Across the United States, the role of the dental hygienist is evolving. As a result, the dental hygiene curriculum must expand from a traditional private practice focus to include other career pathways, such as providing direct access oral health care in alternative settings, practicing in interprofessional health care environments, being an educator, engaging in research, participating in public health efforts, working in corporate settings, being an entrepreneur, and serving in administrative positions.1

Direct access for dental hygienists to provide preventive dental care to vulnerable populations is now part of the practice act in 38 states.2 Settings specified in many of these state practice acts include hospitals, schools, Head Start programs, senior centers, group homes, migrant work facilities, correctional institutions, long-term care facilities, and many more. Dental hygiene graduates of the future must be prepared to work with medically complex populations and individuals with special needs and to demonstrate effective collaboration skills in interprofessional teams. However, it is not clear that dental hygiene education is preparing students for these roles.

Over the past decade, the American Dental Education Association (ADEA) has issued numerous recommendations for change in allied dental education in documents such as the proceedings of the 2006 ADEA Summit on Allied Dental Education; the ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models, approved by the 2011 ADEA House of Delegates; and the Competency Domains for Oral Health Professionals in Emerging Workforce Models recommended by the ADEA Council of Allied Dental Program Directors Task Force on Collaboration, Innovation, and Differentiation.3-5 Despite these recommendations, the 2016 Commission on Dental Accreditation (CODA) Accreditation Standards for Dental Hygiene Programs show few significant changes to support the needed evolution in dental hygiene education to prepare graduates for emerging workforce models and new roles in oral health care of the public.6 These CODA standards remain focused on the private practice role of the dental hygienist with prescriptive minimal clinical hours that typically occur in the controlled on-campus clinic for tracking of student patient care and program outcomes assessment. Competence in care of special needs patients remains limited to treatment planning in these standards, and utilization of extramural clinical sites has become increasingly challenging due to implementation of expectations for prior approval by CODA. CODA Standard 2 addresses the educational program; however, only one clause (2-16) relates to community health promotion and disease prevention. These omissions create a barrier for dental hygiene curricula to expand into less traditional practice settings and effectively educate students for emerging roles within the profession.

In a continuing attempt to address these emerging dental hygiene roles, in 2013 the American Dental Hygienists’ Association (ADHA), in collaboration with the U.S. Department of Health and Human Services, brought together stakeholders to develop learning domains and curricula for a new approach to dental hygiene education to better prepare future graduates.7 Some of the additions to the more traditional domains of dental hygiene education include communication and collaboration with intra- and interprofessional teams and preparation to integrate oral health into the broader health care system. These proposed new domains mirror those in the previous Competency Domains for Oral Health Professionals in Emerging Workforce Models.5

This issue of the Journal of Dental Education addresses some of the domains necessary to prepare graduates for the future of health care, with
three articles focused on intra- and interprofessional education.\textsuperscript{8,10} Two of these articles also explore the value of dental hygiene students’ peer teaching to impact dental and/or medical students’ perceptions of the role of dental hygienists.\textsuperscript{8,10} This research is of particular interest given that many dental schools do not have dental hygiene programs, so dental and dental hygiene students lack the opportunity to work together and appreciate what each brings to the dental team in providing quality care. These studies also suggest ways to bridge the gap between medical and dental communities, especially important for settings in which direct access dental hygienists may provide collaborative care. Another article explores perspectives about dental hygiene roles regarding prevention in dental public health,\textsuperscript{11} a role that was central to the motivation of Dr. Alfred C. Fones, the father of dental hygiene, in establishing the first dental hygiene school in 1913.\textsuperscript{12} Finally, Turner et al. report on their research about millennial dental hygiene students’ learning preferences,\textsuperscript{13} and Smith et al. present the results of a national study seeking to identify barriers and motivations for dental hygienists to pursue graduate education—an important step in the future development of the profession.\textsuperscript{14}

Regarding the impact of new workforce models on dental hygiene education, ADEA President and CEO Dr. Richard W. Valachovic stated, “Education should be out in front of change, but too often it is struggling to keep pace and move forward as professional practice evolves.”\textsuperscript{15} The articles in this issue, along with the many ongoing discussions on these topics, point to ways dental hygiene education can take a leadership role in moving the profession forward to improve oral health care for all.

REFERENCES

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