting on his travels to alternative provider programs, he told me, "I came to recognize that the most significant advantage a dental school-based education program has is its ability to train to a single standard of care, thus ensuring public trust and the respect of the profession."

I also invited Prof. Colleen Brickle, Dean of Health Sciences at Normandale Community College, which had introduced a dental therapist program, to share her thoughts on why a new provider was needed in her state. "These collaborating hygienists [who practice in underserved areas under collaborative agreements] are identifying decay, making referrals to dentists, and coming back six months later to find out that there's been no follow-up," she said. "That's why we need mid-level providers in underserved areas. We have to close the loop to take care of the disease that's out there."

Another perennial topic: the promise of new dental schools and concerns about their proliferation. Our conversation first touched on this topic in [early 2007](#), when I addressed the relationship between dental schools and their parent institutions. Reflecting on the period in the 1980s and 90s when several dental schools closed, I reminded readers that "the lesson that endures unchanged is the critical need for dental schools to mesh their priorities with their parent institutions'."

If you were at the [Point/Counterpoint session at the 2011 ADEA Annual Session & Exhibition in San Diego](#) on whether or not our community should encourage the creation of new dental schools, you probably noted that Dr. Dominick DePaola said very much the same thing. In [May 2008](#), I asked two other participants on that panel for their views on whether "the creation of new dental schools [is] the best or the only way to address access to care issues."

Dr. Jack Dillenberg, Dean of the Arizona School of Dentistry and Oral Health, replied in the affirmative, pointing out that, "Greater than 30 percent of our graduates will provide oral health care in community health center settings in Arizona and around the country."

Dr. Jerry Goldberg, Dean at the Case Western Reserve University School of Dental Medicine, disagreed. "[T]here's no evidence to suggest that dentists will move to rural areas or seek out clients who can't pay just because there are more of us."

I hope you agree that the practice of inviting members of our community to add their voices to the *Charting Progress* conversation has both enlivened this newsletter and enriched our common understanding of the events unfolding around us. Another memorable instance occurred in [October 2010](#), when we began exploring the concept of patient-centered care. I asked Dr. Bob Berkowitz, Chair of the Division of Pediatric Dentistry at the University of Rochester School of Medicine and Dentistry, to share his take on how this concept should be understood at the graduate level. "Regardless of specialty, all residency programs should inculcate their residents with a sense of responsibility, a sense of diligence regarding the gamut of their patients' oral health needs," he explained. "That is the foundation of patient-centered care."

This conversation arose in response to the incorporation of patient-centered care in the new CODA Accreditation Standards for Dental Education Programs. Knowing that dental hygiene program standards had included patient-centered care for many years, I asked Dr. Ellen Grimes, Program Director of Dental Hygiene at Vermont Technical College, to give me her take on this development. She "told me she was thrilled to learn about the new CODA standards related to patient-centered care. 'I worry that in those dental offices that are more production oriented,' she said, 'the patient-centered aspect of care sometimes may not be treated with the respect it deserves.'"

We revisited this topic [this past February](#), when we talked about the draft [Core Competencies for Interprofessional Collaborative Practice](#) (finalized and released earlier this month) that ADEA and five other health professions education associations have just finished crafting. Several of you commented that after reading that issue of *ADEA's Charting Progress*, you felt relieved to finally fully grasp the connection between interprofessional collaborative practice and patient-centered care. I think I have our Past President Dr. Sandra Andrieu to thank for that. I quoted her as saying, "When you have an ill person you care about, and you go from provider to provider and see that they don't have a common language, and that the patients really suffer, it gives you the impetus and the drive to make [interprofessional collaborative practice] a priority."

There are so many other topics I would like to revisit: our robust dialogue on the meaning of professionalism, changes taking place around assessment and licensure, advances in our efforts to increase diversity in our professions, the extraordinary role that corporate members play in our Association, and the global implications of our work, to name just a few. You can see our conversations on all of these and other topics, too, in the [ADEA's Charting Progress archives](#) on our website. For now, I will limit myself to one more observation.

In looking through these letters, a consistent theme that emerges is a shared confidence in our community's ability to tackle tough challenges. We will always face contentious issues, and on many of them, we will disagree. Nevertheless our Association provides a forum where we can engage in informed debate and collaborate to address our community's most pressing challenges.

We saw this just over a year ago with the historic passage of the Affordable Care Act, which addressed key issues of importance to academic dental institutions, required insurance plans to include pediatric oral health services for children up to 21 years of age, and established a public-education campaign focused on oral health care prevention. [As early as 2007](#), we began pondering the emerging debate on health care reform. Our conclusion? "This favorable alignment of current political realities with ADEA's commitment to support policies that promote and enhance access to care creates an unprecedented opportunity for us. We can and must seize this moment." Well, we did, involving members from all corners of our Association and in concert with a broad alliance of organizations that shared our concerns.

And while we're on the topic of American history, let me leave you with the Civil War tale I used to start our conversation five years ago.

Six opposable upper and lower front teeth were what Civil War soldiers needed to bite off the ends of the paper gunpowder cylinders for their muzzle-loaded rifles—and to do so under combat conditions. These were young men, average age 21, but many were sent home for want of six opposable teeth.

A quarter of the reservists in early-deploying National Guard units bound for Iraq had dental problems likely to require emergency care within a year.

The remnants of that more recent war are still with us, and so are the unmet oral health needs of too many of our citizens. That is ultimately what all these other discussions are about. Five years from now, I hope to be able to report on significant progress made in meeting those needs, and on how our dialogue in these pages has helped make it happen.



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