This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

Dental Hygiene Educator Workforce Shortage: A review of the literature

Joni M. Hamilton, RDH, BSDH
Suzanne K. Thompson, RDH, BSDH

ABSTRACT

Purpose Oral health care education programs are facing challenges extending beyond isolated hiring difficulties that reflect broader structural forces shaping the academic workforce. The purpose of this literature review was to examine the structural factors contributing to the dental hygiene faculty shortage and to identify evidence-based strategies that support sustainable recruitment and retention in oral health education programs.

Methods A literature search was conducted using CINAHL, PubMed, ERIC, and Google Scholar. Search terms included: dental hygiene faculty shortage, health professions education workforce, faculty burnout, workload equity, compensation models, and mentoring in health sciences education. Inclusion criteria consisted of peer-reviewed articles published between 2010-2026 that addressed workforce trends, faculty recruitment and retention, accreditation or credentialing requirements, workload models, or the integration of educational technologies. Opinion pieces without empirical or conceptual grounding were excluded.

Results Forty-three articles met the inclusion criteria and were synthesized to identify common structural themes and recommended interventions. Across the literature, four dominant structural contributors to the faculty shortage emerged: compensation disparities between clinical and academic roles, limited graduate education pathways, accreditation and credentialing constraints, and unsustainable workload expectations. Studies also highlighted high levels of burnout, turnover intention, and employment instability among health science faculty. Evidence supported the effectiveness of comprehensive compensation models, structured mentoring and onboarding, equitable workload distribution, and the use of emerging technologies, including artificial intelligence, to reduce administrative burden.

Conclusion Faculty shortages in dental hygiene were shown to be driven by structural, rather than isolated, factors. Programs that rely heavily on part-time faculty experience greater workload imbalance and burnout among full-time educators. Interventions that integrate compensation reform, workload equity, mentoring, and educational technologies offer the greatest potential to stabilize the dental hygiene educator pipeline. Addressing these factors is essential for maintaining accreditation compliance, ensuring instructional quality, and supporting long-term workforce sustainability in dental hygiene education programs.

Keywords dental hygiene education, health professions education workforce, clinical education, faculty recruitment, faculty retention, turnover intention

NDHRA priority area, **Professional development: Education** (evaluation).

Submitted for publication: 4/15/2026; accepted after revision: 6/3/2026

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

INTRODUCTION

A root cause analysis of the health care educator shortage demonstrates that challenges facing oral health care education programs extend beyond isolated hiring difficulties and instead reflect broader structural forces shaping the academic workforce.[1] National analyses across dental hygiene and allied health education similarly identify persistent shortages linked to compensation disparities, limited access to graduate education, and increased credentialing expectations, all factors that collectively narrow the educator pipeline and intensify recruitment challenges.[2] These pressures are compounded by accreditation demands, chronic underfunding, and heavy workloads concentrated among a small number of full-time faculty, creating conditions that make recruitment and retention increasingly difficult.

The purpose of this literature review was to examine the structural factors contributing to the dental hygiene faculty shortage and to identify evidence-based strategies that support sustainable recruitment and retention in oral health education programs. Across the literature, several interconnected challenges consistently emerged: wage differentials between clinical practice and academia, restricted pathways to advanced degrees, accreditation and credentialing requirements that limit hiring flexibility, and workload expectations that contribute to burnout and turnover. Corresponding strategies described in the literature included comprehensive compensation models, structured mentoring and onboarding systems, sustainable workload practices, and the integration of emerging educational technologies to support instructional efficiency. The following literature review analyzes these structural forces within the broader health care educator landscape, with specific attention to their impact on dental hygiene programs. By synthesizing evidence from national reports and peer-reviewed studies, this review highlights the need for coordinated, long-term, evidence-based interventions to stabilize the dental hygiene educator workforce and sustain program capacity. Together, these structural challenges illustrate why a broader, professional framework is necessary to guide meaningful workforce solutions.

METHODS

Literature searches were conducted in CINAHL, PubMed, ERIC, and Google Scholar between January and March 2026 using combinations of the following terms: dental hygiene faculty shortage, health professions education workforce, faculty burnout, workload equity, compensation models, graduate education pathways, accreditation and credentialing, and mentoring in health sciences education. Boolean operators (AND/OR) were used to refine and combine terms to identify literature addressing structural influences on the supply of qualified health care educators, with specific attention to dental hygiene faculty.

Eligible sources included peer-reviewed studies, conceptual analyses, and national workforce or accreditation reports published between 2010 and 2026 that addressed at least one of the following: workforce trends in dental hygiene or allied health education; faculty recruitment and retention; accreditation or credentialing requirements affecting educator supply; workload models or occupational health; compensation structures in health professions education; or the integration of educational technologies. Opinion pieces without empirical or conceptual grounding, articles focused solely on clinical practice, and sources unrelated to faculty workforce issues were excluded. National reports from the American Dental Education Association (ADEA), the American Association of Colleges of Nursing (AACN), and the Commission on Dental Accreditation (CODA) were also incorporated to provide comprehensive coverage of educator demographics, hiring trends, and regulatory expectations that shape faculty supply.

A structured analytic process was used to identify evidence-based interventions reported in the literature. Because the review question sought to examine both systemic contributors and strategies to improve recruitment and retention, interventions such as compensation reform, mentoring and onboarding systems, sustainable workload models, and the integration of emerging technologies were extracted as part of the thematic synthesis. These strategies were not analyzed separately; rather, they were derived

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

directly from patterns observed across the included studies. Organizing both the structural contributors and the recommended interventions within a unified thematic framework ensured alignment with the review's purpose.

RESULTS

A total of 43 sources met the inclusion criteria and were analyzed using a thematic synthesis approach. This analytic method involved identifying recurring patterns across studies and examining areas of thematic convergence and divergence to ensure that the structural contributors reflected consistent findings across the literature. The emphasis was on identifying shared structural factors that emerged repeatedly across the included sources.

Across the literature, four dominant structural contributors to the dental hygiene faculty shortage were consistently identified: compensation disparities between clinical and academic roles, limited graduate education pathways, accreditation and credentialing constraints, and unsustainable workload expectations.[3-6] Studies also reported high levels of burnout, turnover intention, and employment instability among both health science and dental hygiene faculty members.[7-9] Compensation disparities were widely documented as a primary factor influencing educator supply. Multiple sources described a persistent wage gap between clinical practice and academic roles, reinforced by institutional salary structures and state funding models.[3,10] Because many oral health care programs operate within tight budgets, they are often unable to offer competitive salaries, full-time positions, or professional development opportunities. These financial constraints can limit programs' ability to attract and retain qualified educators, contributing to ongoing vacancies.

Limited access to graduate education also emerged as a significant structural barrier. In many regions, particularly rural and underserved areas, clinicians have restricted access to bachelor's and master's degree programs, which are increasingly required for full-time didactic teaching assignments.[11] The literature also notes that this lack of accessible educational pathways reduces the number of dental hygienists eligible to transition into academic roles.

Accreditation and credentialing requirements further narrowed the educator pipeline. Prior to 2025, the Commission on Dental Accreditation (CODA) required all dental hygiene faculty, both didactic and clinical, to hold at least a baccalaureate degree. In 2025, CODA revised this standard, lowering the minimum credential for clinical and laboratory faculty to an associate degree to ease hiring constraints.[5] Despite this change, credentialing expectations continue to limit hiring flexibility for programs located in regions where most practicing hygienists hold only an entry-level associate degree.

Workload expectations were also identified as a major contributor to faculty shortages. The literature describes heavy teaching, clinical, and administrative responsibilities concentrated among a small number of full-time faculty, intensified by persistent staffing imbalances and reliance on part-time instructors.[6,12] National dental educator workforce data indicated that, although full-time hiring outpaced departures in 2024, with 225 new full-time dental hygiene faculty hired compared to 178 who left, turnover remained significant, particularly in dental hygiene and dental laboratory technology programs.[13] Retirement trends further compounded these pressures, as many health care faculty are nearing retirement age.[8] Collectively, the reviewed literature described a workforce landscape characterized by compensation limitations, restricted educational pathways, credentialing constraints, and escalating workload demands, all of which contribute to a shrinking pool of qualified dental hygiene educators (Table I).

DISCUSSION

The reviewed literature demonstrates that faculty shortages in dental hygiene and other health science programs are driven by structural forces that extend beyond individual institutions' hiring practices. Compensation disparities, accreditation requirements, limited graduate education pathways,

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

Table I. Structural Contributors to the Dental Hygiene Faculty Shortage

Factor	Descriptive findings reported in the literature	Representative sources
Compensation disparities	Wage gaps between clinical practice and academic roles; institutional salary structures and state funding models limit competitive pay; constrained budgets reduce the ability to offer full-time positions or professional development.	American Dental Education Association workforce and salary studies
Limited graduate education pathways	Restricted access to bachelor's and master's programs, especially in rural regions; clinicians face financial and geographic barriers to degree completion; limited pathways reduce the pool of eligible educators.	Allied health education literature; regional workforce analyses
Accreditation and credentialing constraints	Prior to 2025, CODA required all faculty to hold a baccalaureate degree; the 2025 revision lowered the minimum credential for clinical/laboratory faculty to an associate degree; credentialing expectations continue to narrow hiring flexibility in regions where most hygienists hold entry-level degrees.	Commission on Dental Accreditation Standards
Unsustainable workload expectations	Heavy teaching, clinical, and administrative responsibilities are concentrated among a small number of full-time faculty, and reliance on part-time instructors intensifies workload pressures.	Health science faculty workload studies
Burnout, turnover, and retirement trends	High levels of burnout and turnover intention; 225 full-time faculty hired vs. 178 departures in 2024; significant turnover in dental hygiene and dental laboratory technology programs; many faculty nearing retirement age.	American Dental Education Association workforce and salary studies

and escalating workload expectations interact in ways that constrain the educator pipeline and undermine long-term workforce stability. These pressures create an environment in which vacancies persist, workloads intensify, and dental hygiene programs struggle to maintain instructional quality. Understanding these dynamics requires examining how structural conditions shape faculty behavior, institutional capacity, and the broader landscape of health professions education.

A recurring theme in the literature was the imbalance between the structural demands placed on academic programs and the resources available to meet them. Compensation disparities contribute to faculty recruitment and retention challenges, as salaries in academia often lag behind clinical earnings, creating financial disincentives and contributing to early-career faculty turnover. While clinical instructor roles in dental hygiene may offer compensation more comparable to private practice settings, these positions involve responsibilities extending beyond patient care, including student supervision, evaluation, and feedback.[3,10]

Full-time faculty, particularly those fulfilling both didactic and clinical roles, face substantially greater workload demands than practicing clinicians. Responsibilities extend beyond clinical supervision to include course development, assessment, accreditation compliance, and institutional service.

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

Teaching-intensive roles, especially in clinical and laboratory settings, require significant time investment that is often not reflected in compensation models. This misalignment contributes to role strain and discourages clinicians from entering or remaining in academic positions. Institutional salary structures and state funding constraints further limit the ability to offer competitive compensation or full-time roles.[4,6] Collectively, compensation limitations, expanded workload expectations, and dual role demands contribute to persistent faculty shortages in dental hygiene and allied health education.

Clinical and didactic instruction in dental hygiene education represent distinct yet complementary components of professional preparation. Clinical teaching emphasizes the development of psychomotor skills, patient-centered care, and real-time clinical decision-making, whereas didactic instruction focuses on theoretical foundations, evidence-based practice, and curriculum delivery. These roles require differing levels of academic preparation and pedagogical expertise but are collectively essential to program integrity and student competency.[14]

Limited access to post-graduate education pathways continues to constrain the educator pipeline. In many regions, particularly rural and underserved areas, clinical dental hygienists encounter geographic, financial, and logistical barriers to completing bachelor's and master's degrees, credentials that are increasingly required for full-time faculty positions with responsibilities for academic course instruction.[11] Although clinical teaching roles may be more accessible for individuals without advanced degrees, they do not sufficiently address the demand for faculty qualified to design, deliver, and evaluate curriculum within accredited dental hygiene programs. Consequently, the limited availability of accessible graduate education pathways reduces the number of dental hygienists eligible to transition into full-time academic positions, perpetuating persistent faculty shortages, particularly in programs outside major metropolitan areas. Without expansion of graduate education opportunities, especially through flexible online and hybrid formats, the educator pipeline will remain insufficient to meet current and projected workforce needs.

Accreditation and credentialing requirements also shape the educator pipeline by defining the minimum qualifications for teaching roles. While changes to CODA's minimum credentials for clinical and laboratory faculty increased hiring flexibility for clinical instruction,[5] they do not fully address the broader structural pressures affecting workforce supply. Dental hygiene programs located in regions where most dental hygienists hold an entry-level associate degree continue to face challenges recruiting qualified faculty. These constraints highlight the need for more coordinated structural strategies to expand educational pathways and strengthen the academic workforce.

Workload expectations emerged as a critical factor influencing faculty retention. Heavy teaching loads, extensive clinical supervision, and escalating administrative responsibilities disproportionately fall on a small number of full-time faculty, particularly in programs that rely heavily on part-time instructors.[6] These workload pressures contribute to burnout, emotional exhaustion, and turnover intention across all sectors in health professions education.[7,15] Retirement trends further compound these challenges, as many faculty are leaving the workplace.[8] As vacancies persist, remaining faculty absorb additional responsibilities, creating a cycle of overload that undermines program stability and long-term workforce sustainability.

The literature also highlights the role of occupational health in shaping faculty retention. Faculty experiencing chronic overload report diminished job satisfaction, reduced scholarly productivity, and an increased likelihood of leaving academia altogether.[6] These occupational health concerns are intensified in programs with limited staffing flexibility, where vacancies have forced remaining faculty to absorb additional responsibilities. The cumulative effect of these pressures contributes to a workforce environment characterized by instability, burnout, and high turnover intention.

Emerging technologies, including artificial intelligence (AI), offer potential avenues for mitigating some of these structural pressures. Artificial intelligence-

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

supported tools have been shown to streamline administrative tasks such as grading, scheduling, documentation, and content updates, thereby reducing the time faculty spend on repetitive clerical work.[15,16] These efficiencies can allow educators to redirect their efforts toward higher-value activities, including student feedback, curriculum development, and clinical instruction. Virtual simulations, adaptive learning platforms, and automated feedback systems further expand instructional capacity by supporting student learning outside of traditional classroom and clinic hours. When implemented intentionally and supported by adequate training, these technologies can enhance teaching effectiveness, reduce workload strain, and improve the overall learning environment. However, the literature also emphasizes that technological solutions must complement, not replace, structural reforms in compensation, workload policy, and faculty development.[17]

Mentoring and onboarding systems have also been shown to be important in shaping faculty retention and long-term career satisfaction. Early career faculty benefit from structured mentoring relationships that provide guidance, role clarity, and support during the transition from clinical practice to academia.[18] Without these supports, new educators often experience uncertainty, isolation, and difficulty navigating academic expectations, all factors that can contribute to early attrition across health professions education. Effective onboarding processes further strengthen retention by clarifying institutional culture, workload expectations, and performance standards. When mentoring and onboarding are intentionally designed and adequately resourced, they function as protective factors that enhance faculty confidence, professional identity formation, and long-term commitment to academic careers.[18]

Equally important are workload policies that acknowledge the complexity of academic labor and protect faculty well-being, along with the intentional integration of artificial intelligence and educational technologies to enhance instructional efficiency and reduce administrative burden.[15] These strategies are most effective when implemented through coordinated action across institutions, state systems, and professional organizations, ensuring alignment among accreditation expectations, funding structures, and workforce development priorities.[5,18]

Finally, the literature emphasizes the need for coordinated structural actions across institutions, state systems, and professional organizations to address the root causes of the faculty shortage. Individual programs cannot independently resolve compensation disparities, accreditation constraints, or statewide funding limitations. Aligning accreditation standards, compensation models, and workforce development strategies can help ensure that programs have the resources and flexibility needed to maintain high-quality instruction.[19] State-level investment in graduate education pathways, competitive salary structures, and faculty development initiatives are particularly important for strengthening the educator pipeline in rural areas with limited access to advanced degrees.

Collaboration with professional organizations also plays a critical role in advocating policy changes, supporting leadership development, and promoting long-term workforce sustainability.[20] Together, these findings underscore the need for comprehensive structural interventions that address the root causes of the dental hygiene faculty shortage. Interventions that integrate compensation reform, expanded educational pathways, mentoring and onboarding systems, sustainable workload models, and strategic integration of educational technologies hold the greatest promise for strengthening the educator pipeline and supporting long-term workforce sustainability. Structural recommendations to address the dental hygiene faculty shortage and strengthen long-term workforce sustainability are shown in Appendix A.

CONCLUSION

The dental hygiene faculty shortage is driven by structural forces that extend beyond individual programs and require coordinated structural solutions. Compensation disparities, limited graduate education pathways, accreditation constraints, unsustainable workload expectations, and occupational health

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

pressures collectively restrict the educator pipeline and undermine long-term workforce stability. Addressing these challenges demands interventions that operate at the same structural level as the forces producing them. Sustained investment in faculty development, workload equity, and educational infrastructure is essential for maintaining high-quality dental hygiene education and advancing the profession.

IMPLICATIONS FOR DENTAL HYGIENE PRACTICE

- Sustaining a strong dental hygiene faculty pipeline is critical to the profession's educational and clinical integrity; without structural support, ongoing faculty shortages may erode academic capacity and ultimately shift dental hygiene practice toward a more task-oriented, technician-focused model.
- Improved workload equity and occupational health among faculty enhance the quality and consistency of clinical instruction, supporting stronger psychomotor skill development and evidence-based decisionmaking in students. Chronic overload contributes to burnout, emotional exhaustion, and turnover intention, conditions that undermine the preparation of dental hygiene graduates entering practice.
- Intentional use of AI tools can "streamline administrative tasks such as grading, scheduling, documentation, and content updates," allowing faculty to devote more time to high-value clinical teaching essential to dental hygiene practice.

DISCLOSURES

The authors have no conflicts of interest to disclose.

Joni M. Hamilton, RDH, BSDH
School of Counseling, Leadership, Advocacy, and Design
College of Education
University of Wyoming
Laramie, WY, USA

Suzanne K. Thompson, RDH, BSDH
School of Counseling, Leadership, Advocacy, and Design
College of Education
University of Wyoming
Laramie, WY, USA

Corresponding author:
Joni M. Hamilton, RDH, BSDH;
jhamilt8@uwyo.edu

REFERENCES

1. Noe RA. Employee training and development. 9th ed. New York (NY): McGraw-Hill Higher Education; 2022. 560 p.
2. Carr E, Ennis R, Baus L. The dental hygiene faculty shortage: Causes, solutions and recruitment tactics. J Dent Hyg. 2010 Fall;84(4):165-9.
3. Hannover Research. Best practices in faculty compensation models [Internet]. Arlington (VA): Hannover Research; 2024 Apr [cited 2026 Feb 20]. Available from: https://www.insidehighered.com/sites/default/files/2024-06/IHE_Best%20Practices%20in%20Faculty%20Compensation%20Models%20%281%29.pdf
4. Boamah SA, Kalu ME, Havaei F, et al. Predictors of nursing faculty job and career satisfaction, turnover intentions, and professional outlook: A national survey. Healthcare (Basel). 2023 Jul 24;11(14):2099.
5. CODA. Accreditation standards for dental hygiene education programs [Internet]. Chicago (IL): American Dental Association; 2026 [cited 2026 Feb 20]. Available from: https://coda.ada.org/-/media/project/ada-organization/ada/coda/files/dental_hygiene_standards.pdf
6. Schmiedehaus E, Cordaro M, Perrotte J, et al. The great resignation in higher education: An occupational health approach to understanding intentions-to-quit for faculty in higher education. Teach Teach Educ. 2023 Mar; 123:103992.
7. Arnett MC, Ramaswamy V, Snay S, et al. A qualitative assessment of dental hygiene educators' COVID-19 related burnout. J Dent Educ. 2022 Nov;86(11):1448-58.
8. Christianson J, Malin K, Leiberg J, et al. Educating to exhaustion: Intention to leave among US full-time nursing faculty. Nurs Educ Perspect. 2026 Mar-Apr 1;47(2):86-95.

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

9. American Association of Colleges of Nursing. Nursing faculty shortage factsheet [Internet]. Washington DC: 2026 [cited 2026 Feb 21]. Available from: https://www.aacnnursing.org/Portals/0/PDFs/Fact-Sheets/Faculty-Shortage-Factsheet.pdf

10. Terry B. Faculty perceptions of challenges to faculty retention in workforce training programs at a higher education center in the southern United States [dissertation]. Minneapolis (MN): Walden University; 2025. Walden Dissertations and Doctoral Studies. 17718.

11. Nathe C. Impact of education on your career. Dimens Dent Hyg. 2020 Jul;18(7):12-14.

12. Kentar L, Boyd LD, Vineyard J, McCarthy J. Effort–reward imbalance among dental and dental hygiene faculty and turnover intention. J Dent Educ. 2025 Aug;89(8):1200-10.

13. ADEA. An analysis of the results of the 2024 ADEA survey of allied dental program directors in the United States [Internet]. Washington DC: American Dental Education Association; 2025 [cited 2026 Feb 20]. Available from: https://www.adea.org/detail-pages/blog/adea---news-and-events/2025/08/12/adea-releases-new-data-report-on-the-results-of-the-2024-adea-survey-of-allied-dental-program-directors

14. Torpey C, Bono LK, Gurenlian J. Effective clinical dental hygiene educators: A qualitative study of perspectives of students and educators. J Dent Educ. 2025 Sep;89(9):1303-04.

15. Saylor J, Evans J, Goodolf D, et al. Exploring burnout and leadership mitigation plans in academic nursing environments. Nurse Educ. 2025 May;50(3):140-44.

16. Troy AM, Bono LK, Gurenlian JR. Educators' perspectives on the use of artificial intelligence in dentistry. J Dent Hyg. 2025 Dec;99(6):40–51.

17. Mehta N, Mehta S, Rubenstein A, Wood SK. Not replaced, but reinvented: AI education pathways to prepare future physicians to lead healthcare transformation. Perspect Med Educ. 2025 Nov 21;14(1):849-59.

18. Pollart SM, Mylona E, Buer T, et al. Exploring the impact of mentoring on faculty engagement and retention among behavioral health faculty in departments of psychiatry and neurology. J Clin Psychol Med Settings. 2024 Oct;31(4):712-22.

19. Nadkarni M, Helenius IM. Leading an academic medical practice. 2nd ed. Berlin (DE): Springer; 2023. Chapter 3, Faculty recruitment and retention; p. 27-37.

20. Sabato E, Doubleday AF, Lee CT, et al. Recommendations for remaining agile in the face of a dental faculty workforce shortage. J Dent Educ. 2023 Mar;87(3):295-302.

This article is open access and may not be copied, distributed or modified without written permission from the American Dental Hygienists' Association.

Appendix A

Structural Intervention Recommendations for the Dental Hygiene Educator Workforce

Redesign Compensation Models

- Increase base salaries to reduce the wage gap between clinical practice and academia.
- Provide additional financial support such as tuition assistance, release time, stipends for advanced credentials, and structured mentorship for clinicians transitioning into teaching.
- Expand tuition benefits for faculty and dependents to support long-term financial stability.
- Adopt holistic compensation models that integrate financial, structural, and life-stage supports (e.g., childcare subsidies, flexible work arrangements, hybrid schedules).

Expand Graduate Education Pathways

- Increase access to bachelor's and master's degree programs in regions with limited educational pathways.
- Provide institutional support for clinicians pursuing graduate degrees, including funding, release time, and mentorship.
- Align with professional recommendations encouraging advanced and doctoral-level preparation to strengthen academic and leadership capacity.

Strengthen Mentoring, Onboarding, and Institutional Support Systems

- Implement structured mentoring programs for early-career faculty and clinicians transitioning from clinical practice to academia.
- Develop intentional onboarding processes that clarify expectations, institutional culture, and teaching responsibilities.
- Ensure institutional support systems address structural pressures such as workload, role clarity, and resource availability.

Develop Sustainable and Equitable Workload Models

- Rebalance teaching, service, advising, accreditation, and clinical coordination responsibilities.
- Provide protected preparation time, instructional resources, and professional development opportunities.
- Reduce reliance on part-time faculty to prevent overburdening the small full-time core faculty.
- Implement workload policies that prevent burnout and support long-term retention.

Integrate Artificial Intelligence and Educational Technologies

- Use AI to streamline administrative tasks such as grading, scheduling, documentation, and content updates.
- Adopt adaptive learning platforms, virtual simulations, and automated feedback systems to reduce repetitive instructional tasks.
- Provide training and support to ensure faculty can use AI tools effectively and ethically, and in alignment with institutional policies.

Coordinate Multi-Level Action Across Institutions and Systems

- Align accreditation, compensation, and workforce development strategies across institutions, state systems, and professional organizations.
- Advocate for statelevel funding models that support competitive salaries and sustainable staffing.
- Collaborate with professional organizations to strengthen the educator pipeline and support long-term workforce sustainability.